

COLLEGE OF CHIROPRACTORS OF ONTARIO



**PUBLIC INFORMATION PACKAGE
FOR COUNCIL MEETING
FRIDAY, DECEMBER 4, 2015 – 8:30 A.M.
VOLUME 1**

RHPA

Duties and Objects of Colleges

Duty of College

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

Objects of College

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

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

Duty

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



COLLEGE OF CHIROPRACTORS OF ONTARIO MISSION AND STRATEGIC OBJECTIVES

MISSION

The College of Chiropractors of Ontario is the self-governing body of the chiropractic profession committed to improving the health and well-being of Ontarians by informing the public and assuring them of competent and ethical chiropractic care.

The College examines, registers and regulates the chiropractic profession and partners with other health professions, their licensing bodies, organizations and government.

*Developed at the strategic planning session in September 2004
Approved by Council on February 8, 2005*

STRATEGIC OBJECTIVES

1. Improve communication of the role, mandate and mechanism of CCO to key internal and external stakeholders.
2. Strive for unity in the public interest, while respecting the diversity within the profession.
3. Optimize chiropractic services in the public interest.
4. Continue to regulate in a fiscally responsible manner: Statutory mandate met and priorities set and appropriately resourced (human and financial).

*Developed at the strategic planning session: October 2010
Confirmed at the strategic planning sessions: September 2012, September 2013*

CCO CODE OF CONDUCT

Executive Committee

Approved by Council: September 28, 2012



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

1. be familiar and comply with the provisions of the *Regulated Health Professions Act, 1991 (RHPA)*, its regulations and the *Health Professions Procedural Code*, the *Chiropractic Act 1991*, its regulations, and the by-laws and policies of the College;
2. diligently take part in committee work and actively serve on committees as elected and appointed by the Council;
3. regularly attend meetings on time and participate constructively in discussions;
4. offer opinions and express views on matters before the College, Council and committee, when appropriate;
5. participate in all deliberations and communications in a respectful, courteous and professional manner, recognizing the diverse background, skills and experience of members on Council and committees;
6. uphold the decisions made by Council and committees, regardless of the level of prior individual disagreement;
7. place the interests of the College, Council and committee above self-interests;
8. avoid and, where that is not possible, declare any appearance of or actual conflicts of interests;
9. refrain from including or referencing Council or committee positions held at the College in any personal or business promotional materials, advertisements and business cards;¹
10. preserve confidentiality of all information before Council or committee unless disclosure has been authorized by Council or otherwise exempted under s. 36(1) of the *RHPA*;

¹ This section does not preclude the use of professional biographies for professional involvement.

11. refrain from communicating to members, including other Council or committee members, on statutory committees regarding registration, complaints, reports, investigations, disciplinary or fitness to practise proceedings which could be perceived as an attempt to influence a statutory committee or a breach of confidentiality, unless he or she is a member of the panel or, where there is no panel, of the statutory committee dealing with the matter;
12. respect the boundaries of staff whose role is not to report to or work for individual Council or committee members; and
13. be respectful of others and not engage in behaviour that might reasonably be perceived as verbal, physical or sexual abuse or harassment.

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

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

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

List of Commonly Used Acronyms at CCO

as at September 2010

Acronym	Full Name
ADR	Alternative Dispute Resolution
BCCC	British Columbia College of Chiropractors
BDC	Board of Directors of Chiropractic
CAC	Chiropractic Awareness Council
CBP	Chiropractic Biophysics
CCA	Canadian Chiropractic Association
CCEB	Canadian Chiropractic Examining Board
CCEC	Council on Chiropractic Education (Canada)
CCO	College of Chiropractors of Ontario
CCPA	Canadian Chiropractic Protective Association
CCRF	Canadian Chiropractic Research Foundation
CFCREAB / Federation	Canadian Federation of Chiropractic Regulatory and Educational Accrediting Boards
<i>Chiropractic Act</i>	<i>Chiropractic Act, 1991</i>
CMCC	Canadian Memorial Chiropractic College
CNO	College of Nurses of Ontario
COBA	Conference of Ontario Boards and Agencies
<i>Code</i>	<i>Health Professions Procedural Code, Schedule 2 to the RHPA</i>
CPGs	Clinical Practice Guidelines
CPSO	College of Physicians and Surgeons of Ontario
CRC	Chiropractic Review Committee
DAC	Designated Assessment Centre
FCCO(C)	Fellow of the College of Chiropractic Orthopedists (Canada)
FCCR(C)	Fellow of the Chiropractic College of Radiologists (Canada)
FCCRS(C)	Fellow of the College of Chiropractic Rehabilitation Sciences (Canada)
FCCS(C)	Fellow of the College of Chiropractic Sciences (Canada)
FCCSS(C)	Fellow of the College of Chiropractic Sports Sciences (Canada)
FCLB	Federation of Chiropractic Licensing Boards
FHRCO	Federation of Health Regulatory Colleges of Ontario
<i>HARP</i>	<i>Healing Arts Radiation Protection Act</i>
<i>HIA</i>	<i>Health Insurance Act</i>
HPARB	Health Professions Appeal and Review Board
HPRAC	Health Professions Regulatory Advisory Council
MOHLTC	Ministry of Health and Long-Term Care
MTCU	Ministry of Training, Colleges and Universities
OCA	Ontario Chiropractic Association
OHIP	Ontario Health Insurance Plan
<i>PHIPA</i>	<i>Personal Health Information Protection Act</i>
<i>PIPEDA</i>	<i>Personal Information and Protection of Electronic Documents Act</i>
<i>RHPA</i>	<i>Regulated Health Professions Act, 1991</i>
UQTR	Université du Québec à Trois-Rivières
WHO	World Health Organization
WSIB	Workplace Safety and Insurance Board

COLLEGE OF CHIROPRACTORS OF ONTARIO

Council Meeting

Friday, December 4, 2015 (8:30 a.m. – 4:00 p.m.) ¹

AGENDA (Public) ²

SECTIONS OF THE CODE FOR IN-CAMERA SESSIONS IF DIRECTED BY COUNCIL	Page No.	ITEM	Action Required	Action By	Priority Level ³
		CALL TO ORDER AND WELCOME ⁴		Hardick	<u>High</u>
		<i>Appoint Parliamentarian</i>		Hardick/ Council	
		1. Consent Agenda	Approve	Council	
	1	1.1 Discipline Committee Report			
	2	1.1.1 CCO v. Dr. Michael Reid (costs decision) ⁵			
	17	1.1.2 CCO v. Dr. Ernest Perry (decision re: finding)			
	44	1.1.3 CCO v. Dr. John Baird (Divisional Court and leave to Court of Appeal decisions) ⁶			
	50	1.1.4 Court decision dated September 24, 2015 re: Dr. Michael Venneri			

¹ Subject to Council's direction. Meeting to end no later than 4 p.m.

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

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

⁴ Please welcome Ms Wendy Lawrence to her first council meeting.

⁵ Dr. Reid is appealing the Discipline Committee's decisions re: finding, penalty and costs.

⁶ The Divisional Court dismissed Dr. Baird's appeal and the Court of Appeal dismissed Dr. Baird's motion for leave to appeal the Divisional Court decisions. Dr. Baird's reprimand is scheduled for Monday, December 7, 2015, and the Discipline Committee's decision has taken effect.

SECTIONS OF THE CODE FOR IN-CAMERA SESSIONS IF DIRECTED BY COUNCIL	Page No.	ITEM	Action Required	Action By	Priority Level ³
	61	1.1.5 FHRCO Discipline training session (October 22,23, 2015) ⁷			
	64	1.2 Inquiries, Complaints and Reports Committee			
	65	1.2.1 HPARB decision dated September 1, 2015 re: Dr. Pisarek			
	76	1.3 Fitness to Practise Committee Report			
		2. Adoption of Agenda	Adopt	Council	<u>High</u>
		3. Adoption of Minutes ⁸			
		4. Committee Reports			
	107	4.1 Executive Committee Report	Verbal Report/ Approve recommendations/ Ratify decisions made in-camera	Hardick/ Council	
Ss. 7 (2) (b)(c) (d)(e)		<i>Move In Camera</i>			
		<i>Office Development Project ^{9 10}</i>	Verbal Report/ Review	Smiley/ Council	<u>High</u>

⁷ Dr. Reginald Gates attended the advanced training.

⁸ Only members present at the meeting should approve the minutes.

⁹ Mr. Neil Smiley will be attending the meeting to provide a verbal report.

¹⁰ Council previously approved submission of applications re: the official plan, rezoning (to allow for the proposed height and density) and site plan approval.

SECTIONS OF THE CODE FOR IN-CAMERA SESSIONS IF DIRECTED BY COUNCIL	Page No.	ITEM	Action Required	Action By	Priority Level ³
		<i>Move out of camera and ratify decisions</i>			
		<i>Ministry of Health and Long-Term Care</i>			
	501	4.1.17 Background information re: CCO public appointments	Welcome!	Council	
	513	4.1.18 Information re: public member information/training (including mandatory accountability sessions)	Verbal Report	Public Members	Medium
	577	4.1.19 Communications starting October 9, 2015 re: Transparency Working Group	FYI		
	583	4.1.20 Minister Hoskins remarks at HealthAchieve November 4, 2015	FYI		
	592	4.1.21 Health Insurance Act Regulation Amendment (dated September 18, 2015)	FYI		
	593	4.1.22 Toronto Star article dated October 21, 2015 “ <i>Health Minister aims to investigate MD pay</i> ”			
	594	4.1.23 Communications from Health Professions Appeal and Review Board	FYI		
		<i>Health Professions Regulatory Advisory Council (HPRAC)</i>			
	602	4.1.25 Information re: referral to HPRAC of RN prescribing	FYI		

SECTIONS OF THE CODE FOR IN-CAMERA SESSIONS IF DIRECTED BY COUNCIL	Page No.	ITEM	Action Required	Action By	Priority Level ³
		Other Chiropractic/Health Related Stakeholders	Primarily FYI subject to questions and verbal reports		
	615	<i>Ontario Chiropractic Association(OCA)</i> 4.1.26 Correspondence dated September 30, 2015 re: request for briefing on Clinic Regulation ¹¹			
	617	4.1.27 Correspondence dated November 13, 2015 re: OCA AGM			
	619	4.1.28 Notice re: Chiropractic Care and Neck Pain: A Primer			
	678	<i>Federation of Canadian Chiropractic (FCC)¹²</i> <i>Canadian Chiropractic Examining Board (CCEB)</i> <i>Canadian Memorial Chiropractic College (CMCC)</i> 4.1.31 Invitations re: Presentations at CMCC including Mr. Friedman's presentation on November 12, 2015			
	693	<i>Canadian Chiropractic Association (CCA)</i> 4.1.32 Miscellaneous Bulletins			
	698	4.1.33 Canadian Clinical Guidelines Initiative – 3 year report to stakeholders			

¹¹ There will be a briefing of all associations on the topic of clinic regulation facilitated by the College of Physiotherapists.

¹² The next FCC meetings are in Toronto on November 28, 2015. Drs Hardick and Shankar and Ms Willson are scheduled to attend.

SECTIONS OF THE CODE FOR IN-CAMERA SESSIONS IF DIRECTED BY COUNCIL	Page No.	ITEM	Action Required	Action By	Priority Level ³
		<i>Chiropractic Awareness Council (CAC)</i>			
	712	4.1.34 Bulletin dated November 2, 2015 re: Chiropractic Masters (Dr. Reid)			
		<i>Federation of Health Regulatory Colleges of Ontario</i>	Verbal Report	Willson	Medium
	716	4.1.35 Court order dated October 27, 2015 giving FHRCO intervenor status			
	742	4.1.39 News Release dated November 20, 2015 re: Recommendations to Strengthen the Ontario College of Trades			
	759	4.1.40 FHRCO Legislative Updates – August and October 2015			
	818	4.2 Advertising Committee Report	Verbal Report/ Approve Recommendations	Lambert/ Council	<u>High</u>
	820	4.2.1 S-016: Advertising (revised)	Approve for distribution and feedback	Council	<u>High</u>
	825	4.2.2 S-016: Advertising (current)	FYI		
	830	4.2.3 G-016: Advertising (revised)	Approve for distribution and feedback	Council	<u>High</u>
	839	4.2.4 G-016: Advertising (current)	FYI		
	846	4.2.5 P-016: Public Display Protocol	FYI		

SECTIONS OF THE CODE FOR IN-CAMERA SESSIONS IF DIRECTED BY COUNCIL	Page No.	ITEM	Action Required	Action By	Priority Level ³
	852	4.2.6 Extracts of Council minutes re: Advertising	FYI		
	861	4.2.7 Various background information re: advertising	FYI		
	873	4.3 Patient Relations Committee Report	Verbal Report/ Approve Recommendations	McCutcheon/ Council	<u>High</u>
	875	4.3.1 G-001: Communication with Patients (new)	Approve	Council	<u>High</u>
	881	4.3.2 G-001: Prevention of Sexual Abuse of Patients	Revoke	Council	<u>High</u>
	889	4.3.3 680 News Marketing Proposal ¹³	Approve	Council	Medium
	894	4.4 Quality Assurance Committee Report	Verbal Report/ Approve Recommendations	Gleberzon/ Council	<u>High</u>
	897	4.4.1 S-009: Chiropractic Care of Animals (revised)	Approve	Council	<u>High</u>
	902	4.4.2 S-009: Chiropractic Care of Animals	FYI		
	907	4.4.3 S-013: Consent	Discuss	Council	Medium
	915	4.4.4 CCO Communique – January 2009	FYI		
	919	4.4.5 P-051: Peer Assessors	FYI		
	922	4.5 Registration Committee Report	Verbal Report/ Approve Recommendations	Starmer/ Council	<u>High</u>

¹³ Consider as part of budget discussion?

SECTIONS OF THE CODE FOR IN-CAMERA SESSIONS IF DIRECTED BY COUNCIL	Page No.	ITEM	Action Required	Action By	Priority Level ³
	924	4.5.1 P-053-Returning to the General Class of Certificate of Registration (revised)	Approve	Council	<u>High</u>
	928	4.5.2 P-053: Returning to the General Class of Certificate of Registration (current)	FYI		
	932	4.5.3 2016 Registration Renewal and P-029: Chiropractic Specialties	FYI		
	935	4.5.4 Various Information re: Fairness Commissioner	FYI		
		5. New Business	Review/ Provide policy direction/ action	Council	Medium
		<i>Current CCO Mechanisms</i>			
	963	5.3 Undertaking from Election Candidates			
	965	5.4 CCO Code of Conduct			
	966	5.5 Confidentiality Undertaking for Council Members			
	968	5.6 Canadian Lawyer article dated September 2015 “ <i>Social media e-discovery: its time is here</i> ”	FYI		
		6. For Your Information	FYI (subject to questions)		
	970	6.1 Historical Overview re: legislative and administrative steps from Dr. Wingfield (November 8, 2015)			
	976	6.2 Information re: ICA Pediatrics Program (from Dr. Liz Anderson-Peacock)			

SECTIONS OF THE CODE FOR IN-CAMERA SESSIONS IF DIRECTED BY COUNCIL	Page No.	ITEM	Action Required	Action By	Priority Level ³
	981	6.3 Canadian Chiropractic article dated October 2015 “ <i>B.C. ramps up plan for new chiropractic school</i> ”			
		<i>Information from Other Regulators College of Denturists of Ontario</i>			
	982	6.4 Announcement dated November 6, 2015 re: Dr. Glenn Pettifer appointed Registrar			
		<i>College of Naturopaths of Ontario</i>			
	983	6.5 Advisory dated August 27, 2015 re: Professionalism when interacting with the College			
	986	6.6 Extract from Newsletter (November 2015)			
		<i>College of Nurses of Ontario</i>			
	998	6.7 Proposed amendments to Register By-laws			
	1003	6.8 Information dated November 9, 2015 re: Regulators’ Nursing Exam			
		<i>College of Psychologists of Ontario</i>			
	1011	6.9 Announcement dated November 3, 2015 re: Appointment of Dr. Rick Morris as Registrar and Executive Director			
		<i>College of Physicians and Surgeons of Ontario</i>			
	1012	6.10 Extract from Dialogue (Volume 11, Issue 3)			
	1017	6.11 National Post article dated October 25, 2015			
		<i>College of Traditional Chinese Medicine and Acupuncturists of Ontario</i>			
	1021	6.12 Invitation to Understanding Scope of Practice Symposium on November 30, 2015 ¹⁴			

¹⁴ Mr. Joel Friedman will be attending.

SECTIONS OF THE CODE FOR IN-CAMERA SESSIONS IF DIRECTED BY COUNCIL	Page No.	ITEM	Action Required	Action By	Priority Level ³
	<i>1024</i>	6.13	Grey Areas(September, October 2015 Editions)		
	<i>1029</i>	6.14	Council Member Terms Chart (October 14, 2015)		
		DATE AND TIME OF MEETINGS ¹⁵			

¹⁵ Please mark your Calendar and Advise Rose Bustria ASAP if you are unable to attend any meetings.

Executive Committee Meeting Dates to June 2016

All Executive Committee meetings are at CCO and are scheduled from 8:30 a.m. – 5:00 p.m. unless otherwise noted.

Year	Date	Time	Event	Location
2016	Tuesday, January 26	8:30 a.m. – 5 p.m.	Meeting	CCO
	Tuesday, March 22	8:30 a.m. – 5 p.m.	Meeting	CCO
	Tuesday, May 31	8:30 a.m. – 5 p.m.	Meeting	CCO

Council Meeting Dates to October 2016

All Council meetings are at CCO and are scheduled from 8:30 a.m. – 4:30 p.m. unless otherwise noted. Scheduled meeting/event dates are as follows:

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

Year	Date	Time	Event	Location
2015	Friday, December 4	8:30 a.m. – 4:30 p.m.	Meeting	CCO
	Friday, December 4	Evening	Holiday Party for Council and Staff	McLean Estate, Estates of Sunnybrook
2016	Tuesday, February 23	8:30 a.m. – 4:30 p.m.	Meeting	CCO
	Tuesday, April 19	8:30 a.m. – 4:30 p.m.	Meeting	CCO
	Wednesday, April 20	8:30 a.m. – 2 p.m.	Meeting (Elections/ Orientation)	CCO
	Wednesday, June 15	6 p.m. – 10 p.m.	Annual General Meeting	TBD
	Thursday, June 16	8:30 – 4 p.m.	Meeting	CCO
	Thursday, September 15	8:30 – 4 p.m.	Meeting	Elmhurst Resort
	Friday, September 16	8:30 – 1 p.m.	Strategic Planning Refresher	Elmhurst Resort

**College of Chiropractors of Ontario
Discipline Committee Report to Council
Friday, December 4, 2015**

1

Core Members: Mr. Scott Sawler, *Chair*
Dr. Angela Barrow, *non-Council member*
Dr. Roberta Koch, *non-Council member*
Ms Judith McCutcheon
Dr. Brian Schut, *non-Council member*
Dr. Vikas Puri, *non-Council member*
Dr. David Starmer
Dr. Pat Tavares

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

Since the last report to council on September 17, 2015, there has been one meeting of the committee on September 26, 2015 by teleconference. Recommendations are anticipated for the February 23, 2016 Council meeting.

The meeting discussed the budget for the discipline committee in the coming year which was brought forward to executive committee and will be brought forward to council. Additionally, discipline panel members expressed interest to explore the preparation of guidance documents and education seminars for panel members. This will be brought forward to executive committee and council once the discipline panel concludes discussions.

One hearing was heard since the last council meeting on Wednesday, September 16, 2015 at 1 p.m. a discipline panel heard Dr. Enrico DiNardo's case.

The Discipline Committees decisions and reasons for the following matters have been released to the parties:

- Dr. Michael Reid (Costs) and
- Dr. Ernest Perry.

On October 23, 2015, Dr. Reginald Gates attended the FHRCO's advanced discipline orientation. All Council members are potential members of a discipline panel and are encouraged to take advantage of the FHRCO's training sessions.

I would like to thank the members of the Discipline Committee for their time and commitment: Dr. Angela Barrow, Dr. Roberta Koch, Dr. Vikas Puri, Dr. Brian Schut, Ms Judith McCutcheon, Dr. David Starmer and Dr. Pat Tavares. I would also like to extend my thanks to all members of council who have given their time to serve on panels.

Respectfully submitted,

Mr. Scott Sawler
Chair, Discipline Committee

INTRODUCTION

Following a hearing on liability regarding Dr. Michael Reid ("Dr. Reid" or the "Member") which took place July 28, 29, 30, 31 and August 14 and 15, 2014 before a panel of the Discipline Committee (the "Panel") a penalty hearing was held. In the conclusion section of the Panel's Decision and Reasons on Penalty dated March 18, 2015, the Panel invited the parties to provide dates to the Panel for when the parties could make submissions on costs.

The parties agreed that they would make those submissions in writing. However as of June 1, 2015, they could not agree on a timeline or process for the submissions. The Chair of the Panel reviewed the email communications between the parties regarding their attempts to agree on how the submissions would be made, on which ILC had been copied. Mr. MacKay then received advice from ILC, and the parties were given an opportunity to comment on that advice. The Chair ultimately set out a schedule and process for making the written submissions. That decision on process can be found at Appendix "A" of this Decision and Reasons for the Decision on Costs.

As a result of following that process, and having regard to the submissions of the parties as set out below, the Panel orders Dr. Michael Reid to pay costs to the College in the amount of \$166,194.50

OVERVIEW

The hearing into allegations of professional misconduct against Dr. Reid took place before the Panel at the College of Chiropractors of Ontario (the "College") on July 28, 29, 30, 31, August 14, and 15, 2014. The allegations against the Member were set out in two Notices of Hearing. One with respect to a complaint made by another chiropractor, Dr. Chris Paynter (this Notice bore the title, "Paynter Complaint"), and the other with respect to behaviour allegedly constituting "Obstructing of Investigation" and bearing that title.

In relation to the Paynter Complaint, the Panel, in its Decision dated November 18, 2014, found that Dr. Reid committed acts of professional misconduct in that:

- I. He committed an act of professional misconduct as provided by subsection 51(1)(c) of the Health Professionals Procedural Code of the *Chiropractic Act*, 1991, S.O. 1991, c. 21, as amended, and paragraph 1(2) of *Ontario Regulation 852/93*, in that during 2011- 2012, he contravened a standard of practice of the profession and failed to maintain the standard of practice expected of members of the profession.
- II. He committed an act of professional misconduct as provided by subsection 51(1)(c) of the Health Professionals Procedural Code of the *Chiropractic Act*, 1991, S.O. 1991, c. 21, as amended, and paragraph 1(33) of *Ontario Regulation 852/93*, in that he engaged in conduct or performed an act, that, having regard to all the circumstances, would reasonably be regarded by members as unprofessional, and in particular with respect to your conduct towards, and communications to, Dr. Chris Paynter during 2011 and 2012.

In relation to Obstructing of Investigation, the Panel, in its Decision, found that Dr. Reid committed acts of professional misconduct in that:

- I. He committed an act of professional misconduct as provided by subsection 51(1)(c) of the Health Professionals Procedural Code of the *Chiropractic Act*, 1991, S.O. 1991, c. 21, as amended, and paragraph 1(2) of *Ontario Regulation*

852/93, in that during 2012- 2013, he contravened a standard of practice of the profession and failed to maintain the standard of practice expected of members of the profession, including but not limited to S-020 – Cooperation and Communication with CCO.

- II. He committed an act of professional misconduct as provided by subsection 51(1)(c) of the Health Professionals Procedural Code of the *Chiropractic Act, 1991*, S.O. 1991, c. 21, as amended, and paragraph 1(28) of *Ontario Regulation 852/93*, in that you contravened the *Chiropractic Act, 1991*, the *Regulated Health Professions Act, 1991*, or the regulations under either of those Acts, and in particular, in 2013, you failed to co-operate fully with a CCO Investigator, contrary to section 76.(3.1) of the Health Professions Procedural Code, including but not limited to failing to respond in a meaningful manner to the CCO investigator's correspondence and to requests for an interview.
- III. He committed an act of professional misconduct as provided by subsection 51(1)(c) of the Health Professionals Procedural Code of the *Chiropractic Act, 1991*, S.O. 1991, c. 21, as amended, and paragraph 1(33) of *Ontario Regulation 852/93*, in that he engaged in conduct and performed an act, that, having regard to all the circumstances, would reasonably be regarded by members as unprofessional, and in particular with respect to:
 - i. his failure to respond in a meaningful and timely way to the CCO's requests in 2012 and 2013 to respond to complaint(s) made about him by Dr. Paynter; and
 - ii. his failure to co-operate fully with the CCO investigator in 2013.

The penalty hearing was held on February 2, 2015, the Panel's decision on Penalty, was released on March 18, 2015.

SUMMARY OF SUBMISSIONS ON COSTS

The College's submissions

In its submissions the College referred to the Panel's legislative authority to order costs in an "appropriate case".

The College asserted that a costs order was appropriate in this case due to a number of factors. The following are some of those factors:

- The serious nature of Dr. Reid's professional misconduct;
- Blatant and deliberate disregard for standards, guidelines and policies over a long period of time;
- Dr. Reid's failure to accept an offer to settle which contained lesser findings than were ultimately found by the Panel;
- The nature of Dr. Reid's defence which was mostly unsuccessful and resulted in a more protracted hearing; and
- The lack of mitigating factors.

The College provided written submissions laying out the details of these points.

In relation to the quantum of costs, the College provided a "Bill of Costs" summarizing the College's legal costs and expenses, the costs and expenses incurred in the investigation of the matter, and the costs and expenses incurred in conducting the hearing up to, but excluding the costs submissions. After the Member raised the issue of the level of detail in the bill of costs summary at paragraph 19 in his written cost submissions of June 12, 2014, the College provided supporting detail on June 25, 2015. The Member was given an opportunity to reply to those further details in advance of the Panel's deliberations.

In the circumstances, Mr. Paliare submitted that a cost order of \$211,816.52, which was 65% of the College's actual costs, would be fair and reasonable.

7

Dr. Reid's submissions

In his submissions Dr. Reid did not dispute that the Panel has the legislative authority to order costs. However, he made submissions as to why the costs awarded to the College should be lower than the amount sought.

The Member submitted that the Panel should give the offer to settle less weight than suggested by the College. The Member relied, in part, on the fact that the College "cannot cite a single case in which any professional disciplinary panel, in any jurisdiction, has considered rejected offers to settle as a factor in determining whether the case is an appropriate one to order costs."¹

With respect to the College's position that the nature of Dr. Reid's defence protracted the hearing, the Member pointed to the Agreed Statement of Fact ("ASF") which served to narrow the issues in dispute and shorten the hearing. Further, the Member asserted that it was the College who called witnesses to give *viva voce* evidence about facts already admitted by Dr. Reid in the ASF. Dr. Reid went on to say the cross-examination of Ms. De La Barra was prolonged by the witness's inability or refusal to answer question directly.

The Member referred to the lack of detail in the bill of costs and submitted that this resulted in difficulties for the Panel to assess the issue of quantum of costs².

¹ Member's submissions Paragraph 6(E)

² This was addressed when the College provided more detail in advance of the Panel's deliberations on costs.

The Member submitted that if the Panel were to order the quantum of costs sought by the College “without any justification of why the costs are reasonable”³ it would risk the creation of a system where members plead guilty to avoid the risk of financial catastrophe from an adverse costs award. Dr. Reid’s submission was that members have the right to make full answer and defence and a large costs order would undermine the Discipline Committee’s credibility. Further with respect of the quantum of costs the Member cited *Andersen v. St. Jude Medical Inc.*⁴ which speaks to the reasonableness of the rates charged and hours spent, and the need to avoid inconsistency with comparable awards in other cases. The Member referred to several of the cases cited in the College’s submissions and highlighted some of the differences between this matter and the cases cited. Dr. Reid also contrasted the legal fees he was billed for responding to the allegations with the College’s legal fees to prepare and make its case, and submitted that the College’s lawyer billed 6.5 times more.

The Member submitted that the quantum should not be more than Dr. Reid paid his own lawyers in legal expenses, an amount he stated was “less than \$32,000.00”.

Following advice from its Independent Legal Counsel, on which the parties were provided an opportunity to comment, the Panel deliberated to decide the issue of costs and prepare this decision and its reasons for the decision.

³ Member’s submissions paragraph 24

⁴ Tab 3, the Member’s written submissions

9

DECISION AND REASONS ON COSTS

AUTHORITY TO AWARD COSTS

A panel of the Discipline Committee has the authority to make an award of costs in favour of the College pursuant to s. 53.1 of the *Health Professions Procedural Code*, S.O. 1991, c. 18, Schedule 2. That section provides:

53.1 In an appropriate case, a panel may make an order requiring a member who the panel finds has committed an act of professional misconduct or finds to be incompetent to pay all or part of the following costs and expenses:

1. The College's legal costs and expenses.
2. The College's costs and expenses incurred in investigating the matter.
3. The College's costs and expenses incurred in conducting the hearing. 1993, c. 37, s. 15.

The section gives this Panel a broad discretion to make an award of costs in favour of the College in an "appropriate case".

The Panel reviewed the written submissions of the parties, as well as its own findings of professional misconduct and in respect of penalty in this matter. It relied on the following to reach its conclusion with respect to costs:

- The Member has the right to defend himself and make full answer and defence to allegations against him;
- Notwithstanding the Member's submission that "the conduct in this matter was not of the greatest severity or importance" and that it "was of moderate importance"⁵, the Panel accepts Mr. Gover's advice that when considering costs "the Panel should be governed by the findings that it made, and the parties'

⁵ Member's submissions Paragraph 40

relative success at the hearing”⁶ The Panel notes the College was successful with respect to all the allegations contained in both Notices of Hearing (although in relation to the allegation of “disgraceful, dishonourable or unprofessional” conduct, the Panel found that it was “unprofessional” rather than one of the more serious variants of this form of professional misconduct);

- In reviewing the transcripts⁷ and our recollections from the hearing, the Panel did not find that Ms. De La Barra was unable or refusing to answer questions directly in cross-examination. The manner of her oral evidence is more accurately described as normal for someone not used to being cross-examined and is unfamiliar with the hearing process;
- With respect to the Member’s submission that there is no other decision that can be looked to where failure to accept an offer to settle was a factor, one only need look to the *CCO v. Dr. Baird* decision on costs released February 7, 2015. Dr. Reid’s own submissions on costs reference this case.

On May 14, 2014, prior to the beginning of the hearing on liability, the College made an offer to settle which included a suspension of the Member’s certificate for 12 months, a reprimand, terms conditions and limitations, admitting to four acts of misconduct, and a costs order in the range \$12,500-\$30,500.00. This is considerably less than the \$211,816.52 now being sought by the College for costs. In not accepting that offer:

- Dr. Reid failed to recognize his misconduct;
 - The costs to establish the acts of misconduct at the contested hearing of July 28-31, August 14 and 15, 2014 became \$325,871.57; and
 - the Panel made 5 findings of misconduct against Dr. Michael Reid.
- Given the number and type of allegations and the fact that the parties had both entered into an Agreed Statement of Facts that narrowed the issues in dispute,

⁶ ILC advice letter July 9, 2015

⁷ Transcripts July 29, 2014 pages 19 thru 34

the six day hearing was longer than what would be expected. The Panel found that some of the reasons the hearing was protracted were:

- Dr. Reid's decision to argue that the word "required" means "voluntary, not mandatory and not enforceable". This was a position that took a good deal of time and was ultimately indefensible;
 - The time spent by Dr. Reid to argue that the policies of the College are simply recommendations and therefore he did not need to comply with them, also a position that was ultimately indefensible; and
 - Dr. Reid's inexplicable position that his conduct, which he admitted in the Agreed Statement of Facts, did not constitute acts of professional misconduct. The Panel found that this meritless defence was the primary cause of the lengthy hearing.
- With respect to the Member's submission that the College insisted that witnesses be called to give *viva voce* evidence about facts agreed to in the Agreed Statement of Facts contributed to the length of the hearing. As previously noted in the decision on the merits,⁸ those witnesses provided an understanding of the effect of Dr. Reid's various attempts to contact Dr. Paynter had on the staff of the office. This was not included in the Agreed Statement of Facts. The Panel noted this evidence was useful and had been relied on in coming to its findings.
 - The Member submitted that the Panel should consider how many lawyers the College utilized, their hourly rates, and the number of hours spent preparing for the hearing.
 - The Panel is aware there are different time demands in preparing a prosecution then there are in responding to prosecution. We have nothing before us indicating the usual or expected difference between legal costs for prosecuting and defending. This may address the Member's

⁸ CCO v. Dr. Reid, released November 18, 2014

submission that the College's lawyer bill was 6.5 times the amount billed by Dr. Reid's lawyers;

- The legal representation the College utilized during this matter was consistent with previous hearings at the College. Dr. Reid could have reasonably anticipated that it would be the same for his hearing when he made the choice to proceed with a contested hearing;
 - There was no evidence that Dr. Reid was somehow limited, financially or otherwise, in also choosing counsel that was "experienced and well versed in practice before of (sic) the Discipline Committee the CCO"⁹;
 - Both parties availed themselves of two lawyers at the hearing, and
 - Although the submissions by the parties indicate a difference in the hourly rates of the lawyers appearing at the hearing the Panel did not find them to be "excessive" as describe in the decision of Master Albert in *Stojanovic v. Bulut et al* when he commented on "\$925.00 per hour for 67 hours" in relation to a motion.
- Dr. Reid previously entered into an undertaking¹⁰ with the College where among other things, he agreed to, review and comply with "all of the College of Chiropractors of Ontario's standards of practice, guidelines, and policies". In choosing to engage in further acts that contrary to the standards of practice, guidelines, and policies of the College, he knew, or he ought to have known that further allegations of professional misconduct would result. Members of the College should not be held financial accountable for Dr. Reid's choices in this area.

Therefore this is an appropriate case where the Panel can award costs in favour of the College.

⁹ Member's submissions on costs: Paragraph 35

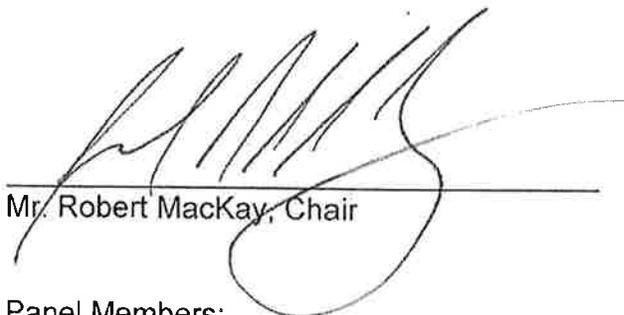
¹⁰ CCO v. Drs. Reid and Cloutier: June 28, 2012

The Panel reviewed the comparable cases put forward by both the parties. Although no other costs order bore the same fact pattern as this matter, the Panel considered the most similar cases for guidance in coming to its conclusion.

The Panel reminded itself that the costs order is not meant to be a penalty. Instead, it is meant to indemnify the College for (typically, a portion of) the costs it has incurred as a result of a member's professional misconduct. Having considered all of the relevant factors in the circumstances of this matter and what is fair and reasonable and for these reasons the Panel makes the following costs order:

The Member is to pay costs to the College of Chiropractors of Ontario approximately 51% of the College's bill of costs, namely of \$166,194.50.

I, **Robert MacKay**, sign this decision and reasons for costs on behalf of the members of the Discipline Panel as set out below.



Mr. Robert MacKay, Chair

Date: August 26, 2015

Panel Members:

- Mr. Robert MacKay
- Ms. Judith McCutcheon
- Dr. David Starmer
- Dr. Pat Tavares
- Dr. Bryan Wolfe

Appendix "A"**RULING ON ISSUES RELATED TO COSTS SUBMISSIONS**Introduction

These issues arise after the parties are unable to agree on a schedule or process for making costs submission to the Panel.

Back Ground

Dr. Michael Reid (the "Member") had findings of professional misconduct made against him which can be seen in the Panel's decision released November 18, 2014. These findings were made with respect to the hearing held July 28, 29, 30, 31, August 14 and 15, 2014.

A hearing on penalty was held February 2, 2015 and the decision on penalty released March 18, 2015. In that decision the Panel invited the parties to, among other things, make submission on costs.

On June 1, 2015 the Panel Chair was advised the parties had been unsuccessful in reaching an agreement on the process and timing of costs submissions. The parties agree with Mr. Brian Gover, Independent Legal Counsel ("ILC"), when he said; Mr. MacKay as Panel chair, can determine the issues related to a scheduling costs submission on the basis of subsection 4.(1) of the *Statutory Powers Procedure Act*.

Therefore, Mr. MacKay requested and received on consent the communications which Mr. Gover was copied on, between the parties in relation to scheduling. This clarified the efforts to date, and the issues as follows

- On April 26, after some apparent negotiations, the parties came to an agreement on a schedule for making costs submissions to the Panel. That agreement was made in emails prior to May 15, which were not provided to the Chair. Nonetheless it could be concluded from the subsequent emails that the parties agree they will make their submission in writing, the College to submit on May 15 and the Member's reply submissions to be on June 1, 2015. What is in dispute is whether or not the schedule was to be acted on or sent to the Panel for approval.
- On May 15, consistent with the purported April 26 agreement the College provides ILC with their costs submission.

- On May 27 Mr. Hakamali's letter on behalf of the Member, makes a new request to the Panel that they reserve their decision on costs until after two appeals that are underway in this matter. He implies he will not make Member's submission on costs on June 1, as they may differ after the appeals.
- May 28 the College replies to Mr. Hakamali's May 27 letter disagreeing with the notion that costs should be considered after the appeals are concluded.
- May 30 Mr. Hakamali's letter acknowledges there was an agreement made April 26 (without detailing what was agreed) and he reiterates his reasons for holding off on costs submissions until after the appeals. Confusingly this seems to contradict the agreement of April 26 which he clearly acknowledges.

Issues

1- Should the Panel receive the College's costs submission on costs outside the 20 day period prescribed by the *Rules*?

2- Should an accommodation be made in relation to the Member's responding submissions as to costs? and

3- Should the Panel reserve its costs decision until after the appeals?

ILC provided Mr. MacKay with advice on the issues and the parties were giving an opportunity to comment on that advice. The Panel Chair has reviewed and considered the advice and the replies to the advice.

Ruling and Reasons

Issue 1

In accepting the advice of ILC when he says the Panel has the power under Rule 2.4 to vary the 20 day requirement of Rule 25.1 I found we have discretion in this area. Furthermore the Panel already has exercised that power and varied the rule in this matter. See the Panel's decision on Penalty dated March 18, 2015, page 12, last paragraph, "Conclusion". were the parties are invited to make submissions on costs. This being 4 months after the release of the decision on liability the inference can be made that the 20 day rule was being varied. Furthermore, both parties have engaged in negotiations for a timetable for making submissions on costs. There can be no doubt the

Member knew costs were being sought and therefore there is no prejudice to the Member in varying the rule.

Issue 2

As the Panel does not have the agreement which set out a schedule for submissions on costs nor did it approve any agreement it cannot consider an accommodation to extend the purported June 1 submission date for the Member.

Therefor we set the deadline for Member's reply submissions to be one week from the date of this ruling. Thereafter the Panel will review the submissions, deliberate on costs and release its decision on costs in due course.

Note: Mr. Hakamali in his letter of May 30 said "before the panel engages in further deliberations on costs". The Panel has not seen any costs submissions. It is our practice when engaging in written submission to have ILC maintain the submissions and provide both to the panel at the same time. That way any one submission is not sitting with the Panel longer than the other.

Issue 3

I accept ILC's advice and the Panel will decide the matter of costs as soon as possible after submissions are received. It is in the public interest for the Panel to resolve the larger matter as soon as is reasonable.

Note: The delay has been in the parties not responding in a timely way to the Panels invitation to make costs submissions as stated in the March 18, 2015 decision.

I, **Robert MacKay**, sign this ruling and reasons for the ruling on behalf of the members of the Discipline Panel.

Mr. Robert MacKay

Date: June 4, 2015

DECISION AND REASONS

INTRODUCTION

[1] A hearing into allegations of professional misconduct against Dr. Ernest Perry took place before a panel of the Discipline Committee (the "Panel") of the College of Chiropractors of Ontario (the "College" or "CCO") April 27, 28, 29, 30, May 1 and June 18, 2015. The College has a mandate to regulate the practice of the chiropractic profession and to govern its members and, in so doing, serve and protect the public interest. The Panel has found that the Member engaged in professional misconduct by breaching subsections 51(1)(b.1) and (c) of the *Health Professionals Procedural Code* (the "Code") of the *Chiropractic Act, 1991*, S.O. 1991, c. 21, as amended, and paragraphs 1(2), 1(5), and 1(33) of *Ontario Regulation 852/93*. Below we elaborate on and explain that decision.

THE ALLEGATIONS

[2] The allegations against Dr. Ernest Perry ("Dr. Perry" or the "Member"), were stated in the Notice of Hearing, dated July 16, 2014. It was filed as Exhibit 1 and set out the allegations against Dr. Perry as follows:

Exhibit 1

1. You have committed an act of professional misconduct as provided by subsection 51(1)(b.1) of the *Health Professionals Procedural Code* of the *Chiropractic Act, 1991*, S.O. 1991, c. 21, as amended, in that during the period 2009 to 2013 you sexually abused a patient known as "L.M."
2. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professionals Procedural Code* of the *Chiropractic Act, 1991*, S.O. 1991, c. 21, as amended, and paragraph 1(2) of *Ontario Regulation 852/93*, in that in that during the period 2009 to 2013 you contravened a standard of practice of the profession or failed to maintain the standard of practice expected of members of the

profession with respect to your conduct toward and/or treatment of a patient known as "L.M."

3. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the Health Professionals Procedural Code of the *Chiropractic Act*, 1991, S.O. 1991, c. 21, as amended, and paragraph 1(5) of *Ontario Regulation 852/93*, in that during the period 2009 to 2013 you abused a patient known as "L.M." verbally and/or physically and/or psychologically and/or emotionally.
4. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the Health Professionals Procedural Code of the *Chiropractic Act*, 1991, S.O. 1991, c. 21, as amended, and paragraph 1(33) of *Ontario Regulation 852/93*, in that during the period 2009 to 2013 you engaged in conduct or performed an act, that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional regarding a patient known as "L.M."

RESPONSE TO ALLEGATIONS

[3] At the outset of the Hearing, the Member denied the allegations contained in the Notice of Hearing (Exhibit 1).

PRELIMINARY MATTER

[4] Mr. Paliare sought and the Panel granted an order pursuant to subsection 47(1) of the Code, namely that no person shall publish the identity of a witness whose testimony is in relation to allegations of a member's misconduct of a sexual nature involving the witness or any information that could disclose the identity of the witness, being the complainant known to us as "Ms. L.M."

OVERVIEW

[5] The facts underlying this matter arose after Ms. L.M. sought care from Dr. Perry in September of 2005. At issue is whether during the course of their interaction, there was concurrently a sexual relationship and a doctor-patient relationship existing between them. If there was such a relationship, the Panel is also required to assess the nature of the physical contact and other conduct: did it involve sexual intercourse or other forms of physical sexual relations, touching,

of a sexual nature, or behaviour or remarks of a sexual nature? Also in question is whether Dr. Perry failed to maintain the standards of practice with respect to his conduct toward and treatment of Ms. L.M.² and whether he verbally, physically, psychologically and/or emotionally abused her. The final point in question is whether Dr. Perry engaged in conduct or performed an act, that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable and unprofessional or not

SUMMARY OF EVIDENCE

[6] The Panel heard the testimony of two fact witnesses: Ms. L.M., called by the College; and Dr. Perry, who testified on his own behalf.

[7] Thirty-one documents were entered into evidence and filed as exhibits at the Hearing. The exhibits were particularly useful to the Panel in the following ways:

- **Exhibit 1** Notice of Hearing, dated July 16, 2014, established the specific allegations, the conduct alleged and the timelines of the allegations.
- **Exhibit 1A** is an Agreed Statement of Facts. This exhibit was admitted on an uncontested basis and was useful to the Panel in that it established the timing and some basic background information.
- **Exhibits 2, 3 and 21** consisted of the Member's Chiropractic Record for Ms. L.M., the Member's Statement of Accounts for Ms. L.M. and Excerpts from Day Sheets from the Member's office during the period December 19, 2011 – February 27, 2012. These

² Of particular significance in this respect are two College standards, Standard of Practice, S-014, *Prohibition Against a Sexual Relationship with a Patient* and Standard of Practice, S-002, *Record Keeping*. Neither party led expert evidence at the hearing.

exhibits were useful to the Panel in that they provided evidence to the Panel of the Member's record keeping with respect to Ms. L.M.

- **Exhibits 4 and 5** were photographs and a floor plan of First Chiropractic Care Centre. These assisted the Panel in understanding the events that were alleged to have taken place.
- **Exhibit 7** was a screen shot of some text messages Dr. Perry sent to Ms. L.M. These assisted the Panel in understanding the relationship between the Member and Ms. L.M.
- **Exhibits 11 and 26** were text messages between Dr. Perry and Ms. L.M., starting November 19, 2012, and continuing through to June 29, 2013. They were useful to the Panel as they demonstrated the type of communication that occurred between the Member and Ms. L.M.
- **Exhibits 16 and 17** consisted of two Standards of Practice, specifically, *The Prohibition Against a Sexual Relationship with a Patient* and *Record Keeping*. The CCO provides these documents to its members in furtherance of its mandate to regulate the profession. They were helpful in that they showed some of what the CCO does to communicate its expectations in relation to the conduct of its members.
- **Exhibits 18 and 19** Two volumes of email communication between Ms. L.M. and Dr. Perry. Volume 1 contained emails and Facebook messages from December 28, 2007 to October 13, 2011. Volume 2 contained emails and Facebook messages from October 17, 2011 to December 31, 2012. They were useful to the Panel in understanding the relationship between Dr. Perry and Ms. L.M.

- **Exhibit 20** was a Google map of Dr. Perry's office location in relation to Ms. L.M.'s home.
- **Exhibits 22, 24 and 30** were screen shots of Ms. L.M.'s Facebook page and the Facebook page of an alias Ms. L.M. created. They were useful to the Panel in determining Ms. L.M.'s credibility.
- **Exhibit 25** was a letter from Mr. David Diamond, a solicitor who Dr. Perry and his wife retained. The letter was directed to Ms. L.M. with respect to certain emails, text messages, phone calls and Facebook messages that will be described more fully elsewhere in our Decision and Reasons. This was useful to the Panel in the assessment of Ms. L.M.'s credibility.
- **Exhibit 27** was an email from Dr. Perry to Ms. L.M. with the subject line reading: NO CONTACT. This email was useful to the Panel in understanding Dr. Perry's reasons for discontinuing contact with Ms. L.M.
- **Exhibits 28 and 29** were email communications between the Member's wife and "cheatinghusbands1963". Dr. Perry alleged that Ms. L.M. was the author of the emails from "cheating husbands1963" email account.

DECISION

Onus and Standard of Proof

[8] The College bears the onus of proving the allegations. As for the standard of proof, we have applied the test set out in *F.H. v. McDougall*³ where the Supreme Court of Canada has made it clear that there is only one standard of proof in civil cases at common law, and that is proof on the balance of

³ 2008 SCC 53

probabilities, which can be expressed as it is more likely than not that the factual events underlying the allegations occurred. The evidence must be sufficiently clear, cogent and convincing to satisfy this test.

Credibility of Witnesses

[9] The Panel assessed credibility of witnesses by reference to the principles set out in the Divisional Court's decision in *Re: Pitts and Director of Family Benefits Branch* (1985), 51 O.R. (2d) 302. In that case, the Court suggested that members of administrative tribunals, which include Discipline Panels of this College, should consider the same criteria as jurors do when called upon to assess credibility. The Court referred to the standard jury instruction on credibility which is set out at Appendix "A".

[10] The Panel carefully weighed the factors set out in the standard jury instruction when it considered the credibility of the witnesses. Its assessment of the credibility of both witnesses who testified at the hearing is as follows:

Ms. L.M.

[11] Ms. L.M. had received treatment from Dr. Perry from September 2005 until November 2012. However, her interactions with Dr. Perry continued until July 2013. The Panel's assessment was that the witness did not appear to be credible in the majority of her testimony. For example, Ms. L.M. was unable to indicate whether Dr. Perry ejaculated or not in the treatment room at the time of the alleged sexual acts taking place.⁴ Ms. L.M. was also inconsistent with her description of her positioning during treatment when she alleged to have noticed Dr. Perry had an erection.⁵

[12] Throughout her testimony, the Panel noticed there were multiple times when Ms. L.M. could not recall the details of certain events that had occurred.

⁴ Transcript April 28, pages 150-151, 167; April 27 page 69

⁵ Transcript April 28, pages 139-143; April 27, pages 68-69

For example, Ms. L.M. could not recall what treatment room she was in or the time of day of her treatment on November 14, 2011 when she first alleged to have seen Dr. Perry with an erection.⁶ The Panel would have expected Ms. L.M. to remember the details surrounding an event such as this.

[13] Ms. L.M.'s evidence around her positioning during her treatment on November 14, 2011 did not make sense from a clinical or common sense perspective.⁷

[14] Ms. L.M.'s description of her own positioning and actions in the treatment room did not strike the Panel as being reasonable or probable. For example, Ms. L.M. testified that she was worried about the positioning of her gown and breast exposure during her treatment.⁸ However, she then claimed to have performed oral sex on Dr. Perry in a treatment room, while, just on the other side of the door, his reception area was filled with other patients.⁹

[15] Ms. L.M.'s memory was selective at times. For example, during cross-examination, Ms. L.M. either refused to answer or had a difficult time recalling many of the events or details being asked of her.¹⁰

[16] At the end of the second day of her testimony, Ms. L.M. shared her concern about being away from work for more than two days and testified that her job was on the line.¹¹ However, at the conclusion of her testimony, Ms. L.M. did not rush back to work, but instead, stayed to hear testimony from Dr. Perry.

[17] The evidence clearly showed the Panel that Ms. L.M.'s behaviour at times was of an emotionally charged and threatening nature. For example, in her text messages to Dr. Perry, she stated: *"It's time you start losing something"*; *"Now*

⁶ Transcript April 28, page 166

⁷ Transcript April 28, pages 124-125; 128-133

⁸ Transcript April 28, pages 170-171

⁹ Transcript April 28, pages 221-222

¹⁰ Transcript April 28, pages 34, 88-89, 116-117

¹¹ Transcript April 28, page 263

*I'm hurt and angry so watch out!"; "I warned you before."; "You brought this out in me so watch out."*¹² During one of her treatments, she walked out and slammed the door in Dr. Perry's face.¹³ Ms. L.M.'s Facebook page also showed a vindictive character. For example on her cover page it states: "*Screw me over and I'll do it to you twice as bad.*"¹⁴ On December 29, 2012, Ms. L.M. posted an article on her Facebook page from CBC Toronto, "Do No Harm: Doctors and Sexual Abuse". She then followed that up with two comments: "*This is for you. Take a look!*" "*Did you take a look yet? Is this the kind of things that scare you?*"¹⁵

[18] The evidence led the Panel to believe that Ms. L.M. was also capable of being responsible for the cheatinghusbands1963 emails and the cyber-bullying Dr. Perry and his wife underwent for 7 months. However, the events that came from cheatinghusbands1963 did not influence the Panel's decision, as it was not proven on the balance of probabilities.

[19] Mindful of the fact that it could accept some, none or all of any witness' testimony, the Panel concluded that it could not rely on all of Ms. L.M.'s testimony; some aspects of Ms. L.M.'s testimony were reliable, but others – particularly as they related to the alleged physical sexual relations between Ms. L.M. and the Member – were not.

Dr. Ernest Perry

[20] Dr. Perry is a chiropractor and the subject of these proceedings. The Panel's assessment of Dr. Perry was that he appeared to be largely honest throughout his testimony. This was shown through his willingness to admit his faults. During cross-examination by the College, he was forthright in admitting to his failures with respect to record keeping. He admitted to having coffee and lunches with Ms. L.M. and visits to her home.¹⁶

¹² Exhibit 11, pages 24-25

¹³ Exhibit 18, pages 1534-1535

¹⁴ Exhibit 30

¹⁵ Exhibit 24

¹⁶ Transcript April 30, page 131, May 1, page 35

[21] Dr. Perry's version of how the treatment took place on November 14, 2011 was clear and made sense clinically.¹⁷ In reaching this conclusion, the Panel relied on its professional members' expertise in assessing Dr. Perry's evidence, but not in the place of expert evidence in relation to chiropractic treatment. The Panel concluded that it was more likely that the treatment took place as described by Dr. Perry than as it was described by Ms. L.M.

[22] The Panel found that Dr. Perry's recollection of the events and evidence in question to be generally consistent even with regard to his omissions of fault. He was able to respond based on what he saw or experienced for the reasons we have already outlined.

[23] Throughout his testimony, Dr. Perry was clear that he had poor record keeping skills. For example, Dr. Perry testified that his computer system and his records did not always reflect the treatment delivered.¹⁸ Dr. Perry admitted that he should have but did not record the reported sexual advances made by Ms. L.M. during her January 26 and 30, 2012 treatments.¹⁹

[24] Dr. Perry did not give a clear response to the assertions made by Ms. L.M. on a few occasions. For example, on March 9, 2012 Ms. L.M. emailed the following: *"After all the time we have spent together both professional and personal and becoming quite intimate". "About our personal stuff...as I told you before we have the most "f%^&*" relationship! Obviously we are attracted to each other and that said we also have and will always have feelings for each other..." "I am not the one who always starts our make out sessions..."*²⁰ Dr. Perry had numerous opportunities to address and deny the obvious assertions of an intimate sexual relationship made by Ms. L.M. He did not deny them in his email communication with Ms. L.M. During the hearing, he did not provide the

¹⁷ Transcript April 30, pages 7-21

¹⁸ Transcript May 1, pages 119-120; Exhibit 2

¹⁹ Transcript April 30, pages 25-26; Exhibit 2 page 404; May 1, pages 25-28

²⁰ Exhibit 19, pages 2489-2490

Panel with an adequate explanation as to the lack of his denial to these allegations set out in emails from Ms. L.M.

[25] The Panel relied on Dr. Perry's evidence, but placed little weight on the reasons Dr. Perry offered with respect to his lack of responses to Ms. L.M.'s descriptive emails.

FINDINGS OF FACT

[26] The Panel made the following findings of fact which it relied upon to come to its conclusions as to whether the forms of professional misconduct alleged in this case had been committed.

Conduct Between Dr. Perry and Ms. L.M.

[27] The Panel relied heavily on the evidence given surrounding the treatments Ms. L.M. received in November and December 2011. Dr. Perry's description of his treatments made sense from a common sense and clinical perspective.²¹ Ms. L.M.'s description of her positioning and Dr. Perry's positioning during her treatment did not make sense, specifically, her arm positioning, Dr. Perry's positioning while massaging her left side, the placement of her gown and her lack of reaction to Dr. Perry supposedly having her full breast in his hand.²²

[28] Ms. L.M.'s description was inconsistent and not credible with respect to what occurred in the treatment room during her treatments in November and December 2011. Ms. L.M. claimed to have noticed that Dr. Perry had an erection, despite also claiming that the lights were off or dim and that she could only see shadows.²³

[29] On December 22, 2011, the first time Ms. L.M. alleged that Dr. Perry took his pants down, she was unable to testify what room she was in, what time of day

²¹ Transcript, April 30, pages 7-21

²² Transcript, April 28, pages 124-125; 129; 130; 137; 140-142

²³ Transcript, April 28, pages 139-140

it was, where she was coming from, where she was going or where his pants were in relation to his knees or ankles.²⁴

[30] Ms. L.M.'s response to whether Dr. Perry would have left the room with an erection changed on three occasions, first being evasive with her answer, then suggesting he gave her a manual adjustment and perhaps the erection went away and finally testifying that her treatment ended with a hug and a kiss.²⁵

[31] Ms. L.M. claimed that she performed oral sex on Dr. Perry during her treatments in the month of January 2012. The Panel was concerned that these events could not have transpired as described by Ms. L.M. Dr. Perry's day sheets showed that he booked more than one patient every 15 minutes. In January 2012, Dr. Perry's day sheets showed that there was anywhere from one to two other patients booked in the same 15 minute time slot as Ms. L.M. It seemed unlikely to the Panel that Dr. Perry could have Ms. L.M. on a TENS unit, massage her, de-robe himself, receive oral sex, rid himself of an erection, get dressed and then move on to adjust his next patients in the time frame allotted.²⁶

[32] Ms. L.M.'s testimony when questioned about whether Dr. Perry ejaculated or not when she claimed to have performed fellatio was inconsistent. Ms. L.M. testified that Dr. Perry ejaculated once during her treatment sessions then testified that she did not know if he ejaculated.²⁷

[33] Ms. L.M. claimed she was upset having to see the receptionist after leaving the treatment room on February 9, 2012 when Dr. Perry told her "this needs to stop" (referring to the sexual advances he claimed she made toward him). Yet seeing the receptionist after performing oral sex on Dr. Perry in the treatment room did not appear to have caused any reaction from Ms. L.M.²⁸

²⁴ Transcript, April 28, pages 166; 172

²⁵ Transcript, April 27, page 69; April 28, pages 150, 151, 167

²⁶ Transcript, April 28, page 178-184; Exhibit 21

²⁷ Transcript, April 28, pages 1780179

²⁸ Transcript, April 28, pages 193-196

[34] The Panel relied on the evidence given by Dr. Perry throughout the hearing but could not accept that the doctor-patient relationship was characterized by appropriate or normal behaviour between himself and Ms. L.M. Specifically, there was inappropriate behaviour that involved repeated boundary violations in going for coffee, lunches and home visits; in particular, those that occurred following Ms. L.M.'s supposed sexual advances.²⁹ Dr. Perry's behaviour was not consistent with a normal doctor-patient relationship. Dr. Perry demonstrated a lack of judgement with respect to the nature of his relationship with Ms. L.M. and he did not respond appropriately, thus violating the standard of practice.

[35] A reasonable response to Ms. L.M.'s March 9, 2012 email, "*I am not the one who always starts our make out sessions...*" and "*at this time our sessions are safe with me*" would be to address the comment in his reply email and be clear that there were no "make out sessions" if indeed there were not.³⁰ This reference to "make out sessions" called out for a denial by Dr. Perry; however, he failed to do so in the reply email to Ms. L.M., nor did he provide an adequate explanation at the hearing.

[36] At an earlier occasion, December 29, 2010, Ms. L.M. sent the following email: "*Our couple of incidents will be kept to ourselves. I do not "kiss and tell" as I hope you know and hopefully same goes for you?? By the way quite different of us but very good!*" Dr. Perry responds, "*ditto*".³¹ This response implied an agreement to Ms. L.M.'s email. Normal doctor-patient communication would suggest that Dr. Perry should have been clear in his response as to the kiss being inadvertent; a "mangiacake" mistake as he alleged in his testimony.

²⁹ Transcript, May 1, page 35, 37-39; April 30, pages 30-33; April 27, pages 97-98

³⁰ Exhibit 19, pages 2489-2490

³¹ Exhibit 18, page 1984

[37] On February 27, 2012, Ms. L.M. emailed the following to Dr. Perry: "*OR was it because you knew YOU weren't going to get anything out of the treatment. Now I know for sure that the only reason you were spending more time and massaging my neck out was that I would get in your pants and stuff!*" Once again, a comment of this kind screamed out for a denial or questioning of some sort from Dr. Perry. Instead he replied: "*Getting something never came into the equation and I/feel that is uncalled for*".³² Dr. Perry had numerous opportunities to address the obvious assertions of an intimate sexual relationship made by Ms. L.M.; however, he did not in the emails.

[38] Dr. Perry did not do what needed to be done to terminate the doctor-patient relationship. It was clear in the emails noted above that Ms. L.M. was looking for more than a doctor-patient relationship. Dr. Perry did not follow the *Standard of Practice S-014, Prohibition Against a Sexual Relationship with a Patient* with respect to communicating proper boundaries for the doctor-patient relationship, referring the patient to another chiropractor or documenting the actions on the patient's chart. Dr. Perry gave evidence that Ms. L.M. leaned into his groin on January 26, 30 and February 9, 2012. Dr. Perry did not document any of these actions by Ms. L.M., nor did he terminate her care at that time.³³

[39] Dr. Perry gave testimony that he told Ms. L.M. that he would provide her with care on an interim basis. She then made a pass at him, suggested they have "something on the side" and he "adamantly told her" that he could not be her chiropractor; however, when Ms. L.M. showed up at his office later that day, he still treated her. This is in direct violation of the standard of practice.³⁴

[40] Dr. Perry's actions appeared to be "grooming behaviour", whether intentional or not. Ms. L.M. had verbalized a clear break in her relationship with

³² Exhibit 19, pages 2472-2473

³³ Exhibit 16, S-014; Transcript, April 30, pages 25-27; May 1, pages 25-26; Exhibit 2, page 404

³⁴ Transcript, April 30, pages 30-33; May 1, pages 37-39; Exhibit 16, S-014

Dr. Perry and in many incidences, he re-initiated the relationship.³⁵ For example, Dr. Perry texted Ms. L.M., “*Should I take your silence as you not coming in today?*” An hour and a half later he texted her again, “*R u avoiding me?*”

[41] Dr. Perry had boundary issues with Ms. L.M. On March 29, 2012, Ms. L.M. emailed the following to Dr. Perry: “*I have a few things to talk with you regarding what happened between us on a personal level. I am not happy at all and how we left things on Monday. I am actually pissed. I will leave it up to you if and when you want to do this. Got the feeling tonite its not something you want to do. If I don't hear from you very soon I will assume that you do not want to talk and we can say our goodbyes.*” Again, an appropriate response would have been for Dr. Perry to address the personal matter that Ms. L.M. was referring to in her email. He should have set up proper boundaries to address the feelings Ms. L.M. had for him, specifically, referring her to a chiropractor outside of his office. Instead, on April 11, 2012, he went to Ms. L.M.'s house for lunch.³⁶

[42] On April 14, 2012, Ms. L.M. emailed Dr. Perry: “*You know I thought you were calling me this morning about what happened between us the other day at my place and walking out on me like that and possibly apologizing but instead you start blaming me for something I am still confused on as I was not really understanding you. Good bye Ernie*”. Dr. Perry agreed in his testimony that there was a note of finality in the email and their relationship could have ended at that time. However, Dr. Perry's reply came in the form of a number of texts in which he apologized and promised to be a better friend and treat her better.³⁷ Common sense would suggest that ending the relationship at this time would have been Dr. Perry's next logical step.

³⁵ Transcripts April 27, pages 52-57, 75-76, 77-78; April 28, pages 207-210, April 29, page 160; April 30, page 29; May 1, pages 31-32; Exhibit 18, pages 2114-2116, 2121-2122, 2160; Exhibit 19, page 2489; Exhibit 7, Exhibit 21, Day Sheets from Dr. Perry's Office, February 27, 2012; Exhibit 11, page 24

³⁶ Exhibit 19, page 2526; Transcript April 30, pages 39-40

³⁷ Exhibit 19, pages 2558-2559; Transcript, May 1, pages 80-81

[43] In Dr. Perry's email to Ms. L.M., dated July 4, 2013, he stated all the reasons why he did not want to maintain contact with her. Nowhere in his reasons did he mention the Facebook message Ms. L.M. sent to Dr. Perry's wife where Ms. L.M. claimed: "*I am the person who he has been cheating on you with.*"³⁸ Again, common sense suggests that if a relationship did not exist between Dr. Perry and Ms. L.M., the devastating results of receiving a message like this would definitely be a reason to not want further contact.

Record Keeping

[44] Dr. Perry's record keeping was clearly deficient. He admitted to having "sub par" notes and record keeping as per the Standard of Practice S-002.³⁹ Dr. Perry admitted he had no chiropractic records for L.M. from 2005-2009. He said he lost them.⁴⁰

[46] Dr. Perry admitted at least a portion of his documentation regarding Ms. L.M. was not correct. During the period August 17, 2009 to April 25, 2011, Dr. Perry kept computerized SOAP notes of treatments. Each note indicated Ms. L.M. had rated her symptoms on a pain scale as part of the assessment. Dr. Perry admitted that while he may not have requested a numeric value, he did assess improvement or deterioration of pain.⁴¹

[47] Dr. Perry admitted in cross-examination that his evidence regarding why Ms. L.M.'s treatment should be discontinued was at odds with his documentation in her chiropractic records. Dr. Perry admitted that he should have, but failed to document discontinuing Ms. L.M.'s care.⁴²

³⁸ Exhibits 13, 27

³⁹ Transcript, May 1, page 136

⁴⁰ Transcript, May 1, pages 115-116

⁴¹ Transcript, May 1, pages 119-120, 168-169; Exhibit 2, pages 56-57

⁴² Exhibit 18, pages 2018, 2033

[48] Dr. Perry's chart does not contain an entry for treatments on November 14, 16, or 17, 2011, although he billed Ms. L.M. for treatment on each of those dates.⁴³

[49] Dr. Perry did not document Ms. L.M.'s alleged sexual advances toward him in his charting (i.e.: touching his groin area). He admitted on cross examination that having a patient make a move for his crotch was unusual and a pretty dramatic thing that should have been documented.⁴⁴

[50] Dr. Perry admitted that he failed to document the treatment he gave Ms. L.M. on April 30, 2012, even though he acknowledged he had a professional obligation to document all patient treatments.⁴⁵

Emotional and/or Psychological Abuse

[51] Dr. Perry persistently re-initiated the relationship with Ms. L.M. and did not terminate the relationship with the patient. In fact, he persisted in contacting her.⁴⁶

[52] After April 25, 2011, Ms. L.M. discontinued treatment over the cost of an exercise ball. Eventually, Dr. Perry asked her if she wanted to come back for treatment.⁴⁷

[53] Dr. Perry admitted that he went to Ms. L.M.'s house on February 27, 2012 and April 11, 2012 following her alleged sexual advances. He went at a time he knew the children were away. He acknowledged that he could have met Ms. L.M. in a public place, a safe environment. Dr. Perry indicated that he thought it was "appropriate" to go to her home.⁴⁸ In the view of the Panel, going to Ms.

⁴³ Exhibit 3, page 203; Exhibit 2

⁴⁴ Transcript, April 30, pages 25-26, May 1, pages 25-28; Exhibit 2, page 404

⁴⁵ Transcript May 1, pages 82-32

⁴⁶ Exhibit 7

⁴⁷ Transcript, April 28, pages 64-68, April 29, page 207

⁴⁸ Transcript, April 30, pages 30-33, May 1, pages 37-39

L.M.'s home after her alleged sexual advances would appear to be inappropriate and again, not represent an example of a normal doctor-patient relationship.

[54] On September 17, 2012 Ms. L.M. indicated she did not want to deal with Dr. Perry anymore. She sent him an email indicating that everything in their personal stuff, friendship and business was done on his terms, and that "*I never would have done what we have done together if I don't have feelings and I thought the same from you then but now I know for sure you didn't and never have.*"⁴⁹ Rather than accept Ms. L.M.'s position that their relationship was over, Dr. Perry emailed her, asking for forgiveness and asking her out to lunch so they could discuss the situation.⁵⁰ Dr. Perry testified that he initiated contact with Ms. L.M. because "*I can't leave it like that. I can't just, you throw this out.*"⁵¹ It is clear that Ms. L.M. had feelings for Dr. Perry. It is the Panel's view that an appropriate response would have been to terminate the relationship. For whatever reason, Dr. Perry continued to try to resolve the differences between himself and Ms. L.M. and in so doing, created emotional anguish for Ms. L.M.

[55] On November 21, 2012, Dr. Perry went to Ms. L.M.'s house. After that visit, texts were exchanged between Dr. Perry to Ms. L.M. Ms. L.M. indicated in her texts that she was not okay after Dr. Perry's visit and went on to say that *it was way too easy for him and it was about time he lost something.* Dr. Perry indicated he wanted to meet with her on Monday for lunch, and repair the damage done to their friendship.⁵² The Panel finds Dr. Perry's repeated behaviour to be emotionally difficult for Ms. L.M.

⁴⁹ Exhibit 19, page 3085

⁵⁰ Exhibit 19, pages 3083-3085

⁵¹ Transcript, May 1, page 109

⁵² Exhibit 11, pages 23-24

OTHER

[56] We relied on the advice given to us by Mr. Gover, the Panel's independent legal counsel, for this hearing. Specifically, the Panel relied on the advice given on:

Evidentiary value of lack of denial:

[57] In an email to Dr. Perry, the complainant L.M. referred to "make out sessions".⁵³ When he responded to the complainant's email, Dr. Perry did not deny that "make out sessions" had taken place but responded to an aspect of her email.⁵⁴ The Panel asked about the use that they could make of this evidence.

[58] Mr. Gover advised us that the Member's failure to deny that he participated in "make out sessions" with the complainant might amount to an "implied admission". The leading Canadian evidence textbook puts it this way:

If it would be reasonable to expect a denial in the face of an accusation, then the party's failure to do so could constitute an implied admission against him or her. Much, of course, turns upon the circumstances to determine whether such an expectation is reasonable. Before such conduct can constitute an admission, the court must be satisfied that there is sufficient evidence from which a jury might reasonably find that the conduct amounted to an acknowledgement of responsibility.⁵⁵

[59] We were advised that in determining what use, if any, to make of this evidence, the Discipline Panel should carefully scrutinize the surrounding circumstances and ask itself whether the reference to "make out sessions" called out for a denial by Dr. Perry, and, if so, whether he has offered an adequate explanation for failing to deny it. If the Panel concluded that the complainant's

⁵³ See Exhibit 19, pp. 2488-2490 – email from L.M. to Dr. Perry sent on March 9, 2012 at 1:18 p.m., where the complainant stated, among other things, "*I am not the one who always starts our make out sessions*" and "*(a)t this time our sessions are safe with me*".

⁵⁴ See Exhibit 19, p. 2488 – the email from Dr. Perry to L.M. sent on March 12, 2012.

⁵⁵ A.W. Bryant, S.N. Lederman and M.K. Fuerst. *Sopinka, Lederman & Bryant – The Law of Evidence in Canada* (Third Edition)

allegation that “make out sessions” had taken place did call for denial and that the Member has not adequately explained his failure to make a denial, the Panel would be entitled to conclude that Dr. Perry admitted that what the complainant alleged actually took place.⁵⁶

Definition of “Disgraceful”, “Dishonourable” and “Unprofessional”:

[60] Allegation No. 4 refers to conduct falling under the so-called “basket clause” in paragraph 1(33) of *Ontario Regulation 852/93*, in which the Member is alleged to have “engaged in conduct or performed an act, that, having regard to all the circumstances, would reasonably be regarded by Members as disgraceful, dishonourable or unprofessional regarding a patient known as “L.M.”.

[61] Independent counsel advised us that “disgraceful”, “dishonourable” and “unprofessional” conduct could each be seen in a spectrum.

[62] “Disgraceful” conduct is conduct that has the effect of shaming the Member and, by extension, the profession. In order to be disgraceful, the conduct should cast serious doubt on the Member’s moral fitness and inherent ability to discharge the higher obligations the public expects professionals to meet.

[63] “Dishonourable” conduct is similar, but need not be as severe. However, “dishonourable” conduct is often the best description for conduct involving dishonesty or deceit. Such conduct is considered in most areas of law to be the most serious and worthy of sanction and in many cases dishonest conduct should also be regarded as “disgraceful”. Both dishonourable and disgraceful involve an element of moral failing. A Member ought to, or will, know that the conduct is unacceptable and falls well below the standards of a professional when he or she commits a disgraceful or dishonourable act. Conduct amounting to fraud, theft, public indecency or assault, would be examples of dishonourable or disgraceful conduct. In general, the more knowledge of the wrongfulness the

⁵⁶ Email from Mr. Brian Gover of Stockwoods, dated July 16, 2015. Counsel for the Member and College Counsel were both afforded an opportunity to comment on independent counsel’s advice.

Member had or ought to have had at the time of the conduct, the more it will tend to be “disgraceful” as opposed to merely “dishonourable”.

[64] By contrast, “unprofessional” conduct does not require any dishonest or immoral element to the act or conduct. Many courts have found that unprofessional conduct includes a “serious or persistent disregard for one’s professional obligations.” This term recognizes the general traits of good judgment and responsibility that are required of those privileged to practice the profession. Whether or not a Member commits an act that disgraces him or her and dishonours the profession, failure to live up to the standards expected of him or her can demonstrate that a Member is, simply put, not professional. However, mere errors in judgment, or discretionary decisions made reasonably (though the Panel might have made them differently) are not properly considered “unprofessional” conduct.⁵⁷

Definition of Grooming Behaviour:

[65] Based on Mr. Gover’s advice, the Panel understood “grooming” is behaviour that is intended to enlist someone else (typically having lesser power in the relationship) in some form of sexual activity. Whether “grooming” behaviour constitutes sexual abuse for the purposes of Allegation No. 1 in the Notice of Hearing requires consideration of the term “sexual abuse” of a patient by a member, as set out in subsection 1(3) of the *Health Professions Procedural Code*. Subsection 1(3) reads as follows:

Sexual abuse of a patient

(3) In this Code,

“sexual abuse” of a patient by a member means,

(a) sexual intercourse or other forms of physical sexual relations between the member and the patient,

⁵⁷ Email from Mr. Brian Gover of Stockwoods Barristers, dated July 16, 2015

- (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.

[66] Obviously, the aspect of this definition that is relevant is (c), “behaviour or remarks of a sexual nature by the member towards the patient”. Independent counsel advised us that it was for the Panel to determine whether the “grooming” behaviour to which it has referred, if found, falls within this definition.⁵⁸

CONCLUSION

[67] At the conclusion of the Hearing, the Panel invited and heard submissions from counsel for the College and counsel for the Member. In advance of our deliberations we received advice from independent legal counsel on the record and in the presence of the parties.

[68] After deliberation and consideration of the evidence, the parties’ submissions and independent legal counsel’s advice, we made a number of findings of professional misconduct. Below we explain these findings, which relate to Dr. Perry’s failure to establish proper boundaries for the doctor/patient relationship with Ms. L.M. and his serious and persistent disregard for his professional obligations.

[69] Having considered the various components of the definition of sexual abuse in subsection 1(3) of the Code, the Panel concluded that the College did prove that Dr. Perry sexually abused Ms. L.M. by touching of a sexual nature, of the patient by the member (paragraph 1(3)(b) of the Code). The Panel carefully weighed the surrounding circumstances around the emails between Dr. Perry and Ms. L.M. The Panel felt strongly that these emails called out for a denial from Dr. Perry; however, he failed to deny, for example, that he had engaged in “make out sessions” with the complainant and did not provide an adequate

⁵⁸ Email from Mr. Brian Gover of Stockwoods Barristers, dated July 23, 2015. This email was duly disclosed to both parties’ counsel.

explanation for failing to deny them. The Panel did not find that Dr. Perry sexually abused Ms. L.M. by having “sexual intercourse or other forms of physical sexual relations” with her (paragraph 1(3)(a) of the Code). In view of the Panel’s assessment of the credibility of Ms. L.M. and the Member, we concluded that there was no clear and convincing evidence that anything beyond “make out sessions” occurred between them. Did Dr. Perry engage in “behaviour or remarks of a sexual nature” toward Ms. L.M. (i.e., conduct described in s. 1(3)(c) of the Code)? The Panel accepts that Dr. Perry’s repeated failures to respect professional boundaries were accompanied by “touching of a sexual nature” (“make out sessions”) as explained above – and therefore concluded that the Member had engaged in “behaviour of a sexual nature” – but found no evidence upon which it could conclude that this behaviour was accompanied by remarks of a sexual nature on the part of Dr. Perry.

[70] Dr. Perry contravened the Standard of Practice, S-014, *Prohibition Against a Sexual Relationship with a Patient*. It clearly states that if a patient suggests or attempts to develop a sexual relationship, the doctor is to inform the patient of the restrictions and communicate proper boundaries for the doctor-patient relationship. The patient is to be referred to another chiropractor if the above actions do not resolve the situation. The actions are to be documented in the patient’s chart. Dr. Perry did not communicate or demonstrate proper boundaries for the doctor-patient relationship, in that he continued to have visits with Ms. L.M. either at her home or outside of the office after she had made alleged sexual advances toward him. Dr. Perry continued an email and texting relationship with Ms. L.M. The Panel felt it was beyond a normal doctor-patient relationship. It was unclear to the Panel whether Dr. Perry or Ms. L.M. initiated her transfer to another chiropractor within Dr. Perry’s office, however, the Panel was in full agreement that Ms. L.M. should have been transferred to a chiropractor outside of Dr. Perry’s office. Dr. Perry once again, violated boundaries by continuing to adjust Ms. L.M. “on the side” after this transfer occurred. Dr. Perry admitted to not documenting in the patient chart any of the

alleged sexual advances Ms. L.M. made toward Dr. Perry while she was receiving active treatment from him.

[71] Dr. Perry contravened the Standard of Practice, S-002, *Record Keeping*, in that he did not have a complete record of Ms. L.M.'s clinical notes. Ms. L.M.'s chiropractic records from 2005-2009 had been lost. Ms. L.M.'s health records did not contain entries for some treatments that had been billed. Dr. Perry did not document Ms. L.M.'s alleged sexual advances made toward him. He also did not document in Ms. L.M.'s health records that she had been referred to another health professional.

[72] The Panel concluded that Ms. L.M. experienced emotional abuse as a result of Dr. Perry's actions. Emails and texts in evidence at the hearing clearly showed that Ms. L.M. did have feelings for Dr. Perry. Evidence also showed that Ms. L.M. was upset in many situations with Dr. Perry's actions, comments or lack thereof. Dr. Perry's inability to communicate clear and proper boundaries to Ms. L.M. created emotional turmoil for her.

[73] The Panel gave careful consideration to the definitions of the terms "disgraceful", "dishonourable" and "unprofessional". The Panel concluded that Dr. Perry engaged in disgraceful behaviour in that his repeated boundary violations were at the heart of why this matter appeared before the Discipline panel. We also concluded that Dr. Perry's conduct was dishonourable. There was an element of moral failing in that he violated the college's standard of practice, *Prohibition Against a Relationship with a Patient*. Finally, the Panel concluded that Dr. Perry acted unprofessionally, having a serious disregard for maintaining the college's *Record Keeping* standard of practice.

[74] In the face of convincing evidence, both in the exhibits and in the testimony of the witnesses that support the findings of facts set out above, the Panel concluded that there is clear, cogent, and convincing evidence to support

the following findings of professional misconduct against the Member: Specifically, the Panel found that the College has met the required burden of establishing that Dr. Perry has committed the following acts of professional misconduct in relation to Exhibit 1, the Notice of Hearing:

1. Dr. Perry committed an act of professional misconduct as provided by subsection 51(1)(b.1) of the *Health Professionals Procedural Code of the Chiropractic Act, 1991*, S.O. 1991, c. 21, as amended, in that during the period 2009 to 2013 he sexually abused a patient known as "L.M."⁵⁹
2. Dr. Perry committed an act of professional misconduct as provided by subsection 51(1)(c) of the Health Professionals Procedural Code of the *Chiropractic Act, 1991*, S.O. 1991, c. 21, as amended, and paragraph 1(2) of *Ontario Regulation 852/93*, in that in that during the period 2009 to 2013 he contravened a standard of practice of the profession or failed to maintain the standard of practice expected of members of the profession with respect to his conduct toward and/or treatment of a patient known as "L.M."
3. Dr. Perry committed an act of professional misconduct as provided by subsection 51(1)(c) of the Health Professionals Procedural Code of the *Chiropractic Act, 1991*, S.O. 1991, c. 21, as amended, and paragraph 1(5) of *Ontario Regulation 852/93*, in that during the period 2009 to 2013 he emotionally abused a patient known as "L.M."
4. Dr. Perry committed an act of professional misconduct as provided by subsection 51(1)(c) of the Health Professionals Procedural Code of the *Chiropractic Act, 1991*, S.O. 1991, c. 21, as amended, and paragraph 1(33) of *Ontario Regulation 852/93*, in that during the period 2009 to 2013 he engaged in conduct or performed an act, that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable and unprofessional regarding a patient known as "L.M."

The parties are directed to make the necessary arrangements for attendance at a penalty hearing.

⁵⁹ It should be noted, however, that Dr. Perry's sexual abuse of the complainant was limited to "touching, of a sexual nature, of the patient by the member" and "behaviour of a sexual nature toward (Ms. L.M.) but did not include "sexual intercourse or other forms of physical sexual relations between the member and the patient".

I, **Angela Barrow**, sign this decision and reasons for the decision as Chair of this Discipline Panel and on behalf of the members of the Discipline Panel as listed below:



Angela Barrow, Chair

November 13, 2015

Date: November 13, 2015

Panel Members:

- Dr. Angela Barrow
- Ms. Georgia Allan
- Dr. Roberta Koch
- Ms. Judith McCutcheon
- Dr. Bryan Wolfe

Ontario Specimen Jury Instructions (Criminal) by the Honourable Mr. Justice David Watt Toronto: Carswell, 2008.

1. Did the witness seem honest? Is there any reason why the witness would not be telling the truth, when it was important to tell the truth?
2. Does the witness have an interest in the outcome of this case? Does the witness exhibit any partisanship, any undue leanings towards the side which called him or her as a witness?
3. The appearance and demeanour of the witness and the manner in which he or she testified. Did the witness appear and conduct himself or herself in an honest and trustworthy manner? It may be that he or she was nervous or confused in circumstances in which he or she found himself or herself while testifying. Is he a man or is she a woman who has a poor or faulty memory, and may that have some effect on his or her demeanour while testifying, or on the other hand, did he or she appear to us to be a witness who is shifty, evasive and unreliable?
4. Was the witness able to make accurate and complete observation about the issues that he or she testified? What opportunities or observations did he or she in fact have? What are his or her powers of perception? Some people are very observant and others are not very observant.
5. Does the witness's testimony make sound common-sense? Was it reasonable? Was it probable? Does the witness show a tendency to exaggerate in his or her testimony?
6. Did the witness have a good memory of the things about which he or she testified?
7. Was the witness's testimony reasonable and consistent with evidence that was provided on an earlier occasion?
8. Was the witness reporting on what they saw or heard or did they formulate evidence based on information received from other sources?

CITATION: Baird v. College of Chiropractors of Ontario, 2015 ONSC 1484
DIVISIONAL COURT FILE NO.: 2/14
DATE: 20150319

ONTARIO
SUPERIOR COURT OF JUSTICE
DIVISIONAL COURT

Sachs, Hambly and M. Edwards JJ.

BETWEEN:)	
)	
Dr. John Baird)	
)	<i>Jerome R. Morse</i> , for the Appellant
Appellant)	
)	
- and -)	
)	
College of Chiropractors of Ontario)	<i>Chris G. Paliare</i> , for the Respondent
)	
Respondent)	
)	
)	
)	HEARD at Toronto: March 3, 2015

2015 ONSC 1484 (CanLII)

H. SACHS J.:

Introduction

- [1] The Appellant is a chiropractor, who is appealing the decisions of the Discipline Committee of the College of Chiropractors of Ontario (the "Tribunal") finding him guilty of professional misconduct, suspending his licence for 15 months and ordering him to pay the Respondent's costs of the proceeding in the amount of \$80,000.
- [2] After the misconduct decision and the hearing with respect to penalty, but before the decision on penalty, the Appellant brought an application before the Tribunal seeking leave to file fresh evidence that he stated was relevant to the question of penalty, but not to the question of misconduct. A procedure was agreed to by all counsel for the hearing of that motion. That procedure did not involve the Tribunal actually looking at the fresh evidence. The Tribunal heard the motion and declined to receive the evidence.
- [3] The Appellant's central submission on this appeal is that the Tribunal erred in law on the fresh evidence application and that if it had received the fresh evidence, this would have had a fundamental effect on its decisions regarding misconduct, penalty and costs.

- [4] The Appellant argues that the Tribunal committed an error in law when it decided the fresh evidence motion without actually reviewing the evidence.
- [5] In making this submission, the Appellant relies on the Court of Appeal's articulation of the test for the admission of fresh evidence in *DeGroot v. Canadian Imperial Bank of Commerce*, [1999] 121 O.A.C. 327, 1999 CarswellOnt 1902, at para. 3:
- [t]he decision whether or not to reopen the motion was discretionary. While the test has been expressed in a number of ways, it essentially comes to this. The court must consider whether the evidence would probably have changed the result and whether that evidence could have been discovered by the exercise of reasonable diligence. The reasonable diligence requirement will, however, be relaxed in **exceptional circumstances** where necessary to avoid a miscarriage of justice.(emphasis added)
- [6] In deciding the fresh evidence application, the Tribunal found that the Appellant had not met the due diligence prong of the test for the admission of fresh evidence. According to the Appellant, the Tribunal could not decide whether this was one of those exceptional cases where the due diligence requirement should be relaxed without actually looking at the evidence.
- [7] There are two problems with this submission. First, in not looking at the evidence, the Tribunal was following a procedure that had been agreed upon by all the parties, including the Appellant. In these circumstances, the Tribunal was entitled to assume that this was not one of those exceptional cases where the due diligence requirement should be relaxed.
- [8] Furthermore, the Agreed Statement of Facts that the parties filed with respect to the fresh evidence motion would have reinforced this assumption. Specifically, the Tribunal was told that the Appellant's counsel did not believe that the fresh evidence would affect the findings of professional misconduct. If it would not have affected the findings of professional misconduct, the Tribunal was entitled to assume that it was not the kind of evidence whose receipt was necessary in order to avoid a miscarriage of justice.
- [9] Secondly, having been apprised of the evidence, it is clear to us that this is not one of those exceptional cases where the due diligence requirement had to be relaxed to avoid a miscarriage of justice. The evidence consists of an e-mail that the Appellant sent **after** all of the conduct giving rise to the findings of professional misconduct had occurred.
- [10] According to the Appellant, the e-mail establishes that after he was confronted by an insurance company investigator about the fact that he was letting a paralegal called Roland Spiegel use his electronic signature on forms that had been submitted to the insurance company, he wrote to Mr. Spiegel and told him that he should immediately stop using his name on the forms. The Appellant argues that this is important because the Tribunal was clearly disturbed by the fact that the Appellant did not take the steps they

would have expected him to take after his meeting with the investigator. According to the Tribunal, if the Appellant had not authorized Mr. Spiegel to use his signature in the way he did, surely he would have “contacted the authorities, or a lawyer, or at least send a letter asking Mr. Spiegel to cease and desist immediately”. (Tribunal Decision, July 19, 2013, page 16).

- [11] The meeting with the investigator occurred on April 1, 2009. The e-mail in question was sent two months later, on May 28, 2009 and it reads:

Hi Roland,

I must ask that effective immediately, you stop submitting applications with either my name or Dr. John Bennett’s name on it. Some insurance investigator got in Dr. Bennett’s face last week and he is pretty upset. I may lose my radiologist over this.

- [12] At best, this e-mail establishes that some two months after his meeting with the investigator, the Appellant took steps to contact Mr. Spiegel in writing. Furthermore, according to the e-mail, he did so, not because he was upset that Mr. Spiegel had been using his name and signature on forms that Mr. Spiegel submitted to the insurance company, but because another doctor was upset about having his name used on these forms.
- [13] This is hardly the kind of evidence that would have caused the Tribunal to re-assess its position that the Appellant’s conduct was not consistent with that of a man who had just found out that his signature was being used in an unauthorized manner. Nor would it have caused the Tribunal to re-assess its position that the Appellant did not take adequate steps to stop the conduct at issue from recurring.
- [14] The furthest the evidence would have gone is to establish that it took the Appellant two months, rather than four and a half months, to advise Mr. Spiegel in writing to stop using his name. In the context of the evidence as a whole, this difference was not significant. It certainly does not approach the kind of difference in evidence that marks the line between a just result and a miscarriage of justice.
- [15] The Appellant’s argument with respect to the reasonableness of the Tribunal’s decisions turns on his submission that if the Tribunal had seen the e-mail, it would not have done what it did. In particular, it would not have preferred the evidence of Mr. Spiegel over that of the Appellant when it came to the arrangement between the two men.
- [16] In this regard, it is important to note that at the hearing before the Tribunal, the Appellant testified that he had only given his electronic signature to Mr. Spiegel to use on one form. For the purposes of the appeal, the Appellant’s counsel conceded that it was reasonable for the Tribunal to find that this was not true; that the Appellant had allowed his signature to be used on a number of forms, not just one form. This is because Mr. Spiegel’s evidence to that effect was confirmed by the testimony of the insurance company investigator, who testified that the Appellant had admitted to her that he allowed Mr.

Spiegel “full reign to use his signature on forms, that he didn’t care what forms Mr. Spiegel used”. (Tribunal Decision, July 19, 2013, page 15). However, according to the Appellant, there was no evidence other than the evidence of Mr. Spiegel that the Appellant collaborated with Mr. Spiegel in coming up with a “scheme” to submit the forms in question to the insurance company. The Appellant denied being part of a scheme and, according to the Appellant, if the Tribunal had had the e-mail, the Tribunal would have believed him on this point.

- [17] There are several problems with this submission. First, as we have already found, the e-mail is not the kind of evidence that would have significantly impacted the Tribunal’s decision. Second, the Appellant is effectively seeking to have us re-try the case and to review the evidence with a view to having us re-assess the reasonableness of believing Mr. Spiegel over the Appellant. It is not our function to weigh evidence or make findings of credibility. Third, having conceded that it was reasonable for the Tribunal to disbelieve the Appellant’s evidence and accept Mr. Spiegel’s evidence about one crucial aspect of the relationship between the two men, why was it unreasonable for the Tribunal to make the same choice about the other aspects of that relationship?
- [18] While the Appellant mainly focused on the difference the e-mail would have made if it had been admitted into evidence, in reply, the Appellant appeared to be arguing that there was no evidence in the record that would have allowed the Tribunal to reasonably draw the inference that the Appellant was part of a scheme. We reject this submission. There was ample evidence from which the Tribunal could have reasonably drawn this inference.
- [19] For these reasons, the appeal is dismissed. In our view, the Tribunal reasonably exercised its discretion in refusing to admit the evidence at issue. Further, even if the evidence had been admitted, this would not have affected the reasonableness of any of the Tribunal’s decisions that are the subject of this appeal.
- [20] As agreed by the parties, as the successful party, the Respondent is entitled to its costs of the appeal, fixed in the amount of \$20,000.00, all inclusive.

H. SACHS J.

HAMBLY J.

M. EDWARDS J.

CITATION: Baird v. College of Chiropractors of Ontario, 2015 ONSC 1484
DIVISIONAL COURT FILE NO.: 2/14
DATE: 20150319

ONTARIO
SUPERIOR COURT OF JUSTICE
DIVISIONAL COURT

H. Sachs, Hambly & M. Edwards JJ.

BETWEEN:

Dr. John Baird

Appellant

– and –

College of Chiropractors of Ontario

Respondent

REASONS FOR JUDGMENT

H. SACHS J.

Released: 20150319

JOHN BAIRD
Appellant

-and- COLLEGE OF CHIROPRACTORS OF ONTARIO
Respondent

Court File No. M44900

COURT OF APPEAL FOR ONTARIO

BEFORE

CRONK J.A. PEPALL J.A.

DATE

19-OCT-15

DISPOSITION OF MOTION

Motion for leave to appeal dismissed,
with costs ^{of the motion} to the respondent, fixed in
the amount of \$1,500, inclusive of
disbursements and all applicable taxes.

*JA Cronk JA.
or Pepall JA
Pham JA*

ONTARIO
COURT OF APPEAL
LAUWERS J.A.

PROCEEDING COMMENCED AT
TORONTO

APPELLANT'S MOTION RECORD

MORSE SHANNON LLP
1 Adelaide Street East, Suite 1001
P.O. Box 196
Toronto, ON, M5C 2V9

Jerome R. Morse (21434U)
Tel: 416.863.1230
Fax: 416.863.1241

Lawyers for the Appellant

RCP-E 4C (July 1, 2007)

49

CITATION: Hyperbaric Oxygen Institute of Canada Inc. v. College of Physicians, et al., 2015 ONSC 6208
ST. CATHARINES COURT FILE NO.: 54641/13
DATE: 2015/10/09

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:)	
)	
Hyperbaric Oxygen Institute of Canada Inc.)	Richard Simmons,
)	for the Plaintiff/Respondent
Plaintiff/Respondent)	
)	
- and -)	
)	
The College of Physicians and Surgeons of Ontario, Dr. Rocco Gerace, Sandra Keough and Dr. Wayne A. Evans)	Michelle Gibbs,
)	for the Defendants/Moving Parties
)	
Defendants/Moving Parties)	
)	
)	
)	HEARD: September 24, 2015

2015 ONSC 6208 (CanLII)

THE HONOURABLE JUSTICE J.R. HENDERSON

ENDORSEMENT ON MOTION

INTRODUCTION

[1] The defendants bring this motion to strike the Statement of Claim pursuant to Rule 21.01(1)(b) on the ground that it discloses no reasonable cause of action, or in the alternative to dismiss the action pursuant to Rule 21.01(3)(d) on the ground that it is an abuse of process. In the further alternative, the defendants request a summary dismissal of the plaintiff's claim pursuant to Rule 20.

[2] The plaintiff, Hyperbaric Oxygen Institute of Canada Inc. (hereinafter called "HOIC"), submits that the claim should not be summarily dismissed. Further, HOIC submits

that if the Statement of Claim is deficient, the court should not strike the pleading, but rather the court should grant leave to amend the Statement of Claim.

THE BACKGROUND

[3] HOIC is a corporation that offers hyperbaric oxygen therapy (hereinafter called “HBOT”) at a clinic in St. Catharines, Ontario. HOIC is owned and controlled by a chiropractor, Dr. Michael Venneri (hereinafter called “Venneri”).

[4] The defendant, the College of Physicians and Surgeons of Ontario (hereinafter called “the College”), is an entity created by statute that is empowered to regulate the practice of medicine in Ontario, and to govern the medical doctors who are members of the College. At all material times the named defendants in this action acted as employees or agents of the College.

[5] As a chiropractor, Venneri is not permitted to administer HBOT; rather HBOT must be administered by a medical doctor. Venneri is not a medical doctor and is not a member of the College. Therefore, as part of its business practice, HOIC employed medical doctors who provided HBOT to patients who attended the clinic.

[6] Pursuant to the *Regulated Health Professions Act*, 1991, S.O. 1991, c. 18 (hereinafter called “the *RHPA*”) and Schedule 2 to the *RHPA*, known as the *Health Professions Procedural Code* (hereinafter called “the *Code*”), the College has the power to investigate any member for an act of professional misconduct or incompetence.

[7] In 2011, the College commenced an investigation into the medical doctors who were employed by HOIC. Subsequently, five staff medical doctors resigned their positions with HOIC, and signed undertakings that they would not practice in the area of hyperbaric oxygen therapy.

[8] HOIC claims that the investigation conducted by the College was unlawful and done in bad faith. It is alleged that the College pressured the five medical doctors into resigning from HOIC. Because HOIC was dependent upon the medical doctors for the provision of HBOT, HOIC claims that the College caused it to suffer economic loss.

[9] In addition, HOIC claims that the College has failed to prescribe any standards for the provision of HBOT, and it further claims that the College has failed to produce the College's files that relate to the investigation of the five medical doctors.

[10] In its Statement of Defence, the defendants submit that at all times the College acted in good faith and in accordance with the governing legislation. The defendants acknowledge that the College did not have a formal policy for the provision of HBOT, but as in similar cases the College relied upon the expertise of its members to identify the expected standards. The College also relies upon s. 36(3) of the *RHPA* in support of its decision not to release the investigation files that were requested by HOIC.

THE LEGISLATION

[11] Rule 21.01(1)(b) reads, "A party may move before a judge,(b) to strike out a pleading on the ground that it discloses no reasonable cause of action or defence."

[12] Rule 21.01(3)(d) reads, "A defendant may move before a judge to have an action stayed or dismissed on the ground that,(d) the action is frivolous or vexatious or is otherwise an abuse of the process of the court."

[13] With respect to the request under Rule 20, the defendants rely on Rule 20.04(2)(a), which reads as follows, "The court shall grant summary judgment if, (a) the court is satisfied that there is no genuine issue requiring a trial with respect to a claim or defence;"

[14] Certain provisions of the *RHPA* must also be considered as follows:

36. (1) Every person employed, retained or appointed for the purposes of the administration of this Act, a health profession Act or the *Drug and Pharmacies Regulation Act* and every member of a Council or committee of a College shall keep confidential all information that comes to his or her knowledge in the course of his or her duties and shall not communicate any information to any other person except,

36. (2) No person or member described in subsection (1) shall be compelled to give testimony in a civil proceeding with regard to matters that come to his or her knowledge in the course of his or her duties.

36. (3) No record of a proceeding under this Act, a health profession Act or the *Drug and Pharmacies Regulation Act*, no report, document or thing prepared for or statement given at such a proceeding and no order or decision made in such a proceeding is admissible in a civil proceeding other than a proceeding under this Act, a health profession Act or the *Drug and Pharmacies Regulation Act* or a proceeding relating to an order under section 11.1 or 11.2 of the *Ontario Drug Benefit Act*.

38. No action or other proceeding for damages shall be instituted against the Crown, the Minister, a College supervisor appointed under section 5.0.1 or his or her staff, an employee of the Crown, the Advisory Council, a College, a Council, or a member, officer, employee, agent or appointee of the Advisory Council, a College, a Council, a committee of a Council or a panel of a committee of a Council for an act done in good faith in the performance or intended performance of a duty or in the exercise or the intended exercise of a power under this Act, a health profession Act, the *Drug and Pharmacies Regulation Act* or a regulation or a by-law under those Acts or for any neglect or default in the performance or exercise in good faith of the duty or power.

RULE 21.01(1)(b) – NO REASONABLE CAUSE OF ACTION

[15] On any motion under this Rule the court must assume that the facts set out in the pleadings are true, unless they are patently ridiculous or incapable of proof. The test is whether it is “plain and obvious” that the Statement of Claim discloses no reasonable cause of action. See the case of *Hunt v. Carey Canada Inc.*, [1990] 2 S.C.R. 959.

[16] In the present case, on a plain reading of the Statement of Claim, it is difficult to ascertain the precise cause of action that is pleaded. In oral submissions, counsel for HOIC

conceded that a negligence claim is not pleaded, and in any event such a claim could not succeed in light of s. 38 of the *RHPA*.

[17] Counsel for HOIC submits that the Statement of Claim should be read to include two separate causes of action, namely misfeasance in public office, and intentional interference with economic relations. Counsel relies upon paragraphs 11 and 12 of the Statement of Claim in support of that proposition. Further, at paragraph 14 of the Statement of Claim, I accept that HOIC makes a claim that the defendants did not act in good faith.

[18] In my view, the Statement of Claim is not broad enough to include the tort of intentional interference with economic relations. The phrase “interference with economic relations” does not appear in the Statement of Claim, and there is no similar phrase that could be interpreted as a substitute.

[19] Moreover, the tort of intentional interference with economic relations is a very narrow tort. In the case of *A.I. Enterprises Ltd. v. Bram Enterprises Ltd.*, [2014] 1 S.C.R. 177, Cromwell J. considered the history of this tort (which has several different names) and wrote at para. 5:

A. What is the scope of liability for the tort of causing loss by unlawful means?

In light of the history and rationale of the tort and taking into account where it fits in the broader scheme of modern tort liability, the tort should be kept within narrow bounds. It will be available in three-party situations in which the defendant commits an unlawful act against a third party and that act intentionally causes economic harm to the plaintiff. (Other torts remain relevant in two-party situations, such as, for example, the tort of intimidation.)

(1) What sorts of conduct are considered "unlawful" for the purposes of this tort?

Conduct is unlawful if it would be actionable by the third party or would have been actionable if the third party had suffered loss as a result of it. The alleged misconduct of

the defendants in this case was not unlawful in this sense and therefore they cannot be held liable on the basis of the unlawful means tort.

[20] Further, at para. 95 Cromwell J. wrote:

It is the intentional targeting of the plaintiff by the defendant that justifies stretching the defendant's liability so as to afford the plaintiff a cause of action. It is not sufficient that the harm to the plaintiff be an incidental consequence of the defendant's conduct, even where the defendant realizes that it is extremely likely that harm to the plaintiff may result. Such incidental economic harm is an accepted part of market competition.

[21] In my opinion, the Statement of Claim in the present case does not contain an allegation of an actionable unlawful act by the College against a third party. In this case, presumably, the third parties would be the doctors who gave undertakings to the College; however, there is nothing in the pleading to suggest that those doctors would have a cause of action against the College. Thus, the pleading does not allege the facts upon which any court could find intentional interference with economic relations, and there is nothing in the Statement of Claim that would inform the defendants that such a claim was being made against them.

[22] Regarding misfeasance in public office, the elements of this tort are concisely set out by Iacobucci J. at para. 23 of *Odhavji Estate v. Woodhouse*, [2003] 3 S.C.R. 263, as follows:

In my view, there are two such elements. First, the public officer must have engaged in deliberate and unlawful conduct in his or her capacity as a public officer. Second, the public officer must have been aware both that his or her conduct was unlawful and that it was likely to harm the plaintiff.

[23] Counsel for the defendants submits that the pleading does not disclose the precise breach of duty that is complained of. Moreover, counsel for the defendants submits that the College owes no duty to HOIC, but that the College has a duty to the public that is precisely prescribed by the provisions of the *RHPA* and the *Code*.

[24] In my view the Statement of Claim certainly lacks particulars, but the portion of paragraph 11 of the Statement of Claim that reads, “In a deliberate and unlawful manner, intended to harm the plaintiff, and in a manner which abused their public office...” when read in conjunction with the balance of that paragraph and paragraphs 12 and 14, is sufficient to inform the defendants that the claim against them is based on the tort of misfeasance in public office. Therefore, I accept that, read as a whole, the Statement of Claim includes the tort of misfeasance in public office.

[25] In this part of the motion counsel for the defendants also made submissions that s. 36(3) of the *RHPA* supported the defendants’ position that HOIC cannot prove a claim for misfeasance in public office. However, in my view, those submissions are more applicable to the request for summary dismissal under Rule 20.

[26] In summary, I will not strike the Statement of Claim pursuant to Rule 21.01(1)(b). That being said, if the plaintiff’s claim had survived the Rule 20 motion, I would have ordered HOIC to bring a motion to amend the Statement of Claim before taking any further steps in the proceeding.

RULE 21.01(3)(d) – ABUSE OF PROCESS

[27] I am not convinced that the Statement of Claim is an abuse of process. Therefore, I will not dismiss the action pursuant to this Rule.

RULE 20 – SUMMARY DISMISSAL

[28] In a motion under Rule 20 the court must consider more than the pleadings; rather, the court must take a hard look at the evidence, consider the use of the fact finding power set out in the Rule, and determine whether there is a genuine issue for trial. See the case of *Hryniak v. Mauldin*, [2014] 1 S.C.R. 87 at paras. 66 to 68.

[29] To succeed on a claim for misfeasance in public office, HOIC must prove the two aforementioned elements, namely, the College must have engaged in deliberate and unlawful conduct in public office, and the College must have been aware that the conduct was unlawful and likely to cause harm. In addition, in this case, because of s. 38 of the *RHPA*, HOIC must also prove that the College did not act in good faith.

[30] It is well known that all of the parties must “put their best foot forward” in a motion under Rule 20. See the case of *Pizza Pizza Ltd. v. Gillespie*, 75 O.R. (2d) 225. However, in response to the defendants’ motion for summary dismissal in this case, HOIC has offered this court very little evidence.

[31] The only evidence from HOIC in response to this motion is a short affidavit from Venneri. In that affidavit, in summary, Venneri makes a bald allegation that the College did not like to see a chiropractor infiltrate its “turf”; that the five named medical doctors were forced to resign from HOIC as a result of the College’s actions; and that the actions of the College caused serious financial hardship for HOIC. In addition, Venneri alleges that the College will not release its investigation files despite the fact that HOIC has now provided the College with written authorizations from two of the medical doctors who were investigated.

[32] In my view, the evidence offered by HOIC on this motion is not sufficient to survive the defendants’ request for summary dismissal. Specifically, on the evidence before me, I cannot find that there are genuine issues as to whether the conduct of the College was unlawful, or whether the College acted in bad faith.

[33] Regarding unlawfulness, it is apparent that the College has a statutory obligation to govern and regulate medical doctors; that the College has broad investigative powers as set out in s. 75 of the *Code*; and that there are certain practical and scientific risks associated with

HBOT that clearly bring HBOT within the purview of the College. There is simply no evidence that the College engaged in an unlawful investigation that went beyond its public duty.

[34] Further, there is no statutory mandate that requires the College to prescribe specific standards for the provision of all medical services. Fields such as HBOT are regulated by the College through the use of medical doctors who have expertise in the area and who can inform the College as to the necessary standards. Thus, again, there is no evidence that the College, or any of its employees or agents, did something unlawful or beyond its mandate.

[35] Regarding bad faith, even if HOIC could somehow establish that the College did something unlawful, it would be an even more remote possibility for HOIC to establish bad faith. At this point, HOIC cannot even articulate the bad faith that occurred, other than to suggest, without supporting evidence, that the College has a bias against chiropractors.

[36] In addressing the lack of evidence before the court, counsel for HOIC submits that any evidence regarding the unlawful conduct of the College or the bad faith of the College would be contained in the College's own investigation files, files that the College refuses to release. The difficulty for HOIC is that whatever might be in those investigation files, any document contained in the investigation files is not admissible in a civil proceeding pursuant to s. 36(3) of the *RHPA*.

[37] In the case of *M.F. v. Sutherland*, [2000] O.J. No. 2522 (OCA) the Ontario Court of Appeal considered s. 36(3), and determined that, even in the face of an allegation of fraud or bad faith, s. 36(3) provided absolute confidentiality with respect to the investigative records.

[38] At para. 29 of the *Sutherland* case Laskin J. wrote:

...The purpose of s. 36(3) is to encourage the reporting of complaints of professional misconduct against members of a health profession, and to ensure that those complaints are fully investigated and fairly decided without any participant in the

proceedings – a health professional, a patient, a complainant, a witness or a College employee – fearing that a document prepared for College proceedings can be used in a civil action. This purpose would be defeated by reading a fraud or bad faith exception into s. 36(3). The mere allegation of fraud or bad faith, however unfounded, could make the provision inapplicable.

[39] In summary, I find that there is no genuine issue as to whether the conduct of the College was unlawful, and there is no genuine issue as to whether the College acted in bad faith.

Therefore, HOIC's claim should be summarily dismissed.

CONCLUSION

[40] For all of the above reasons, pursuant to Rule 20, the plaintiff's claim is dismissed.

[41] The defendants may make written submissions with respect to costs addressed to the trial coordinator in St. Catharines within 15 days of this decision, and the plaintiff shall have 10 days thereafter to deliver responding written submissions.

Henderson, J.

Released: October 9, 2015

CITATION: Hyperbaric Oxygen Institute of Canada Inc. v. College of Physicians, et al., 2015
ONSC 6208
ST. CATHARINES COURT FILE NO.: 54641/13
DATE: 2015/10/09

2015 ONSC 6208 (CanLII)

ONTARIO
SUPERIOR COURT OF JUSTICE

BETWEEN:

Hyperbaric Oxygen Institute of Canada Inc.

Plaintiff/Respondent

and

The College of Physicians and Surgeons of Ontario, Dr.
Rocco Gerace, Sandra Keough and Dr. Wayne A. Evans

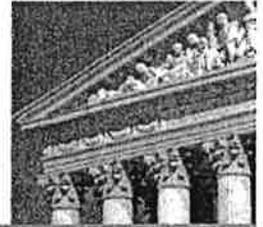
Defendants/Moving Parties

ENDORSEMENT ON MOTION

Henderson, J.

ITEM 1.1.5

CONDUCTING A DISCIPLINE HEARING



Basic Program

**LIMITED SEATING
WEBCASTING AVAILABLE**

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

Faculty:

Brian Gover, LL.B.
Stockwoods LLP &
Richard Steinecke, LL.B.
Steinecke Maciura LeBlanc

Program Objectives

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

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

Discipline Orientation Committee

- **Carolyn Gora (Chair)**, College of Physicians and Surgeons of Ontario
- **Anita Ashton**, College of Physiotherapists of Ontario
- **Barry Gang**, College of Psychologists of Ontario
- **Tina Langlois**, College of Medical Radiation Technologists of Ontario
- **Genevieve Plummer**, Ontario College of Pharmacists
- **Ravi Prathivathi**, College of Nurses of Ontario

8:30 a.m. – 9:00 a.m.

Registration and LIGHT CONTINENTAL BREAKFAST

9:00 a.m. – 9:30 a.m.

Introduction and Legal Framework

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

9:30 a.m. – 10:00 a.m.

Video of a Discipline Hearing

10:00 a.m. – 10:30 a.m.

Principles of Administrative Law

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

10:30 a.m. – 10:45 a.m. **BREAK**

10:45 a.m. – 11:00 a.m.

Fitness to Practice (FTP)

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

11:00 a.m. – 11:30 a.m.

Pre-Hearing Procedures

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

11:30 a.m. – 12:15 p.m.

Roles of Various Participants in the Hearing Process

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

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

1:00 p.m. – 2:30 p.m.

The Discipline Hearing

Through role play, attendees will experience an abbreviated contested hearing

2:30 p.m. – 2:45 p.m. **BREAK**

2:45 p.m. – 3:00 p.m.

The Discipline Hearing (continued)

3:00 p.m. – 4:00 p.m.

Responsibilities of Panel Members

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

4:00 p.m. – 4:15 p.m.

Concluding Remarks and Evaluation

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

See Registration Form for rates and payment information.



Federation of Health Regulatory
Colleges of Ontario

Friday, October 23, 2015
8:30 a.m. – 4:15 p.m.

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

Faculty:

Brian Gover, LL.B.

Stockwoods LLP
&

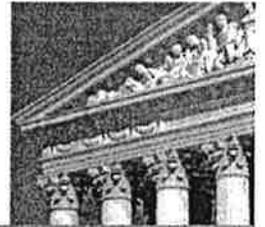
Richard Steinecke, LL.B.
Steinecke Maciura LeBlanc

This advanced program was developed because of the success of the Basic Program and an identified need for advanced training. It is a "beyond-the-basics" learning opportunity for adjudicators. The advanced program will help discipline panel members develop their skills to deal with challenging situations while chairing hearings and deliberations. The program is intended to develop critical thinking and the "how to" needed to meet unique situations. Participants will learn how to confidently control the proceedings, demonstrate fairness, assess the evidence, facilitate panel deliberations and ensure adequate reasons for the decision while meeting head-on, a complex array of challenges that can arise in hearings.

Discipline Orientation Committee

- **Carolyn Gora (Chair)**, College of Physicians and Surgeons of Ontario
- **Anita Ashton**, College of Physiotherapists of Ontario
- **Barry Gang**, College of Psychologists of Ontario
- **Tina Langlois**, College of Medical Radiation Technologists of Ontario
- **Genevieve Plummer**, Ontario College of Pharmacists
- **Ravi Prathivathi**, College of Nurses of Ontario

CONDUCTING A DISCIPLINE HEARING



Advanced Program

8:30 a.m. – 9:00 a.m.

**Registration and
LIGHT CONTINENTAL BREAKFAST**

9:00 a.m. – 9:10 a.m.

Welcome from Federation
Introduction of Faculty and
Participants

9:10 a.m. – 9:15 a.m.

Overview of Day
Introduction to the concepts
of controlling the proceedings,
giving parties a fair opportunity to
participate, explaining the decision,
and managing conflicts/potential bias

9:15 a.m. – 10:45 a.m.

"You're In Charge" – Case Scenarios
Groups of 4-6 members will consider
challenging situations that test the
panel's ability to be in charge of
conducting the hearing and control
the proceedings

10:45 a.m. – 11:00 a.m. **BREAK**

11:00 a.m. – 12:00 p.m.

**"Give Everyone a Chance" –
Role Play**
Attendees will act out scenes which
demonstrate the first and last rule
structure for objections, motions,
and submissions, and how the panel
ensures fairness to the parties

12:00 p.m. – 12:45 p.m.

LUNCH (provided)

12:45 p.m. – 1:45 p.m.

"Only the Evidence" – Case Scenarios
Small groups will discuss and report
on how they would deal with the
evidence and how the evidence forms
the basis for the decision

1:45 p.m. – 2:30 p.m.

"Explain Yourself" – Role Play
Attendees will act out the
deliberation process, highlighting the
Chair's role in leading the deliberation
process and how it is separated
from the reason-writing process. A
perfunctory credibility assessment,
which could lead to an appeal, will be
demonstrated

2:30 p.m. – 2:45 p.m. **BREAK**

2:45 p.m. – 3:15 p.m.

"Explain Yourself" – Role Play
The scenario continues as facilitators
help attendees to understand the
requirements for adequate reasons in
their decisions

3:15 p.m. – 4:00 p.m.

**"No Connection with Participants" –
Group Discussion using Scenarios**
Scenarios will be presented which
demonstrate situations where panel
members may find themselves
unwittingly mingling with the parties
or realize that they may know a
witness from their personal or
professional lives

4:00 p.m. – 4:15 p.m.

Concluding Remarks and Evaluation

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

See Registration Form for rates and payment information.



Federation of Health Regulatory
Colleges of Ontario

Conducting a Discipline Hearing Fall 2015 Registration Form

Basic-October 22nd/Advanced-October 23rd

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

Registrant's Name: _____

Organization: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Phone #: _____ Fax #: _____

Registrant's Email: _____

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

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

Send registration information to: Registrant Person completing form Both

Registrant Information:

Dietary restrictions (e.g., allergies): _____

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

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

Are you willing to participate in a scripted role play? Yes, Basic program Yes, Advanced program No

WEBCAST OPTION AVAILABLE FOR BASIC SESSION ONLY: attending in person attending by webcast

RATE SCHEDULE		Early Bird (Pre-Oct. 9)	Regular Oct 9 & After	Total
Basic	Federation Member*	\$470	\$520	
Basic	Non-Member	\$520	\$620	
Advanced	Federation Member*	\$470	\$520	
Advanced	Non-Member	\$520	\$620	
Basic and Advanced	Federation Member*	\$850	\$950	
Basic and Advanced	Non-Member	\$1030	\$1130	
Rates remain the same for both live session and webcast			Subtotal	
			13% HST (HST #871392825)	
			TOTAL	

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

Submit completed forms to the Federation Office via:

email: info@regulatedhealthprofessions.on.ca, or

Fax: 1-866-814-6456, or

Mail: Federation of Health Regulatory Colleges of Ontario

Suite 301 - 396 Osborne St, PO Box 244

Beaverton ON L0K 1A0

Make cheques payable to:

Federation of Health Regulatory Colleges of Ontario

Payment Method:

Cheque VISA MasterCard AMEX

If by credit card:

Card #: _____ Exp: _____

Cardholder's Name: _____

Signature: _____

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

Cancellation Policy: Cancellations received in writing not less than ten (10) business days prior to the event will receive a full refund. Cancellations received less than ten (10) business days will not be refunded, but substitutions are permitted.

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

Session Location: Osgoode Professional Development Centre
1 Dundas St W, 26th Floor, Toronto ON M5G 1Z3

Submitted to CCO on November 16, 2015

**College of Chiropractors of Ontario
Inquiries, Complaints and Reports Committee Report to Council
Friday, December 4, 2015**

Members: Dr. Gauri Shankar, *Chair*
Ms Patrice Burke, *Public Member*
Dr. Brian Gleberzon, *Council Member*
Dr. Steve Gillis, *non-Council Member*
Mr. Shakil Akhter, *Alternate Public Member*

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

Since the last Council meeting, the Inquiries, Complaints and Reports Committee (ICRC) met on two occasions, and reviewed 17 complaints and one report. ICRC made decisions on 10 complaints. One oral caution was administered, one section 75(a) investigator was appointed and two section 75(c) investigators were appointed by the Registrar. The Health Professions Appeal and Review Board (HPARB) upheld one Committee decisions (attached).

Recommendation 1

The ICRC has had several complaints with respect to social media and the content within. The Committee feels this should be discussed by council with a view of establishing a standard of practice or guideline.

Should further information be required, please do not hesitate to contact me.

I would like to thank the committee for all of their continued hard work, Ms Patrice Burke, Mr. Shakil Akhter, Dr. Steven Gillis and Dr. Brian Gleberzon. Ms Tina Perryman and Ms McKeown keep us on track with all the behind the scenes perseverance.

Respectfully submitted,

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



ITEM 1.2.1

In reply please quote: File # 15-CKV-0094

CONFIDENTIAL

September 1, 2015

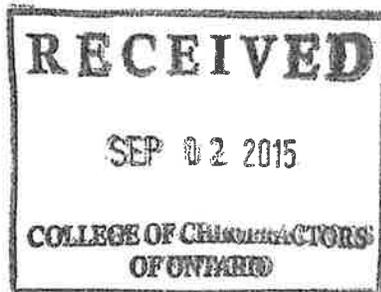
65

Mr. Randall Joshua Herman

Applicant

Dr. Irving Pisarek

Respondent



Dear Mr. Herman and Dr. Pisarek

**RE: COMPLAINT REVIEW - CHIROPRACTIC
RANDALL JOSHUA HERMAN AND IRVING PISAREK**

Enclosed herewith is a true copy of the Decision and Reasons of the Health Professions Appeal and Review Board in the above-noted matter.

While your file is now closed, please note that parties to Complaint Reviews of the Health Professions Appeal and Review Board have the right to request a judicial review of the Board's decision. You may wish to consider obtaining legal advice to determine what options are available to you. To request a judicial review contact the Divisional Court at 416-327-5100.

Yours sincerely,

HEALTH PROFESSIONS APPEAL AND REVIEW BOARD

A handwritten signature in black ink, appearing to be 'Alpha Aberra'.

Alpha Aberra
Case Officer

Encl: Decision dated September 1, 2015

cc: College of Chiropractors of Ontario (CCOPRA File # 14-JL-15)

HEALTH PROFESSIONS APPEAL AND REVIEW BOARD

PRESENT:

Bonnie Goldberg, Designated Vice-Chair, Presiding
 Beth Downing, Board Member
 Norma Grant, Board Member

Review held on August 25, 2015 at Toronto, Ontario

IN THE MATTER OF A COMPLAINT REVIEW UNDER SECTION 29(1) of the *Health Professions Procedural Code*, Schedule 2 to the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, c.18, as amended

BETWEEN:

RANDALL HERMAN

Applicant

and

IRVING PISAREK, DC

Respondent

Appearances:

The Applicant:	Randall Herman
The Respondent:	Irving Pisarek, DC
Support for the Respondent:	Hilda Pisarek
For the College of Chiropractors of Ontario:	Tina Perryman (by teleconference)

DECISION AND REASONS**I. DECISION**

1. It is the decision of the Health Professions Appeal and Review Board to confirm the decision of the Inquiries, Complaints and Reports Committee of the College of Chiropractors of Ontario to take no further action.

2. This decision arises from a request made to the Health Professions Appeal and Review Board (the Board) by Randall Herman (the Applicant) to review a decision of the Inquiries, Complaints and Reports Committee (the Committee) of the College of Chiropractors of Ontario (the College). The decision concerned a complaint regarding the conduct and actions of Irving Pisarek, DC (the Respondent). The Committee investigated the complaint and decided to take no further action.

II. BACKGROUND

3. The Applicant sustained significant injuries when he was struck by a motor vehicle in 1997 while cycling. As a result of his injuries, the Applicant has had treatment from a variety of therapies and a number of health practitioners since the accident.
4. The Respondent is a chiropractor at Advanced Health Care Clinic who treated the Applicant from April 9, 2008 to September 30, 2014 for the injuries sustained in the accident.

The Complaint and the Response

5. The College summarized the Applicant's complaint as follows:
 - The Applicant has been requesting information from his patient file from the Respondent. Despite several requests, the information has not been provided to the Applicant;
 - The Applicant feels the Respondent is being unprofessional by not providing the requested information; and
 - The Applicant paid for all MyoVision — FootMaxx information and an updated assessment report and provided the Respondent with six up-to-date reports to assist him with his work and he has still not completed.
6. In subsequent correspondence, the Applicant complained that his human rights have been violated. The Applicant provided a number of documents to support his allegations.

7. In his response to the College, the Respondent explained that on many occasions he and/or his office staff gave the Applicant copies of documents that he requested. He explained that the Applicant often brought bags or containers of documents to the office and asked for some of the documents to be copied and added to his files, which his staff did. The Applicant asked him to look into the costs of radiology. The Respondent explained that because the Applicant did not have a valid Ontario Health Insurance Plan (OHIP) card, he would have to pay the radiology clinic directly for both the technical and professional components of a radiology report. The Respondent provided a document from the Toronto Digital X-Ray and Ultrasound Clinic dated February 12, 2014, which is a "Quotation for: [the Respondent's] (Cash Patient)." However, the Applicant did not proceed with the imaging once he saw the estimated cost.

8. The Respondent explained that with regard to the MyoVision static assessment/testing, printed copies are easy to reproduce and were given to the Applicant several times. He was charged \$75.00 for the testing but not for the copies. The FootMaxx assessment/testing also costs \$75.00 with no charge for the coloured printed composite image of the stance phase of his gait. This too was provided at the time of service and was also easily reproduced if misplaced by any patient. The Respondent further explained as follows:

However, a coloured copy of a Gait Scan Analysis Report has to be electronically ordered on-line for patients following their request for one. The cost for such a 3-page document at our office is \$25.00 and takes time from a few days or more to be forwarded back to us to be printed for the patient. For this report, the Applicant was told many times by [the Respondent's secretary/wife] that it is not automatically provided to patients. When asked if he wanted it to be ordered, he refused to do so.

9. The Respondent stated that he showed the Applicant a draft chiro-legal report he produced at the request of the Applicant dated June 14, 2010, which included the phrase "functional overlay." The Applicant objected to portions of the report and provided "crafted wording" for both the subjective and objective portions of the report. The Respondent declined to use the language supplied by the Applicant. The Applicant "then stormed out of [his] office with no further action taken in this matter."

The Committee's Decision

10. The Committee investigated the complaint and decided to take no further action.

III. REQUEST FOR REVIEW

11. In a letter dated February 9, 2015, the Applicant requested that the Board review the Committee's decision.

IV. POWERS OF THE BOARD

12. After conducting a review of a decision of the Committee, the Board may do one or more of the following:

- a) confirm all or part of the Committee's decision;
- b) make recommendations to the Committee;
- c) require the Committee to exercise any of its powers other than to request a Registrar's investigation.

13. The Board cannot recommend or require the Committee to do things outside its jurisdiction, such as make a finding of misconduct or incompetence against the member, or require the referral of allegations to the Discipline Committee that would not, if proved, constitute either professional misconduct or incompetence.

V. ANALYSIS AND REASONS

14. Pursuant to section 33(1) of the *Health Professions Procedural Code* (the *Code*), being Schedule 2 to the *Regulated Health Professions Act, 1991*, the mandate of the Board in a complaint review is to consider either the adequacy of the Committee's investigation, the reasonableness of its decision, or both.
15. The Board has considered the submissions of the parties, examined the Record of Investigation (the Record), and reviewed the Committee's decision.

The Parties Submissions

16. The Applicant submitted that the investigation was inadequate as it lacked documentation and that the decision was unreasonable as it was based on misrepresentations and untruths. The Applicant submitted that the Respondent failed to share positive information about him with the Committee. He submitted that the Respondent allowed negative information that the Applicant shared with the Respondent about acts perpetrated against the Applicant or alleged to have involved him to affect their perception of the Applicant. He described events that occurred in the past, such as instances when he was employed at a university in the 1980s or incidents that occurred at his place of religious observation. He described the events that led to his traumatic accident in 1997. He argued that these events all had bearing on the treatment relationship.
17. The Applicant reviewed freedom of information requests he made many years ago pertaining to other matters, and argued that there were intergovernmental conflicts between the Committee and other government agencies.
18. In addition to his oral submissions at the Review, the Applicant read to the Board from a number of documents not contained in the Record, such as reference letters from the 1980s regarding his work in the psychological department at a university. He also submitted numerous documents to the Board in advance of the Review, including annotated copies of the documents contained in the Record and the Board's correspondence. The Board has reviewed the entirety of the Applicant's submissions.
19. The Respondent submitted that the investigation was adequate and the decision reasonable. He submitted that the Record contained the entirety of the information he provided to the Committee. He defended his approach to the Applicant's patient file, noting that while the Applicant may have shared information with him about matters unrelated to the treatment, he recorded information pertinent to the treatment relationship. Additionally, he submitted that he was not aware of some of the information provided by the Applicant at the Review and about which the Applicant claimed had "coloured" the treatment relationship. He denied any discriminatory behaviour on his part and identified examples in his personal life where he has demonstrated tolerance and empathy.

20. An adequate investigation does not need to be exhaustive. Rather, the Committee must seek to obtain the essential information relevant to making an informed decision regarding the issues raised in the complaint.

21. In the course of its investigation, the Committee obtained the Applicant's letter of complaint and subsequent correspondence; a response from the Respondent and subsequent correspondence and the Applicant's patient record. The patient record was quite lengthy and included statements of account; signed consent forms; treatment plans, consultation, examination and progress notes; a MyoVision Static Narrative dated February 13, 2014; a FootMaxx Dynamic Gait and Pressure Analysis Report dated June 10, 2010; a FootMaxx digital composite image of the stance phase of gait dated February 13, 2014; correspondence from the Applicant to the Respondent and to various agencies; copies of radiographs; information about the Applicant's accident and attempts to obtain assistance; notes written by the Respondent's secretary/wife, dated April 9, 2014, April 23, 2014 and April 24, 2014; and a quotation for [Respondent's] (Cash Patient)" from Toronto Digital X-Ray and Ultrasound Clinic dated February 12, 2014. In addition, the patient record included many documents from other individuals and health care providers, involved in the Applicant's care including several chiropractors, a podiatrist, a massage therapist and a physician. The patient record included the draft report from the Respondent dated June 14, 2010, about which the Applicant complained. The Record provided to the Board included copies of the College's correspondence to the parties, the Applicant's signed consents, and the Applicant's written concerns to the College about its standard investigation correspondence.

22. The Board finds that the Committee's investigation covered the events in question and yielded relevant documentation to assess the Applicant's complaint, particularly as he expressed a number of concerns about his file at the Respondent's office.

23. The Applicant has argued that the investigation was entirely inadequate because it lacked documentation. However, the Board is not persuaded that there is any further information that might reasonably be expected to have affected the decision, should the Committee have acquired it. While the Applicant referred the Board to documents such as reference letters written on his behalf many years ago, the Board is not persuaded that had the Committee had these documents, or other similar documents, it would have arrived at a different outcome.
24. Additionally, the Applicant's submissions focused on issues that were not before the Committee and the Committee did not make findings regarding these additional issues. The Board confirms that its review of this complaint is confined to a review of the decision by the Committee regarding the complaint as it was particularized before the Committee, and confirmed by the Applicant, and it will not comment further on these additional areas raised at the Review.
25. While the Applicant has since indicated that he "withdraws" his consent to the Respondent's release of his personal health information, the Board observes that the Record contains the Applicant's signed consent form dated April 9, 2008 allowing the Respondent to release the Applicant's health information for specific purposes, as well the Applicant's signed authorization and consent to investigate for the purposes of the Committee's investigation. Further, the College is obliged to release the entirety of the investigative Record to the Board following the Applicant's request for review of the Committee decision.
26. Accordingly, the Board finds the Committee's investigation was adequate.

Reasonableness of the Decision

27. In considering the reasonableness of the Committee's decision, the question for the Board is not whether it would arrive at the same decision as the Committee, but whether the Committee's decision can reasonably be supported by the information before it and can withstand a somewhat probing examination. In doing so, the Board considers whether the decision falls within a range of possible, acceptable outcomes that are defensible in respect of the facts and the law.

28. Having considered the parties' submissions, the Committee's decision, and the information in the Record, the Board finds the Committee's conclusions to be reasonable for the following reasons.
29. The Committee took no action regarding whether the Respondent inappropriately denied the Applicant access to his records. The Committee reviewed the Applicant's concerns, the contents of the patient file, and the Respondent's explanation of the contents of the Applicant's patient record. The Committee concluded that the documentation was generally consistent as between what the Applicant believed should be in his file and what actually was in the file. The Committee concluded that there was no information to suggest that the Respondent deliberately denied the Applicant access to his records. The Committee concluded that the Respondent's record keeping appeared thorough and accurate. The Committee concluded that the Respondent demonstrated that he understood that patients are entitled to a copy of their record of personal health information and took reasonable steps to fulfill this obligation. The Committee reviewed the statements of account in the patient's record and concluded that they were reasonably accurate and within what the College permitted of its members.
30. The Board finds that the Record supports the Committee's conclusion that there was no information to suggest that the Respondent deliberately withheld information from the Applicant or that the Respondent inappropriately charged the Applicant for copies of information. The patient record in the file offered a contemporaneous verification of the patient-health professional treating relationship, including statements of account and attempts to provide specific services to the Applicant, and thus provided the Committee with ample documentary information on which to arrive at the conclusions it did.
31. On the scope of practice issue, the Committee concluded that the Respondent did not purport to diagnose the Applicant or treat any psychological conditions and that he explicitly stated that any such conditions should be addressed by a qualified mental health professional. The Committee observed that a patient's psychological overlay can be relevant to his/her recovery, and it is appropriate that it be recognized and considered.

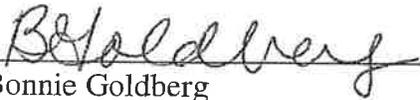
32. The Board finds this conclusion to be reasonable. The Record before the Committee included the draft June 14, 2010 report, in which the Respondent noted that although the Applicant may have developed a psychological impairment such as a functional overlay, it was beyond the scope of his expertise and this report. In the report, he advised addressing these issues with a mental health professional.
33. The Committee, which was comprised primarily of professional members, was entitled to rely on its expertise when assessing the Applicant's concerns as against the Respondent's explanation of his conduct and actions.
34. Additionally, the Record contained reports from other health professionals, which provided further information for the Committee to consider in its assessment of the Applicant's concerns in this regard.
35. The Committee also addressed the Applicant's concerns about a potential violation of his human rights. The Committee noted that the Applicant's concerns appeared to stem from standard correspondence used in the investigative process. The Committee reviewed the correspondence and opined that the letter did not indicate any bias with regard to witness statements or supporting documents. In addition, the Committee could find no information to support the Applicant's allegation that he was being discriminated against on the basis of his mental health status, religion or any other prohibited ground.
36. The Board finds the Committee's conclusions to be reasonable. Other than the Applicant's assertions, there is no information in the Record or placed before the Board at the Review to suggest discrimination or intergovernmental conflicts among agencies.
37. The Board observes that the Committee's legislative mandate is that of a screening committee with regard to complaints received about its members. The Committee considers the information it obtains in order to determine whether, in all the circumstances, a referral of allegations of professional misconduct to the College's Discipline Committee is warranted or if some other remedial action should be taken. The Committee does not conduct a hearing or make findings of misconduct, and the outcome of its investigations may result in complainants continuing to feel that they have concerns that remain unanswered.

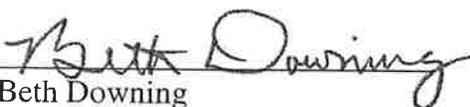
38. The Applicant offered numerous examples of his past prior professional success and experience in the area of psychology as well as information relating to his involvement in the criminal justice system when he believes he was unfairly accused of a variety of incidents. While the Board appreciates the Applicant's attempts to clarify and explain many of his earlier experiences and encounters to provide "context" for the treating relationship with the Respondent, none of this additional information is persuasive in determining that the Committee's assessment of the complaint was unreasonable, particularly as it predated the treating relationship by many years.
39. In conclusion, the information in the Record provides support for the Committee's conclusions and the Board finds the Committee's decision to be reasonable.

VI. DECISION

40. Pursuant to section 35(1) of the *Code*, the Board confirms the Committee's decision to take no further action.

ISSUED September 1, 2015


Bonnie Goldberg


Beth Downing


Norma Grant

**College of Chiropractors of Ontario
Fitness to Practise Committee Report to Council
Friday, December 4, 2015**

Members: Dr. Reginald Gates, *Chair*
Ms Georgia Allan
Dr. Bruce Lambert

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

Committee Mandate

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

The Committee continued to ensure that it was appropriately prepared in 2015. Since our last meeting there were no referrals to the Fitness to Practice Committee. Gladly we have had no meetings.

I would like to thank the Committee members; Ms. Georgia Allan, Dr. Bruce Lambert, and our staff support; Ms. Jo-Ann Willson.

Respectfully submitted,

Dr. Reginald Gates, Chair
Fitness to Practice Committee

Generated Internally

**College of Chiropractors of Ontario
Executive Committee Report to Council
December 4, 2015**

Members: Dr. Cliff Hardick, *President*
Dr. Gauri Shankar, *Vice-President*
Ms Judith McCutcheon, *Treasurer*
Mr. Shakil Akhter
Dr. Liz Anderson-Peacock
Mr. Scott Sawler
Dr. Bryan Wolfe

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

I Introduction

- I am pleased to provide this report to Council and to welcome Ms Wendy Lawrence, CCO's newest public member to her first Council meeting.
- Since the last report to Council, the Executive Committee ("Committee") has met on one occasion, namely October 20, 2015. The draft confidential minutes for the October 20, 2015 meeting are included in the council information package. The priorities for the December 4, 2015 Council meeting are to provide an update with respect to government and stakeholder relations and to review and approve the Committee's 2016 recommended budget so we start 2016 with an approved budget.

IV Ministry of Health and Long-Term Care

- Council members will note that:
 - All public members of health regulatory colleges were recently required to attend a governance training program facilitated by the MOHLTC;
 - MOHLTC has established a Transparency Working Group to work with the colleges on their efforts to enhance public accountability;
 - The Honourable Minister Hoskins has been in the news recently with various articles relating to the negotiations with the Ontario Medical Association.

- The Honourable Minister Hoskins has made a new referral to the Health Professions Regulatory Advisory Council relating to prescribing rights by nurses.

V Chiropractic Organizations/Health Related Stakeholders

- Included in the Council information package is a variety of information relating to various chiropractic organizations and other health regulatory organizations.

- Council members will note the following with respect to other chiropractic organizations:
 - The OCA has requested a meeting to receive a briefing on clinic regulation (a meeting with all associations is being scheduled by the working group);

 - Dr. Shankar, Ms Willson and I will be attending the Federation of Canadian Chiropractic meetings on November 28, 2015; we will provide a verbal report to Council;

 - Dr. Shankar and Mr. Friedman are attending the Canadian Chiropractic Examining Board AGM on Friday, November 27, 2015; They will provide a verbal report to Council; and

 - Mr. Friedman participated in a panel discussion facilitated by Dr. Gleberzon at the Canadian Memorial Chiropractic College of November 12, 2015.

VI Federation of Health Regulatory Colleges (FHRCO)

- Background information concerning various aspects of the work being done by FHRCO is included in the Council information package. Council members will note that:
 - CCO staff continue to participate in the work of FHRCO. CCO will be hosting the full board meeting with all members and guests from the Ministry of Health on December 10, 2015;
 - FHRCO was successful in obtaining intervenor status of a case being appealed by the College of Nurses in which a Discipline Committee found that the college did not have jurisdiction over a retired member;
 - The FHRCO Communications Working Group is reviewing and analyzing the impact of social media on colleges' communications; Mr. Friedmam has been attending these sessions to better inform CCO Council about its communication strategies; and
 - The provincial government has issued a press release indicating it intends to strengthen the role of the Ontario College of Trades which is one of the newer regulators in Ontario.
- Although not specifically part of FHRCO, CCO has joined in the *Clinic Regulation Project*, led by the College of Physiotherapists of Ontario. Efforts on this initiative have progressed to the extent that there is a website with various videos, as well as consultation sessions across the province. Information and a link has also been posted on CCO's website.

VII Conclusion

- In addition to the matters noted above, the Committee is dealing with a number of miscellaneous issues, referred to in the draft, confidential minutes included in the Council information package. I am honoured to be serving as CCO President over the next term and I encourage each of you to communicate with me about any matter. I would be pleased to answer any questions arising from this report.

Respectfully submitted by,

Dr. Cliff Hardick,
President

Rose Bustria

ITEM 4.1.3

From: Jo-Ann Willson
Sent: Friday, October 02, 2015 8:26 PM
To: Rose Bustria
Subject: FW: Story

Exec and Council.

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

College of Chiropractors of Ontario
130 Bloor St. West, Suite 902
Toronto, ON M5S 1N5
Tel: (416) 922-6355 ext. 111
Fax: (416) 925-9610
E-mail: jpwilson@cco.on.ca
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From: Wallace, Kenyon [kwallace@thestar.ca]
Sent: Friday, October 02, 2015 3:41 PM
To: Jo-Ann Willson
Subject: Story

Hi Jo-Ann,

I just wanted to let you know that my investigation into health-care providers issuing false and misleading bills is scheduled to run in tomorrow's paper. Thank you for your assistance over the past few months.

Regards,

Kenyon

Kenyon Wallace
Investigative Reporter
Toronto Star, www.thestar.com
kwallace@thestar.ca
416-869-4734 (office)

Rose Bustria

From: Jo-Ann Willson
Sent: Thursday, September 24, 2015 1:20 PM
To: Rose Bustria
Subject: FW: Toronto Star Question

Exec, Council + me.

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

College of Chiropractors of Ontario
130 Bloor St. West, Suite 902
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From: Wallace, Kenyon [<mailto:kwallace@thestar.ca>]
Sent: Thursday, September 24, 2015 1:17 PM
To: Jo-Ann Willson <jwillson@cco.on.ca>
Subject: RE: Toronto Star Question

Thank you for the confirmation Jo-Ann. Much appreciated.

Kenyon

From: Jo-Ann Willson [<mailto:jwillson@cco.on.ca>]
Sent: Thursday, September 24, 2015 10:14 AM
To: Wallace, Kenyon
Subject: FW: Toronto Star Question

Hello Kenyon –

Yes Dr. Bui completed these conditions (i.e. attended a continuing education program, successfully completed the Legislation and Ethics Examination, attended the Record Keeping Workshop), and his suspension was reduced. Dr. Bui was suspended March 1, 2012 to November 1, 2012. Thank you.

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

College of Chiropractors of Ontario
130 Bloor St. West, Suite 902
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From: Wallace, Kenyon [kwallace@thestar.ca]
Sent: Wednesday, September 23, 2015 5:23 PM
To: Jo-Ann Willson
Subject: Toronto Star Question

Dear Jo-Ann,

I am continuing my research into various health care providers in Ontario found guilty of false or misleading billing by their respective regulatory colleges. Part of my story will look at the case of a chiropractor named Dr. San Bui. Dr. Bui was disciplined in Feb. 2012 for a variety of offences, including false and misleading billing with regard to a number of patients. His penalty included a reprimand and an 11-month suspension. Three months of the suspension were to be removed if Dr. Bui completed a number of conditions, namely a CCO record keeping workshop, a legislative and ethics exam, and a continuing education course.

My question for you is: Did Dr. Bui complete these conditions and was his penalty reduced to 7 months?

Thank you. If you could let me know by the end of the week, I would be grateful.

Sincerely,

Kenyon Wallace
Reporter
Toronto Star
kwallace@thestar.ca
416-869-4734



News / Canada

Web of deceit: Pharmacist billed province for dead patients

More than 100 health-care providers guilty of fake billing in last five years.



DALE BRAZAO/TORONTO STAR

Toronto Optometrist Frank Stepec bilked about \$30,000 from OHIP by improperly billing and was convicted of two counts of fraud under \$5,000, given a conditional sentence of house arrest for three months and ordered to pay the money back. He received a two-month suspension from the College of Optometrists of Ontario.

By:Kenyon WallaceNews reporter, Published on Sat Oct 03 2015

Billing the province for dead patients and creating fake prescriptions from deceased and retired doctors — all part of a Toronto pharmacist's web of deceit.

Using these and other schemes, Amany Hanna bilked more than \$200,000 from Ontario's drug benefit program and was disciplined by the provincial pharmacy regulator.

Hanna is one of 107 health-care professionals found guilty of fake billing during the past five years. Like almost all of them, she kept her licence.

A Star investigation has found that most health-care providers sanctioned by the province's health regulatory colleges for false and misleading billing are allowed to continue practising, even in cases that resulted in criminal fraud convictions. The 25 regulatory colleges the Star reviewed also include bodies that oversee chiropractors, dentists and optometrists.

Hanna, 49, was the manager and part owner of a small pharmacy next door to Humber River Hospital at Finch Ave. and Hwy. 400.

Following a provincial health ministry audit and a police investigation, Hanna pleaded guilty in 2012 to fraud over \$5,000, was given a 12-month conditional sentence and was ordered to pay \$60,000 in restitution to the province.

136

The Ontario College of Pharmacists discipline panel did not revoke her licence. Instead, in Nov. 2014, it issued an 18-month suspension, a reprimand and a requirement to take an ethics course. She was also ordered to pay \$20,000 in costs. The discipline panel called Hanna's conduct "disgraceful, dishonourable and unprofessional."

Hanna will be eligible to continue working as a pharmacist next year.

Hanna did not respond to the Star's numerous attempts to contact her, including two detailed letters left at her home and Highland Creek Pharmacy, the pharmacy in Scarborough her husband operates.

At Hanna's court sentencing hearing in 2012, her lawyer, Marie Henein, said her client's actions were "financially motivated offences" and came shortly after Hanna's daughter was diagnosed with relapsing-remitting multiple sclerosis. Henein said treatment for the disease was costing Hanna and her husband more than \$40,000 a year.

Henein also told the court that Hanna had no criminal record, or any complaints or issues with the Ontario College of Pharmacists prior to the charges.

Hanna and her husband own three cars: a black 2014 Mercedes, a grey 2013 Mercedes and a white 2013 BMW. The couple own two oceanfront condos in Florida, including one in Miami valued at \$1.2 million. In Toronto, the family lives in an upscale Willowdale home with a two-car garage.

Hanna has not paid \$42,000 in legal bills to the law firm Torkin Manes, which represented her at the College of Pharmacists. Torkin Manes, a highly regarded firm, has been trying for more than 10 months to get Hanna to pay her bill, according to a statement of claim filed in Ontario Superior Court.

The provincial health ministry audit, which covered nearly a three-year period, found that Hanna submitted false claims to the Ontario Drug Benefit Program for 20 different drug products that were not dispensed to patients. The ODBP is a provincially funded program that helps cover the cost of prescription medications, primarily for seniors. The ministry found the total fraud amounted to \$202,784.55.

Here are the highlights of the provincial health ministry's audit of Hanna's pharmacy:

65 claims were made for dispensing products to seven dead patients.

More than 3,500 claims with "incorrect" identifying information about the prescribing medical practitioner, including 16 claims from a doctor whose licence to practise had been revoked six years earlier.

Two drug refill claims that came from a doctor who died 10 years earlier.

118 claims for Pico-Salax, a medication used to clean the bowels before a colonoscopy, for a patient who had not been prescribed the drug.

55 claims for the antibiotic Biaxin XL for a patient who had been prescribed the drug just three times.

12 claims for Enbrel, a drug used to treat rheumatoid arthritis and other diseases, over a four-month period after the patient had stopped taking the medication.

More than \$31,000 worth of claims for prescription reviews with patients without any supporting documentation, such as signatures or dates. In one case, Hanna told inspectors she was “sure” she had conducted a review session with a patient two weeks after the patient had died.

Dealing down

Health colleges routinely cut deals to shorten suspensions for members caught making fake billings if certain conditions are met, the Star found.

These conditions include ethics and accounting courses, remedial training and requiring the health professional to pay the college’s costs in building the discipline case.

Most professionals disciplined for false or misleading billing were allowed to continue practising after a suspension ranging anywhere from one month to 18 months.

While most of the discipline summaries posted on the regulatory colleges’ websites contain the allegations and punishments handed out, they often lacked specific details showing how the members carried out their fake billing.

Hanna’s profile on the Ontario College of Pharmacists’ website, for example, contains no information about her fake prescriptions for dead patients. The Star had to ask the college for additional documents used during Hanna’s disciplinary hearing to learn the full extent of her fraud.

Less than half of the public discipline decisions show the dollar amount of the false bills. For those that do, the amounts range from a few hundred to several hundreds of thousands of dollars.

Health professions in Ontario are self-governing, like teachers and lawyers. Each profession has a regulatory college that licenses, oversees and disciplines its members.

This investigation did not examine discipline decisions issued by the College of Physicians and Surgeons, as previous Star stories have focused on doctors. This time, the Star focused on the other 25 health regulatory colleges in Ontario.

Medical malpractice lawyer Paul Harte says that over the past decade, he believes discipline decisions have leaned too far toward emphasizing remediation at the expense of accountability.

“If there were more revocations, you’d expect fewer health-care practitioners who would be willing to risk their licence to make a few bucks,” said Harte.

“It is truly a balancing act. I don’t think you can have an absolute zero tolerance rule, but . . . I think there’s certainly room for the pendulum to swing back toward accountability and general deterrence.”

138

Colleges say that licence revocations are reserved for the most egregious offenders and those members who have a history of discipline. Under the Regulated Health Professions Act, the legislation that governs Ontario's health workers, a revocation of five years is mandatory for certain types of sexual abuse.

There is no mandatory minimum penalty a discipline panel must impose on other professional misconduct, such as the fake billing in many of the cases the Star studied.

Marshall Moleschi, registrar of the Ontario College of Pharmacists, said he is confident that "we uphold our mandate to protect the public interest."

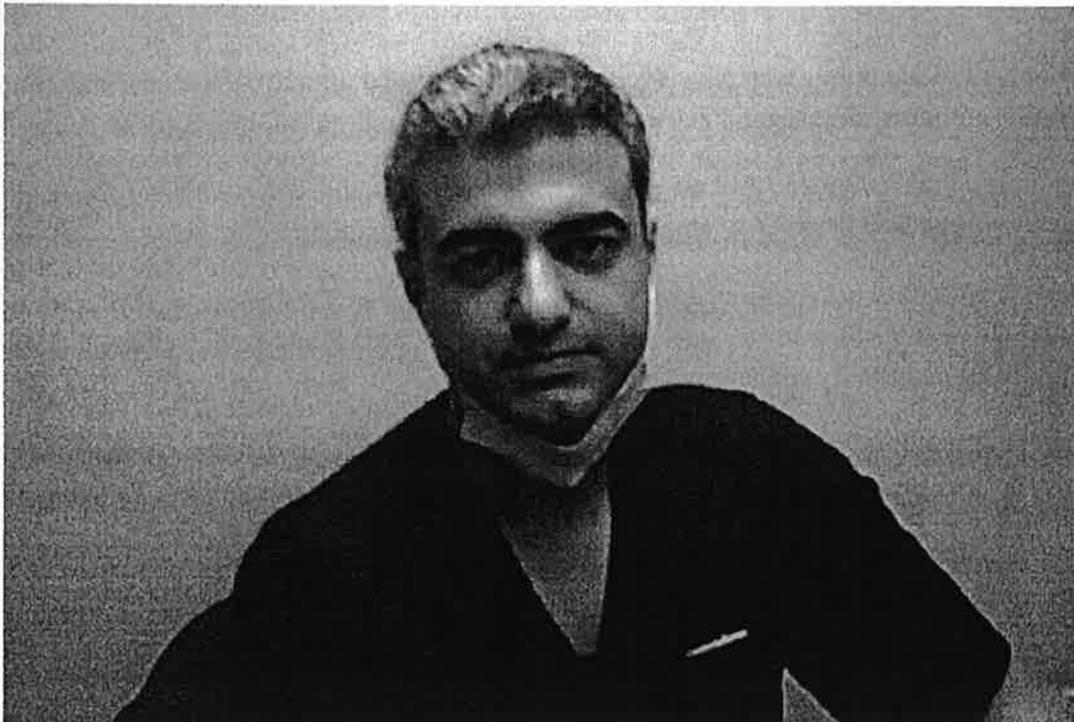
"With respect to this particular matter the assurance to the public is not only found in the individual outcomes of disciplinary cases, but also the transparent disclosure of all disciplinary outcomes on the public register," Moleschi said in an email.

"Any disciplinary finding becomes part of that member's permanent profile and displayed on the public register which is accessed through the college website. Providing this information allows the public to make informed decisions regarding their health-care provider."

These are a few examples of Ontario health-care providers who were caught by their regulatory colleges issuing false or misleading billings. All kept their licences to practise.

***All findings come from publicly available agreed statements of facts.**

Monir Mina



Dentist Monir Mina billed more than \$32,000 for surgery that was "not justified by the records over the course of four months, was aggressive and was done for his own financial gain," according to the Royal College of Dental Surgeons. He received a three-month suspension from the college.

Mina, a dental surgeon in St. Thomas, Ont., billed more than \$32,000 for surgery that was "not justified by the records over the course of four months, was aggressive and was done for his own financial gain," according to the Royal College of Dental Surgeons.

The college said he also took "unnecessary" X-rays on eight separate occasions, "thereby repeatedly and needlessly exposing his patient to radiation," and diagnosed inflammation of the tissue around the teeth without a complete exam. In addition, periodontal measurements taken by Mina did not support the extent of the surgery or the use of bone graft procedures.

Discipline: Three-month suspension; reprimand; ordered to take ethics course and periodontics course; practice to be monitored for 24 months; \$1,000 in costs.

Response: In an interview with the Star, Mina said the billing was done by a former business partner, whom he declined to name.

"It was a friend of mine and he had the majority of the shares. He was the managing partner and he was billing a lot of things electronically," said Mina, adding that it happened when he practiced in Toronto.

He said he was working at five different offices at the time and that he "should have kept my eyes more open."

Joseph Arcuri



FACEBOOK

140

Niagara Falls chiropractor Joseph Arcuri was first disciplined in 2011 after his clinic submitted 374 claims - amounting to \$24,000 - for massage therapy that was never provided. He was then disciplined again in 2013 for false and misleading billing and obstructing investigators from the College of Chiropractors of Ontario. He was suspended for 12 months, but that dropped to seven months after he complied with various conditions, including taking a record-keeping course and an ethics exam.

Arcuri, a chiropractor in Niagara Falls, was first disciplined in 2010 after his clinic submitted 374 claims, amounting to \$24,000, for massage therapy that was never provided. His initial 12-month suspension was reduced to six months when he completed a record-keeping workshop and an ethics exam.

Arcuri hired another chiropractor to see patients during his suspension, but that chiropractor became suspicious that Arcuri was still seeing patients.

College investigators following up found that Arcuri made claims to an insurer for patient treatments under the other chiropractor's name. Those treatments were bogus.

When investigators met with Arcuri, they asked to see invoices, patient ledgers and statements of accounts for 15 patients, but Arcuri said he didn't keep that information. When the investigators asked to see his appointment book, Arcuri said he was "locked out" of his Google calendar. When they asked for the 15 patient files to be handed over, Arcuri simply left his office.

The investigators later returned with a search warrant for the 15 patient files, but when Arcuri handed them over, nine files were missing and had been replaced with other files. After Arcuri said he didn't know where the missing files were, the investigators searched the building and found two boxes of confidential patient files in a basement accessible to a next-door pizza restaurant. They could not find the nine missing files. Despite repeated requests, Arcuri never produced them for the college.

Discipline: 12-month suspension, which was lowered to seven months after Arcuri complied with various conditions, including another record-keeping course and ethics exam; costs of \$10,000.

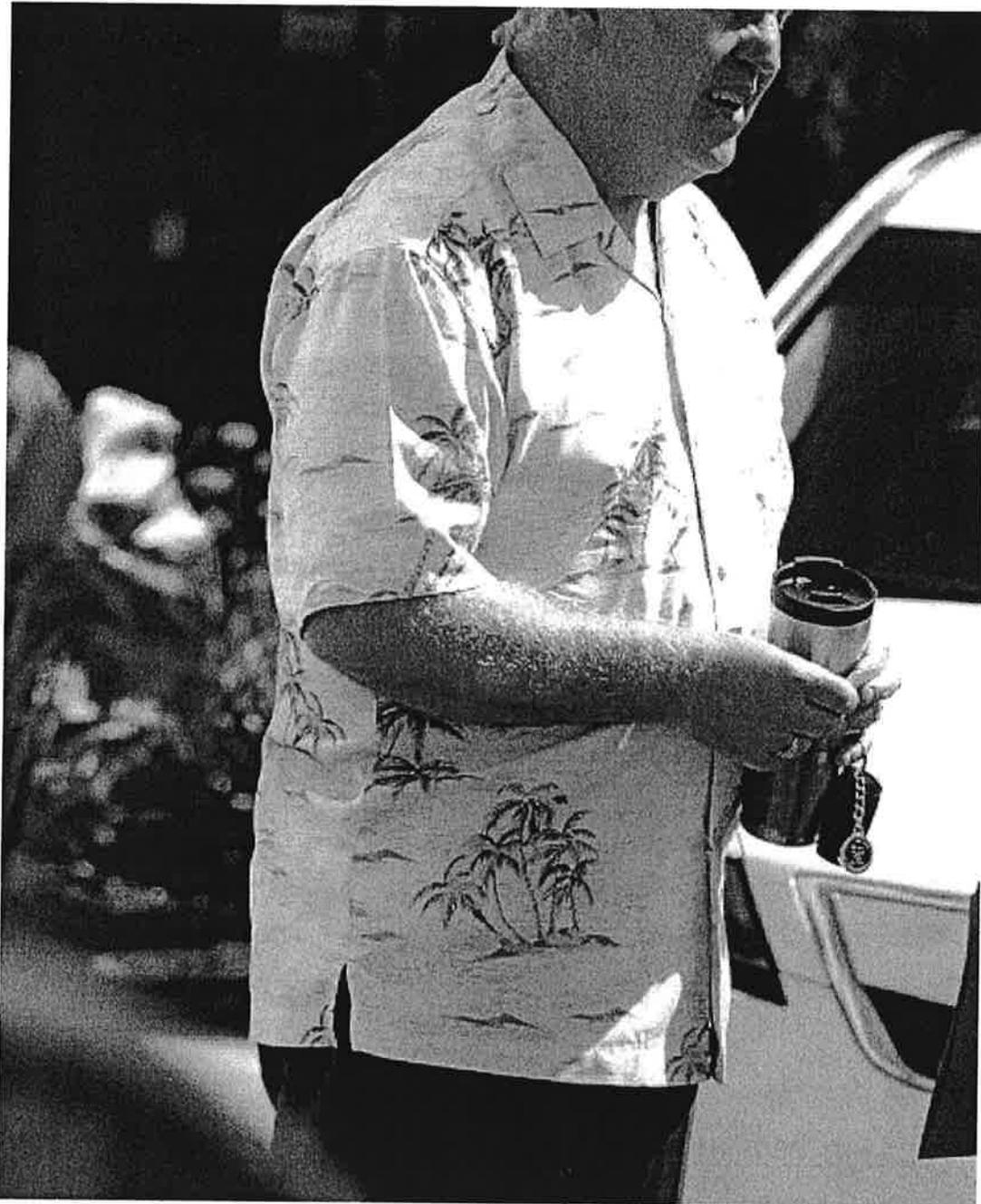
Response: The Star visited Arcuri at his Niagara Falls clinic in an attempt to discuss the allegations, but he declined to comment.

"You have no story really with me. You might be better finding another chiropractor that might respond to your questions," he said.

Frank Stepec



141



DALE BRAZAO/TORONTO STAR

Toronto Optometrist Frank Stepec billed about \$30,000 from OHIP by improperly billing and was convicted of two counts of fraud under \$5,000, given a conditional sentence of house arrest for three months and ordered to pay the money back. He received a two-month suspension from the College of Optometrists of Ontario.

When a patient had one appointment with Toronto optometrist Frank Stepec, he billed OHIP twice. Stepec did that with 32 patients, according to court documents. For another 25 patients, Stepec billed OHIP for multiple minor assessments that were not provided.

In total, Stepec improperly billed OHIP about \$30,000 between Jan. 2007 and Nov. 2009.

He pleaded guilty in criminal court to two counts of fraud under \$5,000, was given three months house arrest and nine months probation. He was also ordered to pay \$30,000 in restitution to

142

OHIP, which he did. Two of his employees were also charged in relation to the fraud, but those charges were dropped.

Stepec's lawyer, Richard Shekter, told court Stepec came to him for help in making restitution to OHIP three months prior to his client's arrest. Shekter said his client's behaviour was "completely out of character" and that Stepec was "truly remorseful."

Discipline: The College of Optometrists of Ontario issued Stepec a two-month suspension; reprimand; \$7,500 in costs.

Response: In an interview with the Star outside his Etobicoke office, Stepec said he proactively took steps to pay the money back because he "just had enough."

Stepec stressed that he did not bill for patients he did not see. "I saw everybody. It's just that I would bill later on."

"I'm a big enough guy to say yeah, that's what I did. You know what I mean? Let's go through the system, let's get it done and all the rest. Obviously the college gets involved because it's a criminal case," he said.

Marni Blumfald



Physiotherapist Marni Blumfald claimed more than \$10,000 in health care services and products between 2009 and 2011 that she never received. She did this by forging the signatures of health care providers on documents she submitted to her insurance company. While she made these claims outside her physiotherapist practice, the College of Physiotherapists of Ontario forced her to serve a three-month suspension.

In one case, the College of Physiotherapists of Ontario disciplined one of its members because of what she did privately.

Blumfald, a Thornhill physiotherapist, forged the signatures of other health-care providers on fake claims for health services and products for herself that she never received. Blumfald received more than \$10,000 in payments from her insurance company, Chambers of Commerce Group Insurance Plan, for these false claims between 2009 and 2011.

While she submitted the claims for herself outside her physiotherapy practice, the college discipline panel stated that it felt it “had an obligation to deter the profession at large” and to show the public that the profession “takes its role as a regulator seriously.”

Discipline: Reprimand; six-month suspension, which was lowered to three months when Blumfald took an ethics course, paid \$3,000 in costs to the college and allowed the college to monitor her practice for three years.

Response: Blumfald stressed to the Star that she did not submit the false bills as part of her practice and repaid her insurance company.

“It was my own personal health benefits,” she said. “If I went to physio or I went to massage, I got receipts. It was my stuff I submitted. Then my insurance company audited me and then my college found out and went after me.”

In a later email to the Star, Blumfald stated: “All I can tell you is: I made a mistake. I paid for it. And I am very thankful to be continuing to provide my therapy services to individuals in need. As I’m a great therapist and love what I do.”

Time frame: 2010-2014

288,000: approximate number of regulated health-care professionals in Ontario, including doctors

26: number of health regulatory colleges in Ontario

107: number of health-care professionals found guilty of false or misleading billing*

99: number of suspensions issued to health-care providers for false or misleading billing

7: number of licences revoked for false or misleading billing

6: number of health-care professionals who resigned while facing allegations of false or misleading billing

1: number of health-care professionals given only reprimands for false and misleading billing

*Discipline data from the College of Physicians and Surgeons of Ontario is excluded.

Ministry of Health
and Long-Term Care

Office of the Minister

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Ministère de la Santé
et des Soins de longue durée

Bureau du ministre

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Télééc. 416 326-1571
www.ontario.ca/sante



501

ITEM 4.1.17

SEP 11 2015

Ms. Judith McCutcheon
175 Carlton Road
Unionville ON L3R 3L7

Dear Ms. McCutcheon:

Congratulations on your reappointment to the Council of the College of Chiropractors of Ontario. I am looking forward to your continued service beginning August 12, 2015 until August 11, 2018.

I am very pleased that you have again taken on this important responsibility to serve the people of Ontario. We expect that you will continue to be committed to the principles and values of public service and that you will perform your duty with integrity.

I have enclosed a copy of the Order in Council which was approved on August 25, 2015.

Again, please accept my congratulations.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Eric Hoskins'.

Dr. Eric Hoskins
Minister

Enclosure

c: Registrar
The Honourable Michael Chan, MPP



Ontario
Executive Council
Conseil exécutif

Order in Council
Décret

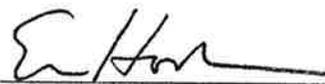
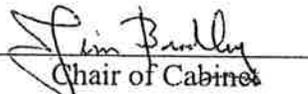
On the recommendation of the undersigned, the Lieutenant Governor, by and with the advice and concurrence of the Executive Council, orders that:

Sur la recommandation de la personne soussignée, le lieutenant-gouverneur, sur l'avis et avec le consentement du Conseil exécutif, décrète ce qui suit:

Pursuant to clause 6(1)(b) of the *Chiropractic Act, 1991*, S.O. 1991, c. 21, the following member be reappointed by the Lieutenant Governor in Council to the Council of the College of Chiropractors of Ontario for a period of three years, commencing on August 12, 2015 to and including August 11, 2018:

Judith McCutcheon
Public Member
Unionville

(reappointed by O.C. 1165/2012)

Recommended  Concluded 
Minister of Health
and Long-Term Care Chair of Cabinet

Approved and Ordered AUG 25 2015 
Date Administrator of the Government

**Ministry of Health
and Long-Term Care**

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**Ministère de la Santé
et des Soins de longue durée**

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Télééc. 416 326-1571
www.ontario.ca/sante



503

OCT - 5 2015

Ms. Wendy Lawrence, LLB
1506-208 Queens Quay West
Toronto ON M5J 2Y5

Dear Ms. Lawrence:

Congratulations on your appointment to the Council of the College of Chiropractors of Ontario. I am very pleased that you have taken on this important responsibility.

As serving the people of Ontario is an honour and a privilege, I know you will be committed to the principles and values of public service and I am confident you will perform your duty with integrity.

I have enclosed a copy of the Order in Council which was approved on September 8, 2015, appointing you for the period September 8, 2015 until September 7, 2018.

The College will be in touch with you shortly to respond to any questions you may have, provide you with information about upcoming meetings and invite you to attend an Orientation Session. You are required to attend the Orientation Session to ensure that you receive the requisite training for your role as a public appointee.

Again, please accept my congratulations on your appointment. I am confident you will find this experience both interesting and rewarding.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Eric Hoskins'.

Dr. Eric Hoskins
Minister

Enclosure

c: Registrar
Han Dong, MPP



Ontario
Executive Council
Conseil exécutif

Order in Council
Décret

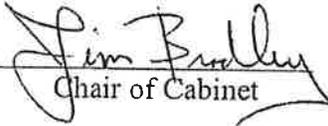
On the recommendation of the undersigned, the Lieutenant Governor, by and with the advice and concurrence of the Executive Council, orders that:

Sur la recommandation de la personne soussignée, le lieutenant-gouverneur, sur l'avis et avec le consentement du Conseil exécutif, décrète ce qui suit:

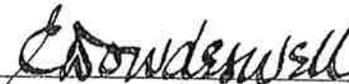
Pursuant to clause 6(1)(b) of the *Chiropractic Act, 1991, S.O. 1991, c. 21*, the following person be appointed by the Lieutenant Governor in Council as a member of the Council of the College of Chiropractors of Ontario for a period of three years, commencing on the date of this Order in Council:

Wendy Lawrence
Public Member
Toronto

Recommended 
Minister of Health
and Long-Term Care

Concurred 
Chair of Cabinet

Approved and Ordered SEP 08 2015
Date


Lieutenant Governor

From: Jo-Ann Willson
Sent: Tuesday, September 08, 2015 11:35 AM
To: Rose Bustria
Subject: FW: Public Appointments - College of Chiropractors
Attachments: Lawrence, Wendy 2015-06-27.pdf

Council.

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

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From: Dhalla, Rosemin (MOHLTC) [mailto:Rosemin.Dhalla@ontario.ca]
Sent: Friday, September 04, 2015 2:34 PM
To: Jo-Ann Willson <jwillson@cco.on.ca>
Cc: Boyd, Thomas (MOHLTC) <Thomas.Boyd@Ontario.ca>; Samo, Ervin (MOHLTC) <Ervin.Samo@ontario.ca>; Da Silva, Lolly (MOHLTC) <Lolly.DaSilva@ontario.ca>
Subject: Public Appointments - College of Chiropractors

Hi Jo-Ann:

Attached is the application of Wendy Lawrence who will soon be appointed to your Council, pending Lieutenant Governor's signature on the Order in Council.

We will keep you informed.

Have a great long weekend!

Thanks,

Rosemin Dhalla
Consultant, Agency Liaison and Public Appointments
Corporate Management Branch
Corporate Services Division
Ministry of Health and Long-Term Care
Tel: (416) 327-8498
Rosemin.dhalla@ontario.ca

506

From: Jo-Ann Willson [<mailto:jpwillson@cco.on.ca>]
Sent: September 3, 2015 2:12 PM
To: Dhalla, Rosemin (MOHLTC)
Subject: RE: Public Appointments - College of Chiropractors

Hello Rosemin - I'd like to invite her as a guest to the meeting on September 17, 2015. Thank you for letting me know.

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

College of Chiropractors of Ontario
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From: Dhalla, Rosemin (MOHLTC) [Rosemin.Dhalla@ontario.ca]
Sent: Thursday, September 03, 2015 1:53 PM
To: Jo-Ann Willson
Cc: Boyd, Thomas (MOHLTC)
Subject: RE: Public Appointments - College of Chiropractors

Hi Jo-Ann:

The potential appointee has already been reviewed by the Standing Committee on Government Agencies, however, her Order in Council will not be signed until September 16th.

Do you want to invite the potential appointee to your meeting as a guest member or postpone your meeting for another date?

Let us know, when you return next week to your office.

Thanks,

Rosemin Dhalla

What do you do when you receive a request for thousands of pages of information spanning five years of patient survey documents and you have limited resources in-house?

Wendy Lawrence, who was legal counsel at Mount Sinai Hospital at the time the request came through, turned to Cognition LLP to assist with the request the hospital received under the Freedom of Information and Protection of Privacy Act.

"We wanted to be transparent and release the records, but [we] wanted to do so in a manner that respected patient privacy," says Lawrence, who is now counsel at another Toronto hospital.

Lawrence says because it was a "high-volume, out-of-the-ordinary request," she decided to outsource the project, primarily because of the size of the request and the fact the records had to be reviewed, redacted for patient privacy, and prepared for disclosure within the legislated timelines.

The hospital sector was brought under FIPPA in 2012. Compliance with FIPPA has been challenging for hospitals, as the legislation can be high-volume and labour-intensive. FIPPA also requires legal expertise, as each line and page of a record must be reviewed by the hospital for applicable legal exemptions that protect important interests such as patient privacy, solicitor-client privilege, or proprietary rights prior to release to a requester.

Mount Sinai partnered with Cognition to implement a legal project management approach to the request. It proposed an approach to the work involving a first-level review by a team of junior lawyers, and then a legal audit of the work completed by more senior lawyers, accompanied by a final review by a project management lawyer, who also provided oversight over the work and acted as the primary contact with Mount Sinai.

Lawrence worked with Jackie Dinsmore, Jason Moyse, and Morgan Borins of Cognition.

Cognition proposed a legal project management team approach, usually reserved for corporate due diligence projects. Lawrence says outsourcing the project made sense instead of having one internal employee and a handful of secondary personnel pulled in to prepare the records for disclosure.

Cognition provided computer software, scanners, and redaction tools to respond to the request and saved the hospital the costs of obtaining these tools on a one-off basis for this particular request. The firm's approach of assigning a legal project team with multiple levels of review, audit, and legal oversight provided Mount Sinai with the assurance that its needs could be met.

The legal project team ensured the work was done in a

Outsourcing saves hospital money and time

thorough manner that assured the hospital it was meeting its legislative obligations. Lawrence says outsourcing the work was cost effective, as it was given more attention than an internal staff member could provide under the legislated timelines.

There were also savings — outsourcing ended up being less than 10 per cent of the cost of a full-time equivalent lawyer. There was no lost time due to re-assigning secondary staff to assist, and no need to obtain equipment to assist with the preparation and redaction of records.

"It was really cost effective. Instead of using the traditional model of having a senior partner and an associate spend several hours doing one review of the records, we had various levels of lawyers — junior and senior — and in a project team that proved to be [a] more cost-effective and more in-depth review," says Lawrence.

Lawrence says there were also improved deliverables, as the hospital did not have to ask for a time extension or delay response. Mount Sinai was also able to receive a more rigorous review of the records (e.g. team of lawyers with multiple levels of review) that ensured patient privacy. ■

STANDING:
Jackie Dinsmore

SITTING:
Wendy Lawrence

CATEGORY: Working with External Counsel
DEPARTMENT SIZE: Small
COMPANY: Mount Sinai Hospital



INHOUSE

AT THE INTERSECTION OF LAW & BUSINESS

Adding value through innovation

2015

innovatio

**WINNERS OF THE
2ND ANNUAL AWARDS
CELEBRATING IN-HOUSE
INNOVATION**

INDUSTRY SPOTLIGHT
WHEN TURTLES TRUMP TURBINES

IN CLOSING
THE TRULY INNOVATIVE QUESTION
WHAT CAN CHANGE

**BRINGING E-DISCOVERY
IN-HOUSE**
UNDERSTAND THE CHALLENGES

Governance Training for Public Appointees to Health Regulatory College Councils

Ministry of Health and Long-Term Care
November 2015

ITEM 4.1.18



Institute on
Governance
LEADING EXPERTISE

Institut sur
la gouvernance
EXPERTISE DE POINTE

513

Agenda

1. Introduction to Public Sector Governance
2. Structures and Accountabilities: *The Regulated Health Professions Act*
3. OIC Appointees: *The Agencies and Appointments Directive*
4. The Public Interest
5. Fairness
6. Wrap up and Summary of Key Themes



Introductions

- Facilitator(s)
- Participants

Learning objectives:

- Familiarize yourselves with the context and practices relevant to good public sector governance in Ontario
- Better understand your role as a public appointee to a Health Regulatory College Council

Icebreaker exercise:

- Share your council experience with the group

About the Institute on Governance

516

- Canadian, independent, not-for-profit based in Ottawa
- Mission: “Advancing better governance in the public interest”
- Explore, develop and promote good governance in the public sphere, both in Canada and abroad
- Collaborate with different levels of government, aboriginal organizations, and non-governmental and volunteer sectors in Canada and abroad



1. INTRODUCTION TO PUBLIC SECTOR GOVERNANCE



What is Governance?

- **Governance** is about:
 - Who makes decisions
 - How decisions are made and who has a voice
 - How accountability is rendered
- Governance helps an organization achieve its mandate, goals and objectives. In a public sector context, it is about achieving outcomes in the public interest as defined by the legislature and the government of the day.
- An organization's constituting instrument (Legislation, Regulation or Order in Council) will typically set out the specific governance structure that will help the agency to meet its goals, support oversight and monitor program and service delivery.



IOG's 5 Principles of Good Governance

- Legitimacy & Voice
- Direction & Purpose
- Effective Performance (including risk management)
- Accountability & Transparency
- Fairness & Ethical Behaviour



Discuss how the 5 principles of good governance are accomplished within the lenses of private, not-for-profit and public governance

	Private	Not-For-Profit	Public
Legitimacy and Voice			
Direction and Purpose			
Effective Performance			
Accountability and Transparency			
Fairness and Ethical Behaviour			



IOG Governance Continuum

- Shift in roles of traditional governance relationships
- Historical evidence of long-standing public sector use of alternative organizations
- Need for a conceptual model for modern public governance



Measuring Autonomy and Control

IOG Continuum Considerations

1. Mandate/Policy Autonomy

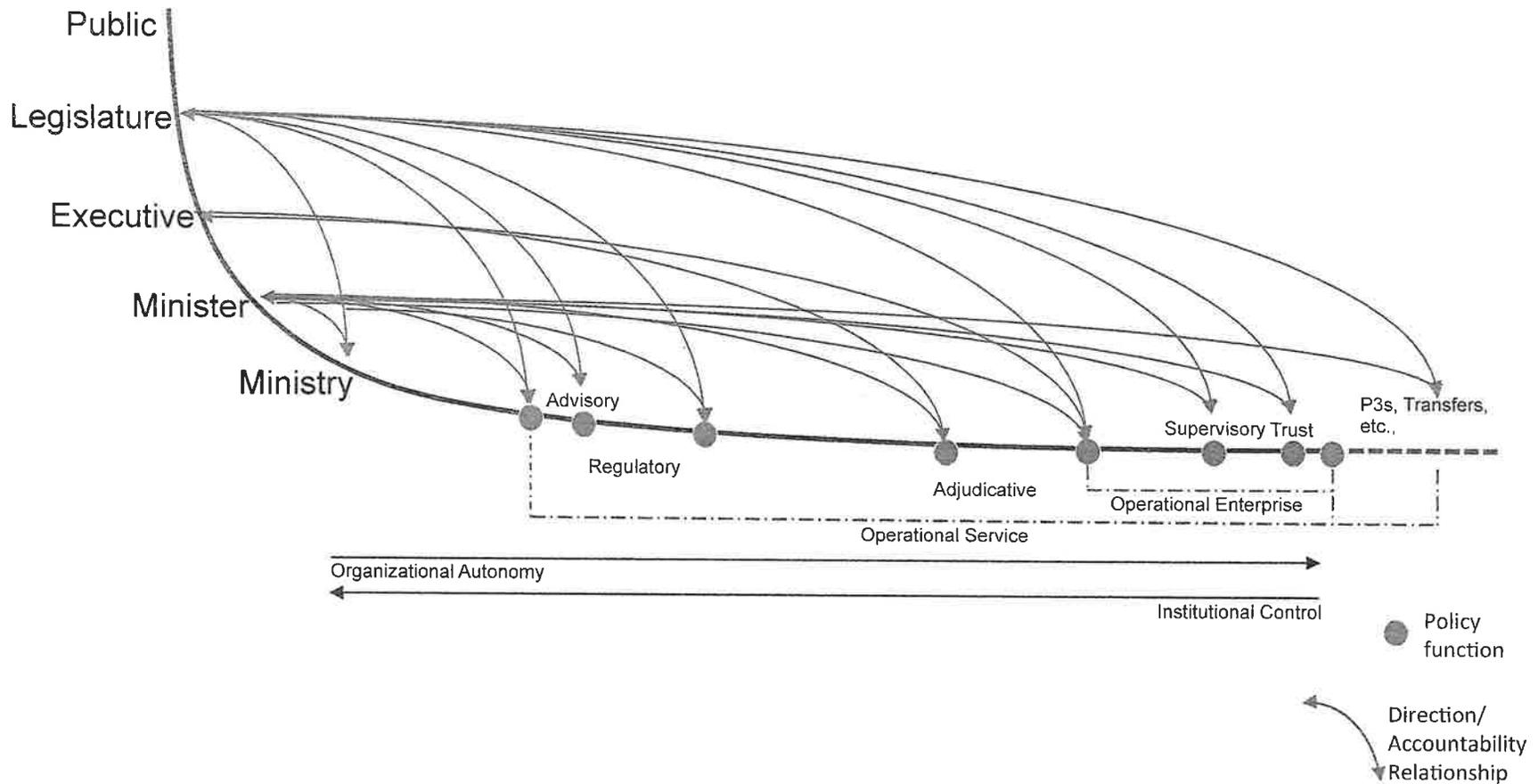
2. Operational/Managerial Autonomy

3. Appointments

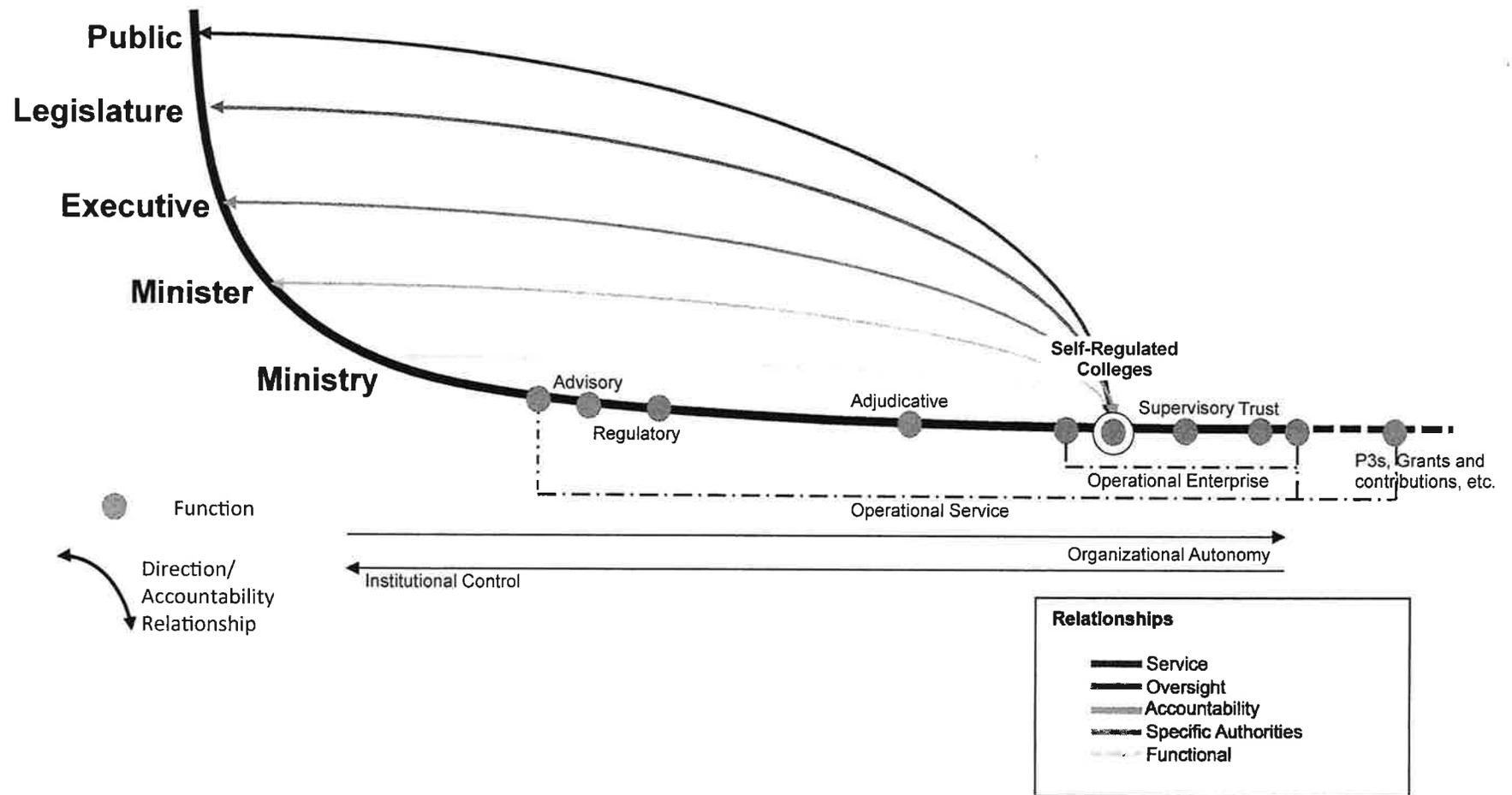
4. Reporting Oversight

5. Legal Personality

The IOG Governance Continuum



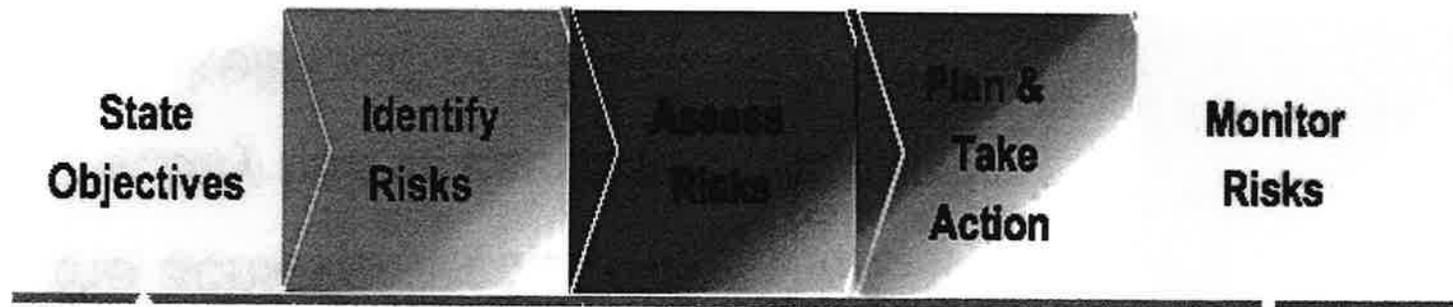
Governance Continuum Relationships



Risk in a Public Sector Context

- Risk is the UNCERTAINTY that surrounds future events and outcomes.
- It is the chance of something happening that will affect the achievement of objectives.
- Usually risk is assessed in terms of:
 - Likelihood of event occurring
 - Severity of impact should it occur
- In principle, risk is a neutral concept though in practice the focus tends to be on risk that interferes in achieving outcomes

OPS Risk Management Process



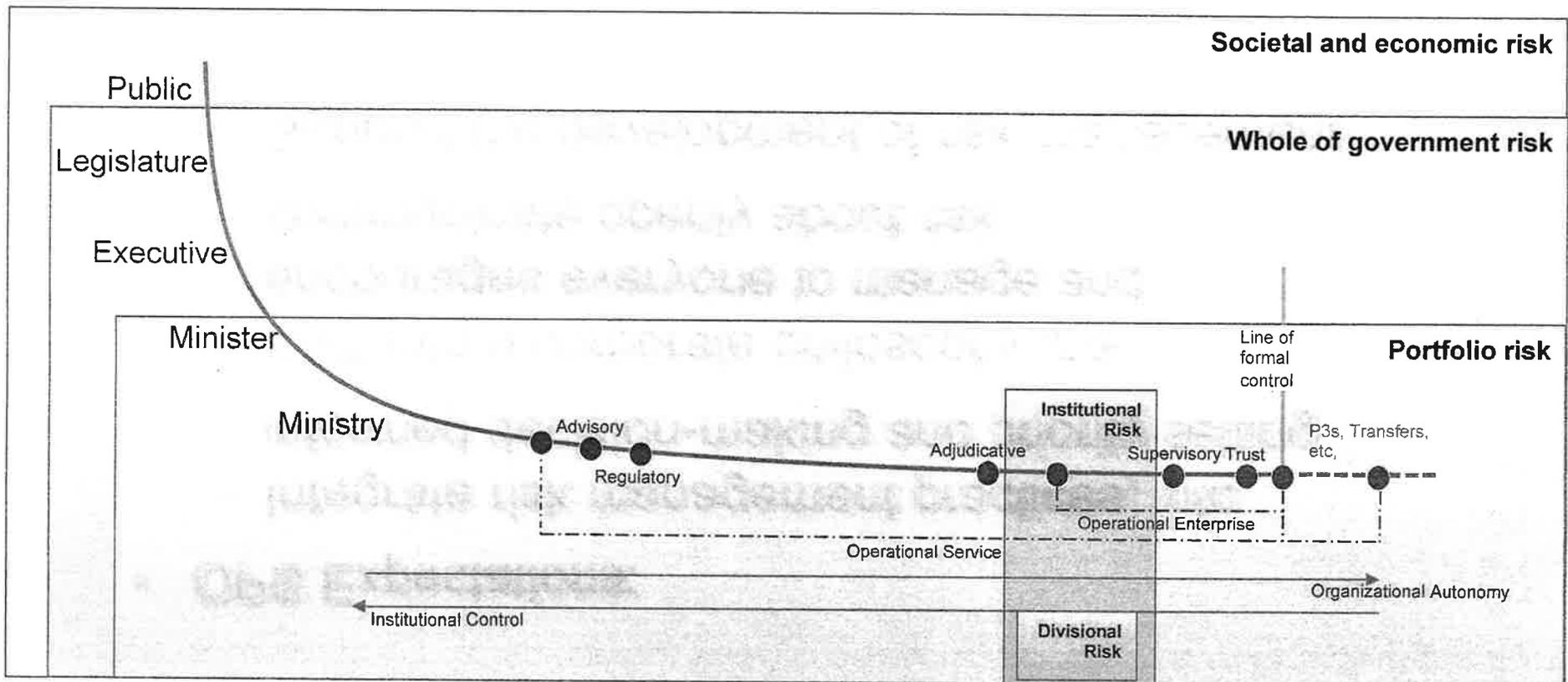
Source: MOF Risk Management How-To Guide

Risk Management Policy

- OPS Expectations:
 - Integrate risk management practices, into informed decision-making and priority setting
 - Cultivate a corporate philosophy that encourages everyone to manage and communicate openly about risk
 - Support the development of risk management competencies through training/other learning opportunities



Risk Migration in the Public Sector



Assessing the Quality of Organizational Governance

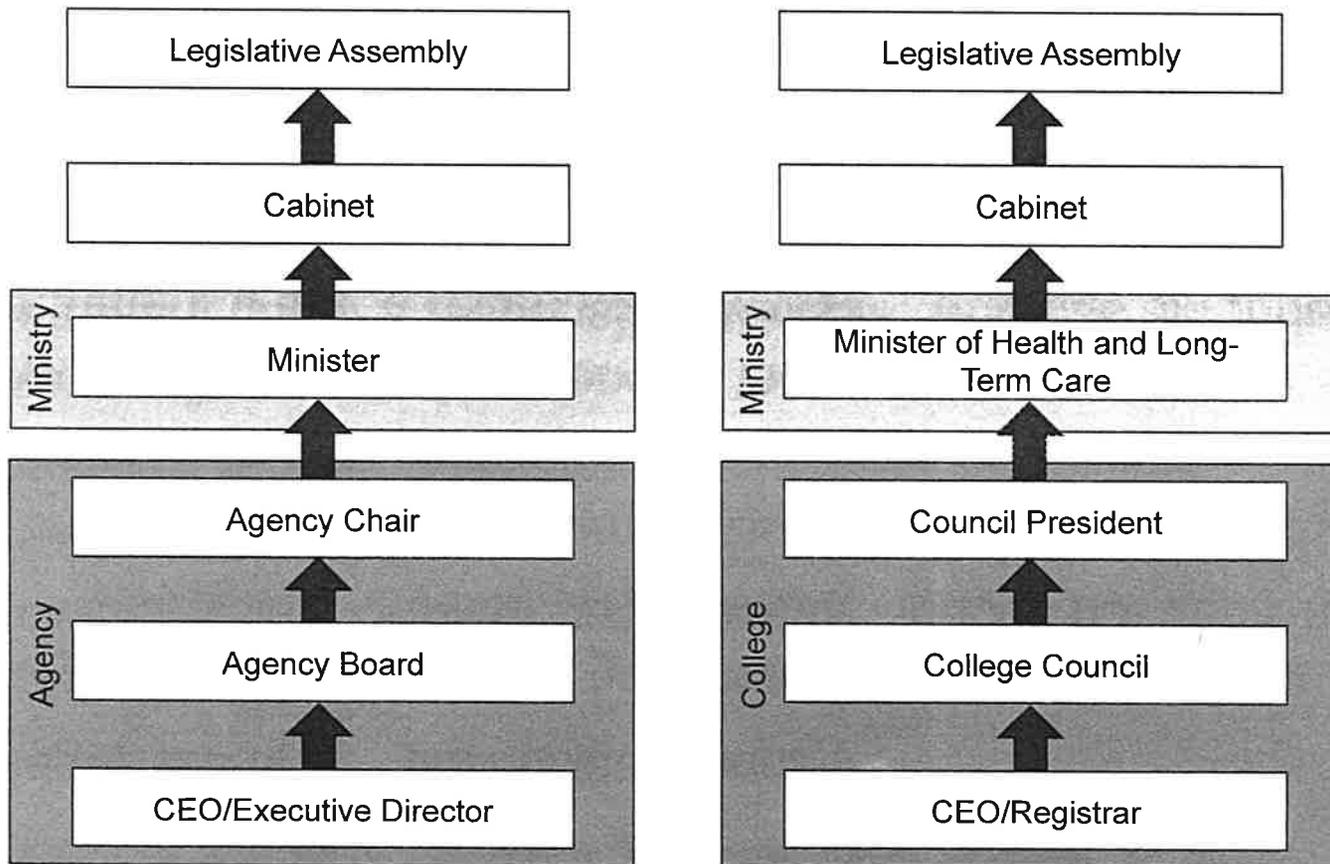
	Governance Indicators	Enablers
Public Policy Outcomes	Accountability	<ul style="list-style-type: none"> • Legitimacy, mandate • Relationship with government • Values and ethics
	Transparency	<ul style="list-style-type: none"> • Reports on Performance • Engages Stakeholders • Communicates
	Stewardship	Excellence in: <ul style="list-style-type: none"> • Finance • People • Operations
	Strategic Focus	<ul style="list-style-type: none"> • Plans and Reacts Strategically • Collaborates • Manages Risk



2. STRUCTURES AND ACCOUNTABILITIES: *The Regulated Health Professions Act*



Accountability: Provincial Agencies and HRCs



Health Regulatory Colleges

- Colleges are NOT “provincial agencies”
 - Most Ontario legislation governing public sector bodies – including the “broader public sector” – does not apply to them
 - Treasury Board/Management Board of Cabinet is not routinely involved in their oversight
- However, like provincial agencies they are established by government under a responsible Minister, who has an underlying accountability for the effective discharge of their mandates
- Established under the *Regulated Health Professions Act, 1991* and governed by that Act, as well as their individual Acts
 - There are 26 health regulatory colleges in Ontario governing 28 professions
 - The *RHPA* colleges regulate over 300,000 healthcare professionals in Ontario



The *Regulated Health Professions Act, 1991* (RHPA)

- Establishes the system of self-regulating health professions in Ontario:
 - to ensure the public receives safe and quality health care services
 - from qualified health professionals
- Common governing framework for all 28 self-regulating health professions:
 - carry out functions relating to registration, investigations, complaints and discipline, quality assurance
 - self-financing
 - regulation and by-law making powers



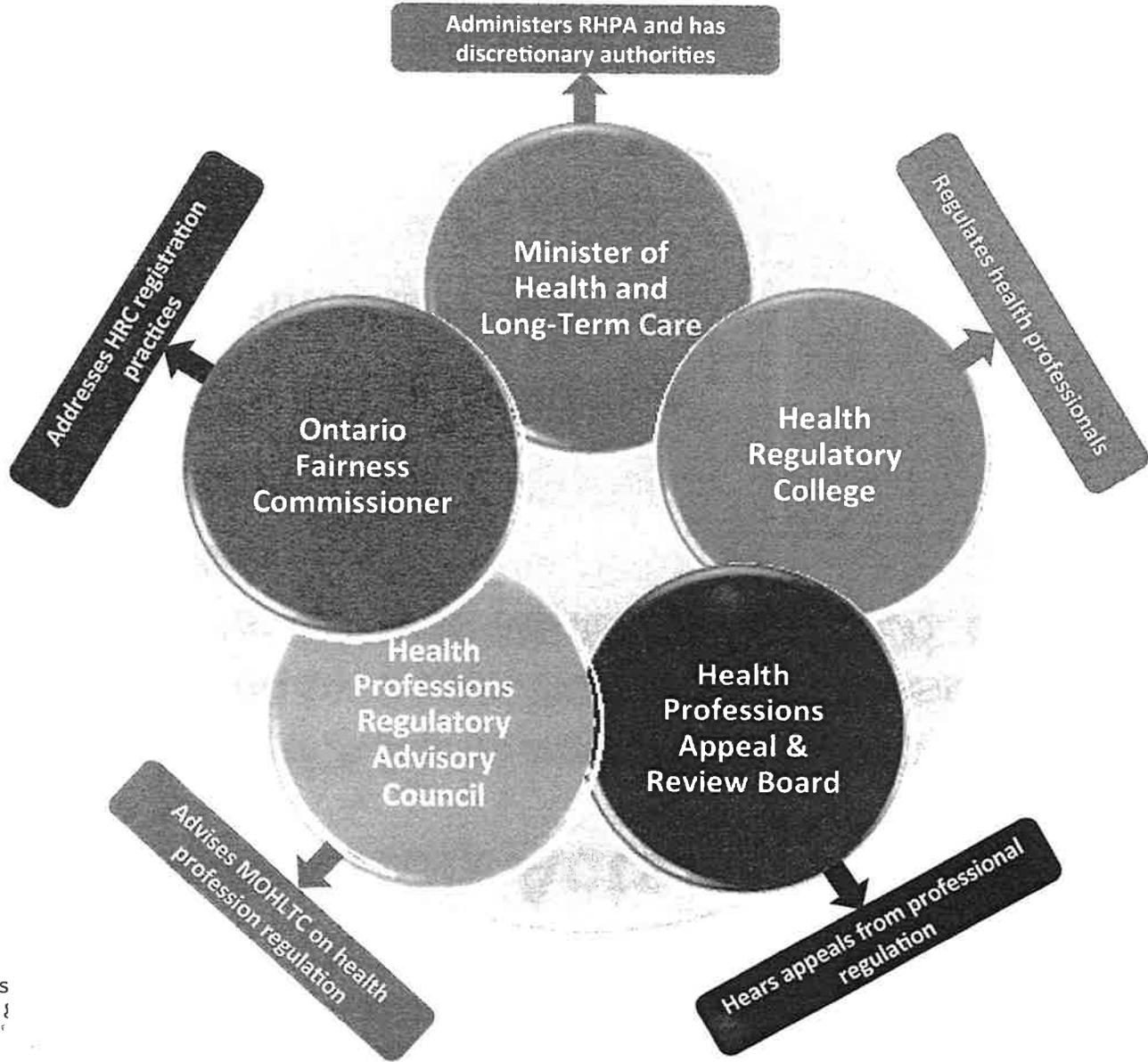
The *Regulated Health Professions Act, 1991* (RHPA)

534

- Prevents unqualified individuals from providing health care services that pose significant risk of harm:
 - restrictions on use of titles
 - controlled/authorized activities
 - regulated health professionals must be members in good standing of health regulatory colleges to practice in Ontario
- Sets out the role and powers of:
 - the Minister of Health and Long-Term Care
 - health regulatory colleges
 - Health Professions Appeal and Review Board
 - Health Professions Regulatory Advisory Council
 - Fairness Commissioner



RHPA: Role Delineation



Health Profession Acts

- In addition to RHPA framework, each health profession is also governed by a specific health profession act (e.g. *Traditional Chinese Medicine Act, 2006, Medicine Act, 1991, etc.*)
- Individual acts include:
 - profession's scope of practice
 - controlled/ authorized acts
 - protected titles
 - composition of the College's governing Council



Health Professions Procedural Code

- The *Health Professions Procedural Code* is set out in Schedule 2 of the RHPA and part of each health profession Act.
- A comprehensive code providing substantive and procedural rights for Colleges, their members and the public, e.g.,:
 - Registering members
 - Fair registration practices, reports and audits
 - Handling complaints
 - Conducting investigations
 - Carrying out discipline and fitness to practice hearings
 - Developing requirements for a quality assurance program
 - Developing a patient relations program
 - Mandatory reporting
 - Funding for victims of sexual abuse by members
 - Rights to appeal to the Health Professions Appeal and Review Board (HPARB) regarding registration and complaint decisions
 - Broad regulation making powers to College Councils



Purpose of Health Professional Regulation

Together, the RHPA and health profession Acts incorporate a number of underlying principles, including:

- Advancing the public interest
- Protecting the public from harm and unqualified, incompetent or unfit providers
- Promoting high quality health care services and accountability of health care professionals
- Providing patients/clients access to health care professionals of their choice
- Achieving equality and consistency by requiring all regulated health professions to adhere to the same purposes, objects, duties, procedures and public interest principles
- Treating individual patients/clients and health professionals in an equitable manner
- Providing flexibility in roles of individual professions through broad scopes of practice
- Zero tolerance for sexual abuse



Health Regulatory Colleges

- Govern the profession and member conduct *in the public interest*
- Self-financing and have day-to-day independence from government in carrying out their statutory responsibilities
- Make regulations under their health profession Act, subject to consultation requirements, prior review by the Minister of Health Long-Term Care, and approval by government
- Appoints a Registrar whose duties are set out in the RHPA
- Subject to confidentiality requirements



Key Functions of Health Regulatory Colleges

540



Key Functions of Health Regulatory Colleges

Registration / Entry to Practice

- Set the registration requirements for entry into the professions
- These requirements are the primary method of assuring the public that a practitioner is competent and qualified to practice

Quality Assurance

- Develop and operate a program to assure the quality of practice of the profession and promote the continuing competence of members
- Components of this program are set out in the Code and the ministry expects they will be included in the regulation

Standards of Practice

- Develop standards of practice on how health professionals do their jobs in an effective, safe and ethical manner
- Members of health professions are legally obliged to adhere to standards of practice



Key Functions of Health Regulatory Colleges

Professional Misconduct

- Act or omissions that breach accepted ethical and professional behaviour
- All regulated health professions are expected to have a regulation clarifying what constitutes misconduct

Complaint and Discipline Processes

- Colleges **must** investigate written complaints made about a member's practice
- If determined to be substantiated the member may be referred to discipline and subject to penalties such as suspension or revocation



Health Regulatory Colleges: Councils

- Each HRC is governed by a Council that serves as the College's board of directors
- Composition of the particular College Council is prescribed in the health profession Act (*e.g. Medicine Act, 1991*)
- Composition usually approximately 51% professional members and 49% public members
 - Public members are appointed by the government (OIC)
 - Professional members are elected by members of the profession



Health Regulatory Colleges: Councils

- Manages and administers the College's affairs
- Has By-law making authority
- Has regulation-making authority (subject to review by the Minister and Lieutenant Governor in Council approval)
- Must appoint one of its employees as Registrar
- Conducts its business at formal meetings (open to both College members and the public)



3. OIC APPOINTEES: *The Agencies and Appointments Directive*



Roles and Responsibilities for OIC Appointments

- Treasury Board/Management Board of Cabinet
 - Establishes ranges and/or rates of remuneration for government appointees; approves changes to remuneration of appointees; grants exceptions or exemptions where relevant
- Minister of Finance
 - Responsible for providing approvals under Sec. 28 of FAA for classes of government appointee indemnities and individual government indemnities falling outside of approved classes
- Ministers
 - Act, with PAS, as prime contact with respect to any appointment within their portfolio; obtain approval of TB/MBC before specifying rate of remuneration for appointees; obtain written approval of President of TB/Minister of Finance before providing indemnity to appointees

Roles and Responsibilities for OIC Appointments (cont'd)

- Deputy Ministers
 - Ensuring ministers and ministries are aware of directive requirements; provide justification for rates of remuneration, and provide information to PAS to enable maintenance of inventory of rates of remuneration
- Treasury Board Secretariat
 - Responsible for advice and assistance to ministries on process to remunerate individuals
- Public Appointment Secretariat (PAS)
 - Provides advice to Minister on Public appointment processes
- Standing Committee on Gov't Agencies
 - Reviews OIC appointments for terms of over one year; intended appointees may be interviewed



Health Regulatory Colleges: Agencies & Appointments Directive

548

- Public appointees are subject to the requirements of the *Agencies and Appointments Directive* (Part 3)
 - Remuneration
 - Ethical Framework
 - Travel, Meal and Hospitality Expenses Directive
 - Indemnification

Agencies & Appointments Directive

- The Agencies & Appointments Directive sets out the framework for accountability for agencies and details the key tools for compliance and reporting. *Elements of the Directive apply to all people appointed by the government to undertake any function on behalf of the government, including people who are appointed by a minister under the authority of a ministry act or by the Lieutenant Governor in Council.*
- The Directive sets out:
 - the principles of an appointment
 - the term of appointments
 - remuneration rates
 - required approvals
 - conflict of interest
 - indemnification
 - requires agency Chair/ CEO attestation annually
 - requires all provincial agencies to publicly post governance documents on a government/agency website



Appointments and Appointee Remuneration

As individuals:

- Government appointments will respect the needs of the entity to which they have been appointed but will also reflect the diversity of the people of Ontario
- An element of public service is implied in any appointment in the Government of Ontario therefore remuneration may not necessarily be competitive with the marketplace

Ethical Framework

- Government appointees are required to full the duties of their appointment in a professional, ethical and competent manner and avoid any real or perceived conflict of interest.
- A government appointee shall:
 - Not use or attempt to use his or her appointment to benefit himself or herself or any person or entity;
 - Not participate in or attempt to influence decision making as an appointee if he or she could benefit from the decision;
 - Not accept a gift that could influence, or that could be seen to influence, the appointee in carrying out the duties of the appointment;
 - Not use or disclose any confidential information, either during or after the appointment, obtained as a result of his or her appointment;
 - Not use government premises, equipment or supplies for purposes unrelated to the appointment;
 - Comply with such additional requirements, if any, established by the entity to which the person is appointed



Ethical Framework (cont'd)

- An appointee must declare a personal or pecuniary interest that could raise a conflict of interest concern at the earliest opportunity to the Chair or to the responsible minister
- Payments for appointees will be made to the person named in the appointment instrument, not to a sole proprietorship, partnership, corporation, or charity
- Appointees are entitled to reimbursement for work-related expenses in accordance with the Travel, Meal and Hospitality Expense Directive and any other TB/MBC directives
- Appointees are not entitled to reimbursement of professional dues or fees



Indemnification

- Government appointees may be indemnified for claims arising from their acts or omissions in the performance or intended performance of their duties as appointees, provided that they acted honestly and in good faith, with a view to the best interests of the college
- Appointees who enjoy statutory immunity from claims in respect of acts or omissions that occur in the good faith execution of their duties as appointees may be indemnified for legal expenses incurred in successfully asserting this statutory defence
- Appointees will not be indemnified in instances of bad faith, willful misconduct or gross negligence



Travel, Meal and Hospitality Expenses Directive: Key principles

- Taxpayers dollars are used prudently and responsibly with a focus on accountability and transparency.
- Expenses for travel, meals and hospitality support government objectives.
- Plans for travel, meals, accommodation and hospitality are necessary and economical with due regard for health and safety.
- Legitimate authorized expenses incurred during the course of government business are reimbursed.
- Best practices are in place, including:
 - Prior approval to incur expenses is obtained.
 - Other options for meetings are always considered before travel is approved, including audio or video conferencing.
 - Corporate travel cards are used for authorized business travel and business related expenses.
 - The government's vendors of record for travel-related services are used whenever possible.

Values in Action

- The value of frugality or “modesty” / acting with prudence
- Transparency:
 - perception and optics
 - oversight of public monies
- Maintaining a culture of openness
 - Be an effective steward of the public interest
 - Avoid secretive behavior and act with due respect to law and ethical standards



Values in Action

- **Diversity and Inclusivity:**
 - Ontario is one of the most diverse multicultural jurisdictions in the world, and this should be reflected in the decisions, norms and values of public institutions
 - Colleges, their councils and therefore council members have a responsibility to model a culture of accommodation and inclusiveness and diversity
- **Accessibility**
 - Colleges have a duty to make all efforts to ensure there is access to people with various disabilities including access to the building, meeting materials and the ability to participate in the discussion and decisions



3. THE PUBLIC INTEREST



The Public Interest

- Lay members of college councils perform a vital service: providing a public interest perspective on the self-regulation and disciplinary process
- Self-regulation reflects the complexity of establishing professional standards and of assessing conduct against those standards
- However, it carries implicit conflicts and risks
 - Professionals bring practitioners' perspective: professional empathy may overtake sensitivity to patient needs
 - General concern for reputation of the profession can present conflicts
- Lay representation counterbalances this and helps to maintain public confidence in the system



The Public Interest: Legal Basis for Self-Regulation

- Health professions self-regulate **under the authority of the legislature**
 - *Regulated Health Professions Act*
 - Health Professions Regulatory Advisory Council
 - ongoing authority of Minister and oversight of MOHLTC
- Self-regulation is **NOT** an inherent right of medical practitioners
 - a measured judgment of how best to serve the public interest
 - subject to numerous conditions and standards
 - subject to revocation



The Public Interest: Minister's Duty

- Minister's duties:
 - To ensure professions are regulated in the **public interest**
 - To ensure appropriate **standards** of practice are developed and maintained
 - To ensure individuals have **access** to health professions of their choice
 - To ensure patients are treated with **sensitivity and respect**
- These are the *goals* of of the system: self-regulation is a (possible) *means*



The Public Interest: Minister's Powers

- Minister's powers:
 - To inquire into the state of practice in a locality or institution
 - To review a college's activities
 - To compel college to make, revoke or amend regulations
 - To require college to do anything necessary or advisable to carry out intent of the Act
- These powers are extensive and reflect the underlying conditionality of self-regulation



The Public Interest: Professional Members

562

- The majority of council members will typically be professional members – i.e., drawn from and selected by the profession itself
- Such members possess medical and related expertise that is essential to the council’s work – e.g., in determining standards of practice
- The expertise of these members clearly provides critical input into the deliberations of the council, but it does not supplant the role of public members
- Professional members have a responsibility to assist public members in understanding their professional perspectives and considerations – for example by answering any questions public members may have
- Public members should bring their perspectives to bear on such issues – for example by explaining how a particular approach or suggested outcome might be perceived by the public, and to ensure that there is adequate sensitivity to such concerns in the decision-making process



The Public Interest: Public Members

- Ontario's approach to self-regulation reflects a high-level of concern for the public interest
 - lay members constitute a potentially large percentage of college members
 - lay members sometimes become presidents
 - establishes a significant counterbalance
- *Regulated Health Professions Act* provides
 - High standard of ministerial duty
 - Extensive residual authorities to enforce those duties
- Lay representation is a key instrument for enabling these statutory provisions



The Public Interest: Risks

564

- Within this framework lay members can be vulnerable to certain risks:
 - excessive deference to professional members & hesitancy to challenge their views
 - Lay members may become co-opted and forget the “public” perspective
 - insufficient attunement to professional criteria
 - lay presidents may become figureheads
- Need to be mindful of the fiduciary responsibility of *all* members



The Public Interest: Fiduciary Duties

- All members have a fiduciary duty towards the college
- Definitions:
 - “A duty of utmost good faith, trust, confidence and candour”
 - “A duty to act with the highest degree of honesty and loyalty towards another person and in the best interests of the other person”
- Duty is owed to the *purposes* of the college (and ultimately the legislation), not to the profession
- Members are not delegates: they bring a particular perspective and then act in the best interests of the organization



Serving the Public Interest: How?

- How do lay members discharge their responsibility to support the public interest?
 - Help professional members understand the view that may be taken by those outside the profession
 - Help ensure that considerations beyond those of the profession are taken into account
 - Ensures that complaints are fully considered, with full regard to patient's interests
 - Can provide “common sense” views on issues such as access and sensitivity/respect



Serving the Public Interest: How?

- How do lay members discharge their responsibility to support the public interest?
 - Recognize what is at stake for both the practitioner and the public
 - Inform oneself about the context in which the practitioner operates
 - Read all cases thoroughly and ask in advance about any terminology or issues you don't understand



The Public Interest

- What do *you* bring to the table?

Case study



5. FAIRNESS



Four Principles interpreted

The Health Professions Procedural Code requires colleges to provide registration that is transparent, objective, impartial and fair.

The Ontario Fairness Commissioner interprets these 4 principles as such:

- **Transparency**
 - openness, accessibility and clarity around process and information
- **Objectivity**
 - consistent application and validation of tools, procedures, criteria and validity of these
- **Impartiality**
 - identification of potential sources of bias and maintenance of systems to address the biases
- **Fairness**
 - in substance, process and perception



Responsibilities of Fairness Commissioner under RHPA

- Assess the registration practices of a College
- Specify audit standards, scope and procedures
- Establish eligibility requirements to conduct audits and a roster of eligible individuals
- Monitor and advise colleges on third parties relied on by a College to assess the qualifications of individuals applying for registration by the College
- Provide advice and recommendations to the Minister, including advice and recommendations that a College do or refrain from doing any action respecting a contravention by a College
- Perform such other functions as may be assigned by the Lieutenant Governor in Council



6. WRAP UP AND SUMMARY OF KEY THEMES



From: Jo-Ann Willson
Sent: Friday, October 09, 2015 3:50 PM
To: Rose Bustria
Subject: FW: Public Appointee Accountability Program
Attachments: MOH Memo Oct 09, 2015.PDF

Exec and Council.

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

College of Chiropractors of Ontario
130 Bloor St. West, Suite 902
Toronto, ON M5S 1N5
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-----Original Message-----

From: Regulatory Projects (MOHLTC) [<mailto:RegulatoryProjects@ontario.ca>]
Sent: Friday, October 09, 2015 3:29 PM
To: boriordan@caslpo.com; fsmith@cocoo.on.ca; Jo-Ann Willson <jpwillson@cco.on.ca>; ltaylor@cdho.org; ifefergrad@rcdso.org; jrigby@cdto.ca; Mary Kennedy <MKennedy@denturists-cdo.com>; melisse.willems@collegeofdietitians.org; 'Basil.Ziv@Collegeofhomeopaths.on.ca'; brenda.kritzer@coko.ca; kwilkie@cmlto.com; corinne.flitton@cmto.com; lgough@cmrto.org; k.dobbin@cmo.on.ca; ED@cnomail.org; fkhan@coptont.org; pgarshowitz@collegeoptom.on.ca; mmoleschi@ocpinfo.com; rgerace@cpso.on.ca; stanchak@collegept.org; rmorris@cpo.on.ca; joyce.rowlands@crpo.ca; taylor@crto.on.ca; cristina.decaprio@ctcmpao.on.ca; Andrew.parr@collegeofnaturopaths.on.ca; elarney@coto.org
Cc: Amodeo, John (MOHLTC) <John.Amodeo@ontario.ca>; Henry, Allison (MOHLTC) <Allison.Henry@ontario.ca>; Weir, Mike (MOHLTC) <Mike.Weir@ontario.ca>
Subject: Public Appointee Accountability Program

Hello,

Please see memo attached inviting all public appointees of health regulatory colleges to participate in mandatory training sessions provided by the Ministry of Health and Long-Term Care. Please distribute this memo to the public appointees of your Council. A response from all public appointees must be received by no later than October 21, 2015.

574

RSVP's are to be sent to Rachel Starr, Policy Analyst, at rachel.starr@ontario.ca<mailto:rachel.starr@ontario.ca>.

Thank you,

**Ministry of Health
and Long-Term Care**

**Health Human Resources
Strategy Division**

12th Floor
56 Wellesley Street West
Toronto ON M5S 2S3
Tel.: 416 212-7885
Fax: 416 327-1878

**Ministère de la Santé
et des Soins de longue durée**

**Division de la stratégie des ressources
humaines dans le domaine de la santé**

12^e étage
56, rue Wellesley Ouest
Toronto ON M5S 2S3
Tél.: 416 212-7885
Téléco.: 416 327-1878



HLTC2968IT-2015-399

October 9, 2015

MEMORANDUM TO: Registrars and Executive Directors
Health Regulatory Colleges

FROM: Denise Cole
Assistant Deputy Minister
Health Human Resources Strategy Division

RE: Public Appointee Accountability Program

Good governance is always of vital importance across the public sector and, as you know, has become a topic of increased public discussion over the past few years. In keeping with the spirit of the Government's *Agencies and Appointments Directive, 2015*, the Ministry of Health and Long Term Care (MOHLTC) has worked with an external vendor, the Institute on Governance, to develop a Public Accountability Program to expand public members' understanding of their roles as well as acquaint them with the principles, policies and best practices related to public sector governance in Ontario.

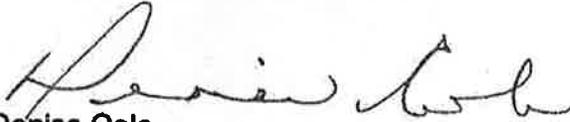
The program is designed to orient and support the public appointees to the Health Regulatory Colleges in fulfilling their duties. All appointees are required to attend one of the five program sessions, which will be delivered on the following dates:

Monday, October 26, 2015 (Queenston Room);
Friday, October 30, 2015 (Queenston Room);
Thursday, November 5, 2015 (Trent Room);
Thursday, November 12, 2015 (Temagami Room); and
Friday, November 13, 2015 (Temagami Room).

All rooms are in the Macdonald Block Complex, 2nd Floor, 900 Bay Street, Toronto. Sessions will run 9:00 a.m. to 4:00 p.m. Public members' regular per diems will be paid and travel expenses will be covered for this mandatory training, and lunch will be served.

Please contact Rachel Starr, MOHLTC at rachel.starr@ontario.ca or (416) 327-8638 to register for one of the sessions. Thank you for your ongoing work and we are looking forward to working with you in future endeavors.

Sincerely,



Denise Cole
Assistant Deputy Minister
Health Human Resources Strategy Division

- c: Mike Weir, CAO and Assistant Deputy Minister, Corporate Services Division
Allison Henry, Director (A), Health System Labour Relations and Regulatory Policy Branch
John Amodeo, Director, Corporate Management Branch

From: Jo-Ann Willson
Sent: Friday, October 09, 2015 4:37 PM
To: Rose Bustria
Subject: FW: Transparency Working Group

Exec and Council.

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

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From: Henry, Allison (MOHLTC) [<mailto:Allison.Henry@ontario.ca>]
Sent: Friday, October 09, 2015 4:33 PM
To: boriordan@caslpo.com; fsmith@cocoo.on.ca; Jo-Ann Willson <jwillson@cco.on.ca>; ltaylor@cdho.org; ifefergrad@rcdso.org; jrigby@cdto.ca; Mary Kennedy (MKennedy@denturists-cdo.com) <MKennedy@denturists-cdo.com>; melisse.willems@collegeofdietitians.org; basil.ziv@collegeofhomeopaths.on.ca; brenda.kritzer@coko.ca; kwilkie@cmlto.com; corinne.flitton@cmtto.com; lgough@cmrto.org; k.dobbin@cmo.on.ca; ED@cnomail.org; Elinor Larney <elarney@coto.org>; fkhan@coptont.org; pgarshowitz@collegeoptom.on.ca; mmoleschi@ocpinfo.com; rgerace@cpso.on.ca; stanchak@collegept.org; rmorris@cpo.on.ca; Joyce Rowlands (J.Rowlands@crpo.ca) <J.Rowlands@crpo.ca>; taylor@cрто.on.ca; cristina.decaprio@ctcmpao.on.ca; Andrew Parr <Andrew.Parr@CollegeOfNaturopaths.on.ca>
Cc: Lamb, David (MOHLTC) <David.Lamb@ontario.ca>; Cheng, Stephen (MOHLTC) <Stephen.Cheng@ontario.ca>; Holm, Bruna E. (MOHLTC) <Bruna.Holm@ontario.ca>; Starr, Rachel (MOHLTC) <Rachel.Starr@ontario.ca>; An, Linda (MOHLTC) <Linda.An@ontario.ca>
Subject: Transparency Working Group

Hello Registrars/Executive Directors,

As you know, the Health Human Resources Strategy Division at the ministry has established transparency strategy which aims to build on existing efforts to enhance and standardize measures adopted by health regulatory colleges to increase their transparency practices in support of the *Patients First: The Action Plan for Health Care*.

The Ministry is now seeking to advance the strategy by establishing the Transparency Working Group (TWG), comprised of representatives of the ministry, colleges and from the wider health system, as well as members of the public to advise and assist the ministry in shaping and implementing the transparency strategy.

578

I am writing to let you know that we will be setting up the TWG for its first meeting later this month and would like to share further information

To this end, we will be hosting a short teleconference on **Friday, October 16 from 3:15 to 4:00PM** in which the Ministry will share further information about the expectations and composition of this working group.

Dial in information is as follows: 416-212-8013; Access Code: 3400650#

Please let Rachel Starr know whether you will be in attendance. Rachel can be reached at rachel.starr@ontario.ca or at 416-327-8638.

We look forward to speaking with you next Friday. Have a great long weekend.

Allison

Allison Henry, A/Director
Health System Labour Relations and Regulatory Policy Branch
Health Human Resources Strategy Division
12 Floor, 56 Wellesley Street West
Toronto ON M5S 2S3
416-327-8543

Rose Bustria

From: Jo-Ann Willson
Sent: Tuesday, October 20, 2015 2:33 PM
To: Rose Bustria
Subject: FW: Transparency Strategy - Transparency Working Group

579

Council.

Jo-Ann Willson, B.Sc., M.S.W., LL.B.
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From: Henry, Allison (MOHLTC) [mailto:Allison.Henry@ontario.ca]
Sent: Tuesday, October 20, 2015 2:08 PM
To: boriordan@caslpo.com; fsmith@cocoo.on.ca; Jo-Ann Willson <jpwillson@cco.on.ca>; Itaylor@cdho.org; ifefergrad@rcdso.org; jrigby@cdto.ca; Mary Kennedy (MKennedy@denturists-cdo.com) <MKennedy@denturists-cdo.com>; melisse.willems@collegeofdietitians.org; brenda.kritzer@coko.ca; kwilkie@cmlto.com; corinne.flitton@cmto.com; 'lgough@cmrto.org' <lgough@cmrto.org>; 'k.dobbin@cmo.on.ca' <k.dobbin@cmo.on.ca>; ED@cnomail.org; Elinor Larney <elarney@coto.org>; fkhan@coptont.org; pgarshowitz@collegeoptom.on.ca; 'mmoleschi@ocpinfo.com' <mmoleschi@ocpinfo.com>; 'rgerace@cpso.on.ca' <rgerace@cpso.on.ca>; stanchak@collegept.org; rmorris@cpo.on.ca; taylor@ccto.on.ca; cristina.decaprio@ctcmpao.on.ca; Andrew Parr <Andrew.Parr@CollegeOfNaturopaths.on.ca>; 'j.rowlands@crpo.ca' <j.rowlands@crpo.ca>; basil.ziv@collegeofhomeopaths.on.ca
Cc: Lamb, David (MOHLTC) <David.Lamb@ontario.ca>; Holm, Bruna E. (MOHLTC) <Bruna.Holm@ontario.ca>; Santolin, Anna (MOHLTC) <Anna.Santolin@ontario.ca>; Starr, Rachel (MOHLTC) <Rachel.Starr@ontario.ca>
Subject: Transparency Strategy - Transparency Working Group

Hello All,

Very many thanks for attending the teleconference on Friday October 16, 2015 where we were able to discuss the next steps for the Health Human Resources Strategy Division's Transparency Strategy and the creation of the Transparency Working Group (TWG).

As we mentioned, we're looking to move quickly and the first meeting of the group will be taking place on October 26th for the College representatives only. I want to take this opportunity to follow up on a couple of items:

580

Firstly we'd like to thank you for the great response we had to the co-Chair position. As a result we're pleased that Irwin Fefergrad, Registrar, Royal College of Dental Surgeons of Ontario has agreed to take on this role and we look forward to working with him.

Also as we noted on the teleconference, we will be reaching out in the next couple of days to those of you whose staff we have identified as potential College representatives on the TWG. Again, while it won't be possible for all colleges to have direct representation on the TWG, we've done our best to ensure a broad cross section of perspectives through those we've selected and there will be a chance for input as the Transparency Strategy develops as a whole.

We will of course share a final list of college participants by the end of this week and will keep you updated on the progress on the TWG.

Again, thank you for taking time out of your busy schedules to participate on the teleconference last Friday. We look forward to working collaboratively with each college in the near future.

Allison

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From: Jo-Ann Willson
Sent: Friday, October 30, 2015 2:39 PM
To: Rose Bustria
Subject: FW: Transparency Working Group Update

Council.

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From: Henry, Allison (MOHLTC) [mailto:Allison.Henry@ontario.ca]
Sent: Friday, October 30, 2015 2:31 PM
To: boriordan@caspo.com; fsmith@cocoo.on.ca; Jo-Ann Willson <jwillson@cco.on.ca>; ltaylor@cdho.org; jrigby@cdto.ca; Mary Kennedy (MKennedy@denturists-cdo.com) <MKennedy@denturists-cdo.com>; melisse.willems@collegeofdietitians.org; brenda.kritzer@coko.ca; kwilkie@cmlto.com; corinne.flitton@cmtto.com; 'lgough@cmrto.org' <lgough@cmrto.org>; 'k.dobbin@cmo.on.ca' <k.dobbin@cmo.on.ca>; ED@cnoemail.org; Elinor Larney <elarney@coto.org>; fkhan@coptont.org; pgarshowitz@collegeoptom.on.ca; 'mmoleschi@ocpinfo.com' <mmoleschi@ocpinfo.com>; 'rgerace@cpsy.on.ca' <rgerace@cpsy.on.ca>; stanchak@collegept.org; rmorris@cpo.on.ca; taylor@crto.on.ca; cristina.decaprio@ctcmpao.on.ca; Andrew Parr <Andrew.Parr@CollegeOfNaturopaths.on.ca>; 'j.rowlands@crpo.ca' <j.rowlands@crpo.ca>; basil.ziv@collegeofhomeopaths.on.ca
Cc: ifefergrad@rcdso.org; Lamb, David (MOHLTC) <David.Lamb@ontario.ca>; An, Linda (MOHLTC) <Linda.An@ontario.ca>; Starr, Rachel (MOHLTC) <Rachel.Starr@ontario.ca>
Subject: Transparency Working Group Update

Hello all,

Just a quick note to update you about the Transparency Working Group.

Firstly, we'd like to thank you all for the support you've shown for the approach we've taken in bringing the project forward. We appreciate that there's something of a leap of faith about this, but it's a great opportunity to move together with the goal of greater transparency within our regulatory system.

The Working Group

Next, and as promised, we'd like to introduce you to the Transparency Working Group itself. While we're still putting together the patient/public and sector memberships, the College representatives are in place and are as follows:

582

- **Kevin McCarthy**, Manager, Strategy, College of Nurses of Ontario
- **Maureen Boon**, Senior Advisor, Executive Office, College of Physicians and Surgeons of Ontario
- **Anne Resnick**, Deputy Registrar, Ontario College of Pharmacists
- **Caroline Morris**, Director of Professional Practice, College of Medical Radiation Technologists of Ontario
- **Anita Ashton**, Director, Professional Practice, College of Physiotherapists of Ontario
- **Marina Solakhyan**, Manager, Governance and Regulatory Policy, College of Midwives of Ontario
- **Jeremy Quesnelle**, Director of Professional Practice, College of Naturopaths of Ontario

We're sure you'll agree that we've got a great group who will be able to represent a very broad set of perspectives are excited about getting started!

First Meeting

As many of you know, the TWG had its first meeting yesterday with the view to working on implementation of the four pillars of the strategy that were referenced in the call on October 16, 2015.

At the outset the group will be looking at common approaches that can be applied across all colleges to:

- a) Making more Information Publicly Available, and
- b) Making the Decision-Making Process More Open and Accountable.

We'll continue to ensure that you receive key updates on the group's progress at regular intervals via email as the work unfolds but we want to make sure that the group has the latitude to explore the issues and provide its best advice and assistance in advancing the strategy and we're looking for you to support this approach.

Thank you,

Allison

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From: Jo-Ann Willson
Sent: Wednesday, November 04, 2015 2:57 PM
To: Rose Bustria
Subject: FW: Minister Hoskins Remarks at HealthAchieve Today
Attachments: Minister Hoskins Remarks at HealthAchieve - 4nov2015 - DISTRIBUTION.pdf

Council.

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From: Araneda, Derrick (MOHLTC) [mailto:Derrick.Araneda@ontario.ca]
Sent: Wednesday, November 04, 2015 2:48 PM
To: Araneda, Derrick (MOHLTC) <Derrick.Araneda@ontario.ca>
Subject: Minister Hoskins Remarks at HealthAchieve Today

Good Afternoon,

Today Minister Hoskins gave remarks at the HealthAchieve conference. We wanted to share a copy of the speech with you. Please feel free to share with those who may be interested. If you have any questions, feel free to let me know.

Sincerely,

Derrick Araneda

Director of Stakeholder Relations
Office of the Honourable Dr. Eric Hoskins
Ontario's Minister of Health & Long-Term Care
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Remarks to the 2015 HealthAchieve Conference

Dr. Eric Hoskins

Minister of Health and Long-Term Care

4 November 2015

CHECK AGAINST DELIVERY

Good morning everyone. Thank you for that very kind introduction.

And thank you for inviting me to be here for HealthAchieve.

I have heard from so many of you that this year's conference has been especially inspiring – and that inspiration comes from the outstanding sessions HealthAchieve has organized, from the speakers you've heard, and of course, from the quality of the conference attendees.

But I also think a good amount of that inspiration comes from this year's theme—Innovation.

Hearing innovative ideas, meeting people like you who have overcome challenges by breaking with the status quo, by embracing a relentless drive to think bigger—that inspires me. And let me tell you, as Ontario's Minister of Health and Long-Term Care, I couldn't be more inspired by the work that you do and the innovation you achieve.

As a government and a system, we need to do a lot more to embrace innovation—but we're committed to rising to that challenge. I hope you had the chance to visit our government's booth to learn about some of the ways we are embracing innovation, and helping to bring your innovative ideas to fruition.

I also hope you had the opportunity to meet our new Chief Health Innovation Strategist, Bill Charnetski. Bob Bell and I are so excited to have Bill on our team.

Innovation, of course, is about more than new technologies. Innovation is fundamentally about new ideas: identifying a need and coming up with a new way of meeting it. So we need to embrace new ideas as well as new technologies, if we are to transform our system for the better.

System transformation—it's an idea and a process that I spoke about last year, and it's an idea that Minister Matthews has spoken about too. It's almost like HealthAchieve has become the podium of record for Ministers of Health to talk about system transformation.

And that's fair—system transformation is a complex undertaking, and you're a sophisticated audience, made up of leaders from across the health care system.

After all, you've lived system transformation. Ontario's hospitals, especially, have been some of our most innovative partners as we move to a more patient-centred system.

We haven't made it easy for you—I know that by holding the line on budget increases, the government has asked a lot of you. But you've responded by being the best partners we could hope to have. You've responded by showing leadership, dedication, and a fundamental commitment to the well-being of your patients.

That fundamental commitment is not unique to hospitals and to those who make them run. It is what motivates every single one of us here in this room to get out of bed in the morning, whether you work on the front-lines or whether you work to keep the lights on.

The well-being of patients—putting patients first—is what motivates me as the Minister. It's what motivates me as a family doctor and as a public health specialist. It's what motivated me before I got into politics. And it will motivate me long after I leave the political world.

So here at HealthAchieve, I want to talk about how that commitment we all share, to the well-being of our patients, must drive system transformation. And how, by embracing new ways of doing things, we can build a system that better understands and meets the needs of our patients—no matter their background, their income, or where they live.

Today, here at HealthAchieve, I want to invite you to join me in breaking from the status quo.

Together with you—always as partners—we will embrace true system transformation. We will embrace change.

Change that is bold.

Change that doesn't just tinker around the edges.

Change that improves the structure of our system in a profound way, always focused on better access for our patients and better care when they need it most.

I want to talk to you today about why I believe we must undertake structural change to our health care system.

And then I want to talk to you about how we'll achieve our goals.

For me, as a lifelong physician and public health specialist, who has worked around the world to provide care to those in need, the “why” of system transformation is a quintessentially Canadian idea. It is the fundamental promise of our universal health care system.

It is the promise that every person, no matter who they are, no matter where they live or how much they earn... every person deserves equitable access to health care.

Fundamentally, for me, the “why” of system transformation, is health equity.

A couple of weeks ago, Health Quality Ontario released their annual Measuring Up report. I was pleased to see in that report that we're doing well or holding steady on a number of important

indicators. But one area where we need to improve—and where we can't afford to delay—is in closing the gaps that exist between different geographic areas of the province.

And when you see that data, you see that geography is only part of the story. We're talking about gaps in our success at treating populations with low socio-economic status. We're talking about populations where we haven't done enough to address the social determinants of health.

And HQO's findings are just one example.

Dr. Kwame McKenzie and his team have been working on this issue for years at the Wellesley Institute, and the Toronto Central LHIN has been focusing on health equity, including at its recent symposium less than two months ago.

A movement is building across the country for equitable access to drugs through a national pharmacare program – and I'm proud to have brought together my provincial and territorial colleagues to make the point loud and clear that the time has come for national pharmacare – that no one should have to choose between paying for medication or putting food on the table.

And I will continue to advocate for national pharmacare with our new federal government, and at our January provincial/territorial health ministers' meeting in Vancouver.

The movement for greater health equity is building. And it is informed by solid evidence.

To take the example just of Toronto, the disparities in health equity here are much too stark. In his groundbreaking report, Dr. David Hulchanski at the University of Toronto identified three cities within Toronto—the three Toronto's—characterized by serious income polarization.

Now, we know that income is a key social determinant of health. But what the Three Toronto's study illuminated is that Torontonians with the highest income also live in areas of the city with the highest concentration and best quality of health care services.

In other words, they don't just have better outcomes—which is what we already know very well about social determinants of health—but better access.

And that's a stark illustration of exactly what our challenge really is.

Several years ago, when our government released the Poverty Reduction Strategy with the goal of lifting children out of poverty, we called it Breaking the Cycle.

It's time we also broke the cycle of poor health outcomes and fulfill our responsibility as a health care system to deliver universal and equitable access to services.

After all, putting patients first... truly putting patients first... is not about prioritizing our easiest patients. It's prioritizing the patients who need our services the most. And bringing those services to them. It's about embracing a population-based approach to delivering care.

As a policy-maker, I am well aware that delivering on a promise of health equity isn't something the health care system can do alone.

True health equity requires a "Health in All Policies" approach. It requires breaking down the silos between health policy and social policy. It requires better integration not just within a system, but across government.

In the months and years ahead, you have my commitment that I will do my part at the government level—I will be an active champion for health equity, for Health in All Policies, working across government and with my Cabinet colleagues on a strategy to address the social determinants of health, to improve the health equity of all Ontarians.

And as we take on that work, there is a central role that our health care system must play. In short, we must lead the way.

We must move beyond a system where care is good quality, but is too often fragmented, disconnected, or siloed.

We must reorganize our system in a bold and transformational way so that we can deliver on our promise of health equity—of equitable access. We must build a system that best meets the needs of Ontarians, that closes gaps, and brings services to the people who need them most.

That is a system that puts patients first. That is the "why" of system transformation.

But just as important as the "why," is the question of "how."

I believe that a system that best meets the needs of patients in an equitable way is one that is truly population-focused, and that is deeply integrated at the local level.

That starts with strong local governance.

And that was the driving force behind the creation of our Local Health Integration Networks – that local governance is the best way to meet a population's local needs, not by managing everything from our offices here in Toronto.

I have had the pleasure of travelling to meet with most of the LHIN boards across the province, and I've been so impressed with their depth of local knowledge, and with the capacity that each of our LHINs has shown to be true local managers of the health care system.

LHINs know the needs of their population – and they know the partners and service providers who care for that population.

They've become much more sophisticated and they must continue to evolve.

LHINs have the capacity to play a role that better acknowledges the true importance of local decision-making and local management.

And that includes primary care.

As part of our recent discussions on the future of our health care system, we have benefited immensely from the work of a number of skilled experts—including the recommendations of Dr. David Price and Elizabeth Baker, along with their fellow panel members.

In their report, they call for primary care providers to be better integrated among themselves, and within the health care system at the local level.

Though the Baker-Price report is just one voice, it is a powerful one. And it has reinforced my belief that primary care is an important bedrock of our health care system. It must be organized around the needs of patients, and around the local population that we serve.

As we move forward with implementing our primary care guarantee—that every Ontarian who wants one will have a primary care provider—and with our commitment to significantly improve same-day or next-day access to care, I look forward to consulting with all of our health care system leaders on the best way to achieve this transformation.

But make no mistake—I believe that if we are to transform our system to one that is focused on population health and equitable access, the time is right for more local governance, and for our LHINs to play a much greater role.

After all, there is perhaps no more important quality of a health care system that puts patients first than the quality of being integrated. That goes for our system of primary care, but you know it's true for our system as a whole.

And that means our home and community care system as well.

We have begun to take important steps to transform our home and community care system so that it delivers better and more consistent care for the patients who rely on our services.

We have followed the advice of experts like Gail Donner and her panel. They told us to ensure that form follows function—that we focus first on offering more consistent services that meet the needs of the local population—before we have the much-needed discussion on structure.

With that in mind, I launched our home and community care roadmap, with 10 concrete steps we will take to improve the patient, client, and caregiver experience in home and community care. We have begun to implement the roadmap, including the first phase of our bundled care projects—they were pioneered at St. Joe's in Hamilton with their Integrated Funding Model—and they're a real example of integrated care at the local level.

Now the time has come for us to have a conversation about the structure of the system.

We owe it to patients and providers to be bold—we owe it to them to be transformational.

We should ask ourselves—to deliver better results for our patients, to deliver more equitable access to the services our population needs, is it time to reconsider the relationship between our CCACs and the LHINs? Is it time to consider deeper integration? And might that be the best way to provide consistent and targeted care that addresses the needs, first and foremost, of the local population?

These are questions our ministry is considering, always guided by the recognition that... home care leadership, our coordinators and our care providers... all of them are essential and their functions remain necessary in an integrated future.

As we move forward, we will continue to benefit from your advice and expertise. But what I'm certain of is that we must never take our eyes off the goal of true integration.

End-to-end, population-based integration across the health care system. That includes public health; it includes primary care; and it includes home and community care.

An integrated system, for the benefit of our patients.

Integration is not a new idea. And the people in this room have been instrumental in driving integration in our health care system. Across all of our LHINs, across all of our hospitals and our CCACs and our primary care organizations and our providers, you have taken the lead on projects that have improved patient outcomes by delivering integrated health care.

But our work has only begun. To truly transform our health care system into one that puts patients first, we cannot limit integration, using it on a project-by-project basis. We need system-wide integration.

Let me give you an example. Hospitals in rural Ontario, in collaboration with the Ontario Hospitals Association, have been leading change that captures exactly what I mean—focusing on end-to-end integration of services from public health, primary care, mental health, the management of chronic diseases, acute care, home and community care, long-term care, and palliative care.

End-to-end integration. That's the end-state of an initiative called Rural Health Hubs, and in the coming weeks, I will be announcing the first successful sites.

I love Rural Health Hubs because they move the yardstick forward on integration—by leaps and bounds. They do it in a population-based way. And they address that important equity of access issue for people who live in rural communities.

Greater equity through greater integration. I believe that is the future of our health care system. And we have evidence that it works.

Look at the success of our Health Links – which target the province’s most complex patients.

With their emphasis on care coordination and integrated care, Health Links have been tremendously effective at bringing care to the people who need it most.

Through our 82 Health Links, nearly 10,000 of the patients most in-need have individualized, coordinated care plans.

Care coordinators have helped to break down the silos in our system, filling in gaps, and helping patients navigate the system... patients most at-risk of falling through the cracks.

They have shown that integrated care can deliver better results not just when it comes to individual patient outcomes, but when it comes to health equity as well. After all, we know that these five percent of patients that Health Links target often experience precarious housing, with higher incidents of poverty and other social determinants of health.

Some of the most innovative Health Links have recognized the importance of health equity in everything they do. They have sought not just to integrate service providers within the health care system; they have reached out to include and integrate a broader range of social service providers, like those that provide housing.

Because as we work together to improve health equity—to bring services to the people who need them most—integration will only make our efforts more effective. It can only lead to better outcomes for our patients.

Today—as I’ve laid out my vision of the “why” and the “how” of the changes we hope to make—I’ve asked you to join me in envisioning a system transformed... a system that delivers equitable access to the services our patients need... A system that sends care where it’s needed most... A system that puts patients first and is singularly focused on their well-being.

We have made great strides together in moving toward that system. But there is much more work to do, and lots of changes to make.

But we can do it together. There are no partners I would rather have than this dedicated group of people who, day-in-and-day-out, strive always to provide the best care to the people who depend on us.

Over the coming months, my ministry will be actively engaging with stakeholders and the public as I develop my plan for the next steps of system transformation.

I hope you will join us, and contribute your expertise, your experiences on the front-lines, and yes, your frank advice. We can’t succeed without it.

591

This is not work that will be easy. But it is, ultimately, work that we have done before. It is putting patients first; it's what you do every day, and it's what you do better than anyone else.

It bears repeating—there are no partners I'd rather have as we take on the kinds of changes we've envisioned here today.

Stronger local governance. Greater integration.

And ultimately, more equity... more care...for those Ontarians who need it most.

Thank you.

ONTARIO REGULATION 283/15

made under the

HEALTH INSURANCE ACT

ITEM 4.1.21

Made: September 16, 2015
 Filed: September 18, 2015
 Published on e-Laws: September 18, 2015
 Printed in *The Ontario Gazette*: October 3, 2015

Amending Reg. 552 of R.R.O. 1990
 (GENERAL)

1. (1) The definition of “schedule of benefits” in subsection 1 (1) of Regulation 552 of the Revised Regulations of Ontario, 1990 is amended by adding the following paragraph:

28. Amendments dated September 1, 2015 (effective as of October 1, 2015);

(2) The definition of “schedule of benefits” in subsection 1 (1) of the Regulation is amended by adding the following paragraph:

29. Amendments dated September 1, 2015 (effective as of April 1, 2016);

2. The Regulation is amended by adding the following section:

37.10 (1) Despite subsection 37.1 (2), the amount payable for an insured service rendered by a physician in Ontario, as set out in the schedule of benefits, shall be reduced by 1.3 per cent if the service is rendered on or after October 1, 2015.

(2) For greater certainty, the reduction under subsection (1) is in addition to, and not in place of, any other reduction provided for under this Regulation.

3. The Regulation is amended by adding the following section:

37.11 (1) Despite subsection 37.1 (2) where, in respect of a fiscal year, \$1,000,000 has already been payable from the Plan for the professional component of insured services rendered by a physician in Ontario after all the adjustments under this Regulation to the amount set out in the schedule of benefits have been applied, the amount payable to the physician for the professional component of insured services rendered in Ontario for the remainder of the fiscal year shall be reduced by 1 per cent.

(2) For greater certainty, the reduction under subsection (1) is in addition to, and not in place of, any other reduction provided for under this Regulation.

(3) In this section,

“fiscal year” means the period beginning on April 1 in one year, and ending on March 31 in the following year;

“professional component” has the same meaning as in the schedule of benefits.

Commencement

4. (1) Subject to subsections (2) to (4), this Regulation comes into force on the day it is filed.

(2) Subsection 1 (1) and section 2 come into force on October 1, 2015.

(3) Subsection 1 (2) comes into force on April 1, 2016.

(4) Section 3 shall be deemed to have come into force on April 1, 2015.

Health minister aims to investigate MD pay

Province imposes two rounds of fee cuts on doctors after failing to reach an agreement

**ROB FERGUSON
AND THERESA BOYLE**
STAFF REPORTERS

Health Minister Eric Hoskins says he wants to create a task force to tackle the thorny issue of how doctors get paid.

He met with the Ontario Medical Association on Tuesday and urged that the organization representing the province's 28,000 doctors take part in the proposal.

The idea to create a task force was first proposed last December by Ontario's former chief Justice Warren Winkler who served as a conciliator during contract negotiations between the province and its doctors.

The two sides never reached an agreement and the province has

since imposed two rounds of unilateral fee cuts on doctors. The OMA says that, in total, physician fees have been slashed by 6.9 per cent this year.

Hoskins says he needs to divert the money from the \$11.6-billion physician services budget into home care. He maintains that Ontario doctors are the best paid in Canada, earning an average of \$368,000 before expenses. (Some doctors, for example, family physicians get much less than that while specialists, for example, ophthalmologists, get much more.)

In his report, Winkler warned that the two sides were on a "collision course" unless significant reforms were made.

Hoskins said he wants to follow through on Winkler's recommendation to create a task force to make recommendations for improving and funding physician services.

"One of the things Winkler spoke to was putting together a team from the



MICHAEL BRYANT/TRIBUNE NEWS SERVICE FILE PHOTO

Health Minister Eric Hoskins says he needs to divert money from the \$11.6-billion provincial physician services budget into home care.

OMA and from the ministry and other stakeholders, to really, in a serious way for quite frankly the first time, look at the issue of physician com-

penensation and the delivery of health services by physicians," Hoskins said. "(It would address) how they can and should be best compensated,

how to create a sustainable way of doing that, how to frame it within the reforms that are taking place in the health-care system. There's a lot we can do together," he added.

The OMA has so far issued no public response. The organization's board of directors is gathering on Wednesday and plans to discuss the Hoskins' meeting.

In an email update sent to doctors on Monday, OMA president Dr. Mike Toth said board members plan to discuss next steps, including possible legal action. The update hints that doctors may be preparing to take some sort of job action.

Toth wrote that 200 physician leaders met on Sunday and held a "brainstorming exercise designed to test and confirm innovative and impactful actions that members might undertake in various clinical settings and geographic areas across the province."

From: Jo-Ann Willson
Sent: Wednesday, September 16, 2015 3:10 PM
To: Rose Bustria
Subject: FW: Message Regarding the HPARB's Annual Stakeholder Meeting
Attachments: 2015.09.16 - Stakeholder Message.pdf

Exec and Council.

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

College of Chiropractors of Ontario
130 Bloor St. West, Suite 902
Toronto, ON M5S 1N5
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From: Dunscombe, Anna (MOHLTC) [<mailto:Anna.Dunscombe@ontario.ca>]
Sent: Wednesday, September 16, 2015 2:59 PM
Cc: van der Vliet, Sara (MOHLTC) <Sara.VanderVliet@ontario.ca>; Vauthier, Janice (MOHLTC) <Janice.Vauthier@ontario.ca>
Subject: Message Regarding the HPARB's Annual Stakeholder Meeting

Dear Registrar,

Please find attached correspondence sent on behalf of Sara van der Vliet, Registrar of the Health Professions Appeal and Review Board.

Thank you,

Anna Dunscombe

A/ Executive Assistant and Researcher
Health Boards Secretariat
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4
416-327-8514
416-327-8524 (facsimile)

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595

September 16, 2015

Ontario Regulatory Health College Registrars
Via Email

Dear Registrar,

**RE: HEALTH PROFESSIONS APPEAL AND REVIEW BOARD
2015 STAKEHOLDER MEETING**

The Health Professions Appeal and Review Board (the Board) remains committed to an open dialogue with all stakeholders and values the feedback received from the Ontario Regulatory Health College community.

As you may recall, in past years the Board has held a Stakeholder Meeting in the fall months in order to facilitate open lines of communication, as well as providing a venue to inform about Board process changes and important administrative updates. Due to a very busy fall season this calendar year, we regret to inform you that the Board will postpone its 2015 Stakeholder Meeting, and instead looks forward to meeting with you again in 2016.

We appreciate that you may have topics of interest affecting your college, and we invite you to communicate these updates to the Board either through myself directly, or to the Board Chair by linking with our Executive Assistant and Researcher, Anna Dunscombe.

The Health Professions Appeal and Review Board looks forward to meeting with you again in 2016 and wishes you a pleasant fall season.

Yours truly,

A handwritten signature in black ink, appearing to read 'Sara van der Vliet'.

Sara van der Vliet
Registrar

c.: Janice Vauthier, Chair
Health Professions Appeal and Review Board



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 Chair
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 Tel (416) 326-1550
 Fax (416) 326-1549
 Web site www.hprac.org
 E-mail
Thomas.Corcoran@hprac.org

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 Président
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 Toronto ON M5S 2S3
 Tél (416) 326-1550
 Téléc (416) 326-1549
 Site web www.hprac.org
 Courriel
Thomas.Corcoran@hprac.org

Dear Registrar,

On November 4th the Minister of Health and Long-Term Care requested that the Health Professions Regulatory Advisory Council (HPRAC) conduct consultations to assess three models of Registered Nurse (RN) prescribing and make recommendations on which model is the most appropriate for Ontario. The letter is attached.

You will note that the referral letter expects HPRAC to provide its advice by the end of March 2016. This deadline implies that certain components of HPRAC consultation process will be shortened – not omitted. For this reason, HPRAC will be requesting that all stakeholders, including your College, who wish to provide input to HPRAC on this referral, do so in the timeframes indicated. In the coming days a questionnaire will be submitted to your College requesting input on the referral.

HPRAC's provision of the best possible recommendations to the Minister is dependent on the expertise and input provided by stakeholders such as your College. I am confident that you and your organization will provide excellent input, despite the shortened consultation period.

Should you have any questions, please do not hesitate to contact the new Executive Coordinator Gwen Gignac (gwen.gignac@ontario.ca) at 416-327-8126. I have provided you with an introduction to Ms. Gignac in the attached PDF document.

Sincerely,

Thomas Corcoran
 Chair
 Health Professions Regulatory Advisory Council



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 12th Floor
 Toronto ON M5S 2S3
 Tel (416) 326-1550
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 Site web www.hprac.org
 Courriel
Thomas.Corcoran@hprac.org

November 9, 2015

Dear colleagues,

I am pleased to welcome Gwen Gignac to the Executive Coordinator role on an interim basis at the Health Professions Regulatory Advisory Council (HPRAC) while Christy Hackney takes a leave of absence.

Gwen has over 17 years of experience with the Ontario Public Service with the last 15 years focused on health professional regulation with the Ministry of Health and Long-Term Care. She has worked extensively with health regulatory colleges providing policy advice on proposed regulations under the *Regulated Health Professions Act, 1991* and its associated health profession specific Acts.

She has developed and administered funding programs such as the Interprofessional Care/Education Fund and worked collaboratively with the Ministry of Training, Colleges and Universities on issues of interprofessional care and education. Gwen holds a BA from York University in Conservation and Environmental Studies and a post-diploma certificate in Regulatory Law Administration from Seneca College.

Her experience in the OPS will be of significant value to HPRAC as we continue to advance our mandate to provide the Minister with sound, independent, evidence-informed recommendations.

Sincerely,

Thomas Corcoran
 Chair
 Health Professions Regulatory Advisory Council

Ministry of Health
and Long-Term Care

Office of the Minister

10th Floor, Hepburn Block
80 Grosvenor Street
Toronto ON M7A 2C4
Tel. 416 327-4300
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Ministère de la Santé
et des Soins de longue durée

Bureau du ministre

Édifice Hepburn, 10^e étage
80, rue Grosvenor
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Télééc. 416 326-1571
www.ontario.ca/sante



605

HLTC2968IT-2015-362

NOV 04 2015

Mr. Thomas Corcoran
Chair
Health Professions Regulatory Advisory Council
56 Wellesley Street West, 12th Floor
Toronto ON M5S 2S3

Dear Mr. Corcoran:

On February 26, 2015, Premier Kathleen Wynne and I affirmed our government's commitment to authorize registered nurses (RNs) to prescribe drugs. This proposed change in the scope of practice of RNs aligns with our vision of a health care system that puts patients first by providing increased access to care.

As the decision has been made that this change in scope will occur, this referral to the Health Professions Regulatory Advisory Council (HPRAC) is not seeking advice on whether the scope of practice of RNs should be expanded to include prescribing drugs, but rather, I am asking the Council to conduct broad consultations with key partners within the nursing and health care community to assess the following three models of RN Prescribing:

- Independent Prescribing;
- Supplementary Prescribing; and
- Use of Protocols.

I am requesting that HPRAC provide me with the results of its consultation along with its recommendations related to which model is most appropriate for Ontario. I would like this report no later than March 31, 2016.

I recognize that this referral is a departure from the typical referrals that HPRAC has received in the past; however, given your extensive expertise in broad-based consultations, your undertaking this work will be of tremendous value to the policy development required to implement this change in the scope of practice of RNs.

.../2

606

- 2 -

Please extend my appreciation to the Council for supporting this important initiative. If you have any questions, please contact Denise Cole, Assistant Deputy Minister, Health Human Resources Strategy Division (HHRSD) at denise.cole@ontario.ca or at 416-212-7688.

Yours sincerely,

A handwritten signature in black ink, appearing to read "Eric Hoskins". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Dr. Eric Hoskins
Minister

c: Denise Cole, Assistant Deputy Minister, HHRSD
Presidents and Registrars of the Regulated Health Professional Colleges

From: Jo-Ann Willson
Sent: Thursday, November 05, 2015 1:42 PM
To: Rose Bustria
Subject: FW: Registered Nurse Prescribing Referral Letter
Attachments: RN Prescribing HPRAC Referral Letter (2015-11-04).pdf

Council.

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

College of Chiropractors of Ontario
130 Bloor St. West, Suite 902
Toronto, ON M5S 1N5
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From: Regulatory Projects (MOHLTC) [mailto:RegulatoryProjects@ontario.ca]
Sent: Thursday, November 05, 2015 1:31 PM
To: Regulatory Projects (MOHLTC) <RegulatoryProjects@ontario.ca>
Subject: FW: Registered Nurse Prescribing Referral Letter

Please see the attached letter from the Hon. Dr. Eric Hoskins, Minister of Health and Long-Term Care.

Voyez la lettre ci-joint de l'honorable Dr. Eric Hoskins, ministre de la Santé et des Soins de longue durée.

**Ministry of Health
and Long-Term Care**

Office of the Minister
10th Floor, Hepburn Block
80 Grosvenor Street
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608

HLTC2968IT-2015-362

NOV 04 2015

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Chair
Health Professions Regulatory Advisory Council
56 Wellesley Street West, 12th Floor
Toronto ON M5S 2S3

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.../2

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Yours sincerely,



Dr. Eric Hoskins
Minister

c: Denise Cole, Assistant Deputy Minister, HHRSD
Presidents and Registrars of the Regulated Health Professional Colleges

Ontario chiropractic act: history 2015

The Legislative History of The Use of The Title Doctor by Chiropractors in Ontario

1914. The Ontario Medical Act was passed. Section 49 of the Act stated "Any person not registered pursuant to this Act and takes or uses any title, name, addition or description implying or calculated to lead people to infer that he is registered under this act or that he is recognized by law as a physician, surgeon, accoucheur or licentiate in medicine, surgery or midwifery shall incur a penalty of not less than \$25.00, nor more than \$100.00"

1925. Section 49 of the Ontario Medical Act was repealed and was reworded with the following additions: "Any person not registered pursuant to this Act and takes or uses any title, name addition or description implying or calculated to lead people to infer that he is registered under this act or that he is recognized by law as a physician, surgeon, accoucheur or licentiate in medicine, surgery or midwifery,--- *or who assumes, uses or employs the title Doctor or Surgeon or Physician or any affix or prefix indicative of such titles as an occupational designation relating to the treatment of human ailments, or advertises or holds himself out as such,* shall incur a penalty of not less than \$25.00 nor more than \$100.00. "

Therefore, prior to the year 1914 there was no statutory restriction on the use of the prefix "doctor" or "Dr."but that was changed in 1914 and again in 1925 when section 49 of the Ontario Medical Act was revised.

1925. The Drugless Practitioners Act was also passed. A Board of Regents was created to control and regulate the practice of Chiropractors, Chiropodists, Drugless Therapists, Masseurs and Osteopaths. The Board, with the approval of the Lieutenant Governor in Council was empowered to make regulations:

(f) For designating the manner in which any person registered under this Act may describe his qualifications or occupation and prohibiting the use of any title, affix or prefix which in the opinion of the Board is calculated to mislead the public as to the qualification of any such person and for allowing the use of any affix or prefix not forbidden by section 5.1 of the Medical Act, which in the opinion of the Board will correctly describe the qualification or occupation of such person.

Drugless Practitioner was defined in the Act. Drugless practitioner means any person who practises or advertises or holds himself out in any way as practising the treatment of any ailment, disease, defect or disability of the human body by manipulation, adjustment, manual or electro-therapy or by any similar method.

Classification of Chiropractors: Chiropractor shall mean any person who practises or advertises or holds himself out in any way as practising the treatment, by diagnosis including all diagnostic methods, spinal analysis, direction, advice written or otherwise of any ailment, disease, defect or disability of the human body by

methods of adjustment by hand of one or more of the several articulations of the human body, more especially those of the spinal column, as taught in colleges of Chiropractic and approved by the Board.

1952. Drugless Practitioners Act (Office Consolidation) Chapter 127. The Board of Directors of Chiropractic was created. It replaced the Board of Regents. It exercised all of the powers that the Board of Regents would have had, had it not been replaced. Its responsibility was to regulate chiropractors under revised terms of the Drugless Practitioners Act. Dr. Harry A. Yates was appointed Chairman by Order in Council. Subsequent chairmen of the BD of C were:

Sept. 1961: Dr. Harold W.R. Beasley,

Sept. 1974: Dr. Stephen West,

Feb. 1985: Dr. Fred. Barnes,

Feb. 1986: Dr. Robert Wingfield

Feb. 1988: Dr. Edward Burge

Drugless Practitioners Act, Para. 6. The Board, with the approval of the Lieutenant In Council, may make regulations,

(f) for designating the manner in which a person registered under this Act may describe his qualifications or occupation and prohibiting the use of a title, affix or prefix that in the opinion of the Board is calculated to mislead the public as to the qualification of any such person and for allowing the use of any affix or prefix not forbidden by the Medical Act that in the opinion of the Board will correctly describe the qualification or occupation of such person.

Drugless Practitioners Act: Regulation 248, Para.14: As an occupational designation, chiropractors may describe themselves as chiropractors only.

.....

1955. On January 14, the Ontario Chiropractic Association established The Legislation Committee of the OCA. It tabled its report in August 1957, authored by the chairman, Dr. H.W.R. Beasley in a substantial hard backed volume. (CMCC archives)

The committee members were: Drs. J. A. Langford, D. Komesch, S. Evans, A.E. Homewood, R.K.Partlow, J.H.Ford, S.F. Sommacal, C.A. Greenshields, J.W. Ellison, J.L. McCarthy.

Legal Counsel was Merton J. Seymour OBE. Q.C., and G.G. Nichols .

The mandate of the Legislation Committee was to study the various aspects of the profession's needs and desires and it identified 26 different articles of study. The committee was to make recommendations based in part on a comparison with legislation in other jurisdictions in North America. Article No. 8 was to identify the use of the title "Dr." or "Doctor" in all of the other jurisdictions.

3.

Article No. 8 reported that in all jurisdictions across the United States, the use of the title was permitted in every state except Washington, Wisconsin and Tennessee. In Canada the title was permitted in Manitoba, Saskatchewan and Alberta but not in British Columbia and Ontario. Most jurisdictions required that chiropractors also be identified additionally in some way as "chiropractor".

.....

1974. (1) The Medical Act of 1970 and the Medical Act of 1973 were repealed and replaced by the Medical Act of 1974.

(2) Any reference in any act or regulation to the Medical Act shall be deemed to be a reference to this Part. 1974, c.47, s68.

The Medical Act 1974, Para.67-(2). Subject to the provisions of Parts (ii) Dentistry and (v) Optometry... any person not licenced under this part who takes or uses any name, title, addition or description implying or calculated to lead people to infer that he is licenced or registered under this Part or that he is recognized by law as a physician, surgeon, accoucheur or a licentiate in medicine, surgery or midwifery, or who assumes, uses or employs the description or title "doctor", "surgeon" or "physician" or any affix or prefix indicative of such titles or qualifications as an occupational designation relating to the treatment of human ailments or physical defects, or advertises or holds himself out as such, is guilty of an offense and on summary conviction is liable for the first offense to a fine of not more than \$1,000 and for each subsequent offense to a fine of not more than \$2,000. 1975 c. 63, s.33

1980. The Health Disciplines Act was enacted. The chiropractic profession had negotiated for many years with the Ministry of Health during the decade of the 1970's, to be included as Part vii HDA. There were irreconcilable differences between the profession and the Ministry, particularly on scope of practice and x-ray issues. The negotiations were unsuccessful and the Chiropractic profession would have to wait until the next round of legislation discussions, which were expected to be many years in the future.

The language of Para. 67-(2) of the Medical Act, 1974 was carried forward in the amended version of the HDA, Part III, Medicine. This preserved and carried forward the language of the legislated prohibition upon any person who was not a physician, dentist or optometrist from using the title "doctor" as an occupational designation.

.....

From its origin in 1952, the Board of Directors of Chiropractic acknowledged and publicized the prohibition of the use of "Dr" or "Doctor" on signage and letterhead on the grounds that such usage would be an offense under the provisions of the Medical Act and subsequently, of the Health Disciplines Act. Students at CMCC were instructed on this matter and the prohibition was well understood by Ontario chiropractors. Historically, the Board had undertaken to caution those chiropractors against which complaints were lodged by the CPSO.

1986. At its very first meeting, in February 1986, the newly appointed Board of Directors of Chiropractic was chaired by Dr. Robert Wingfield who had been a member of the previous board. The newly appointed Board members were: Dr. Ted Burge, Dr. Bert Brandon, Dr. Sharon Lunney and Ms Sylvia Pusey. Dr. Stan Stolarski was Registrar. A leading agenda item was a complaint filed by the College of Physicians and Surgeons of Ontario.

The CPSO complained that it had conducted a routine telephone sampling of Toronto area chiropractors, and had found that the majority had answered their office phones "Dr. so and so's office...which is contrary to the provisions of the Health Disciplines Act"

It continued "The college has appreciated the care with which the Board has seen to it that the restrictions on the use of the title as set out in the Health Disciplines Act are complied with by its registrants and also the care with which the Board, like this College, sees to it that its own advertising regulations are adhered to" "I must tell you that the College continues to have some concern with the use of the term doctor by a number of your registrants...."

At the meeting, the Chair advised the members that a review undertaken by the chair of the pertinent legislation revealed that if the Board should decide to reverse its historical policy on this matter, the way forward could lie through the legislative language "occupational designation". Occupational designation for a chiropractor is "Chiropractor", not "doctor" or "Dr". So long as a registrant was identified as "chiropractor", the board policy could permit "doctor" or "Dr" on signs etc. The board's legal counsel Don Brown QC was consulted at length. The Board had the legislative authority to interpret the Regulations under the Act. The Board then advised the CPSO that it had studied the matter and determined that a chiropractor does not offend the Drugless Practitioners Act or The Health Disciplines Act by using the title "Doctor" or "Dr". so long as the Registrant was identified as "Chiropractor" For several months thereafter the Board was prepared for a reply from the CPSO but there was none and the matter was considered closed.

Because of ongoing HPLR discussions, the Board decided that it would be in the best interests of the profession to refrain from broadly publicising its interpretation of the Regulations at that time. However, the Ontario Chiropractic Association Executive was informed in confidence with respect to the OCA membership. Never the less it was expected that this would be an identified discussion topic at some future HPLR meeting when precedents would be identified..

The subject of use of titles did in fact arise near the end of the HPLR discussions. In a meeting between Mr. Alan Schwartz of the HPLR and BD of C chair Dr. Ted Burge, Mr. Schwartz suggested that the use of the title doctor should be considered only for graduates of degree granting institutions. Dr. Burge consulted with Lawyer Allan Freedman, the long time legal counsel to Canadian Memorial Chiropractic College.

5.

Mr. Freedman advised him that all professions using the title doctor do so by authority of the professional licensing body and not because of any particular university or degree. It was clear that the Board of Directors of Chiropractic had exercised that authority in 1986.

The Regulated Health Professions Act became law in 1991. The Act contained a restriction on the use of the title "Doctor":

Subsection (1): Except as allowed in the regulations under this Act, no person shall 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 individuals. 1991, c. 18, s.33(1)

Subsection (1) does not apply to a person, who is a member of,

(a) the College of Chiropractors of Ontario

(b) the College of Optometrists of Ontario

(c) the College of Physicians and Surgeons of Ontario

(d) the College of Optometrists of Ontario

(e) the Royal College of Dental Surgeons of Ontario. 1991, c.18, s33 (2)

There was no longer any reference to occupational designation.

Robert M. Wingfield

From: Jo-Ann Willson
Sent: Wednesday, September 30, 2015 9:53 AM
To: Rose Bustria
Subject: FW: Clinic Regulation Project
Attachments: Clinic Regulation Project - LTR Sept 30.pdf

Exec and Council.

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

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From: Bob Haig [mailto:rdhaig@chiropractic.on.ca]
Sent: Wednesday, September 30, 2015 9:40 AM
To: Jo-Ann Willson <jwillson@cco.on.ca>
Cc: Kristina Peterson (kristyp@tbaytel.net) <kristyp@tbaytel.net>; Deborah Proudfoot <dproudfoot@chiropractic.on.ca>
Subject: Clinic Regulation Project

Hi Jo-Ann:

The attached letter asks for a briefing on the Clinic Regulation Project.

Bob



Dr. Bob Haig
 Chief Executive Officer
 Ontario Chiropractic Association
 Tel: 416-860-4155 or 1-877-327-2273 ext. 4155



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September 30, 2015

Jo-Ann Willson
Registrar, College of Chiropractors of Ontario
130 Bloor St. West, Suite 902
Toronto, ON M5S 1N5

Re: Clinic Regulation Project

Dear Jo-Ann:

At an earlier CCO Council meeting there was a presentation by the College of Physiotherapists of Ontario on the Clinic Regulation Project. We understand that there are eight or nine colleges participating in this, and that in some cases there have been consultations with either the membership or the association.

This is of great interest to the OCA and we would be interested in knowing, for example:

- Is there draft legislation?
- What is the state of discussion with the government?
- How are clinics to be defined?
- Will this affect only non-RHP owned and operated clinics?

Could we arrange a briefing of the OCA by the CCO?

Thanks for your consideration.

Sincerely,

A handwritten signature in black ink that reads "R. Haig D.C.".

Dr. Bob Haig, D.C.
Chief Executive Officer

From: Jo-Ann Willson
Sent: Friday, November 13, 2015 6:59 PM
To: Rose Bustria
Subject: FW: OCA AGM

Council.

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

College of Chiropractors of Ontario
130 Bloor St. West, Suite 902
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Tel: (416) 922-6355 ext. 111
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E-mail: jpwilson@cco.on.ca
Web Site: www.cco.on.ca

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From: Bob Haig [rdhaig@chiropractic.on.ca]
Sent: Friday, November 13, 2015 4:58 PM
To: Alison Dantas (ADantas@chiropractic.ca); Dr. Greg Dunn (gdunn@ccpaonline.ca); David Wickes (dwickes@cmcc.ca); Jo-Ann Willson
Cc: Kristina Peterson (kristyp@tbaytel.net)
Subject: OCA AGM

Hello all:

I wanted to let you know that this year we have a very truncated AGM because it is squeezed in on the afternoon of December 5 between the OCA Board meeting and the Awards Gala in the evening. We would of course love to have you and your presidents attend and be introduced, but we will not be able to provide time for you to bring greetings.

Please let us know if you are able to attend.

Bob

 **Dr. Bob Haig**
Chief Executive Officer
Ontario Chiropractic Association
Tel: 416-860-4158 or 1-877-327-2273 ext. 4158

rdhaig@chiropractic.on.ca
www.chiropractic.on.ca

618



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CHIROPRACTIC CARE AND NECK PAIN: A PRIMER

ITEM 4.1.28

WHAT THE GUIDELINES SAY

The annual prevalence of non-specific neck pain (also referred to as mechanical neck pain) is estimated to range between 30% and 50%. Persistent or recurrent neck pain is reported by an estimated 50% to 65% of patients one to five years after initial onset. Twenty-seven percent of patients seeking chiropractic treatment report neck or cervical problems.³ Thus, treatment of neck pain is an integral part of chiropractic practice.⁴

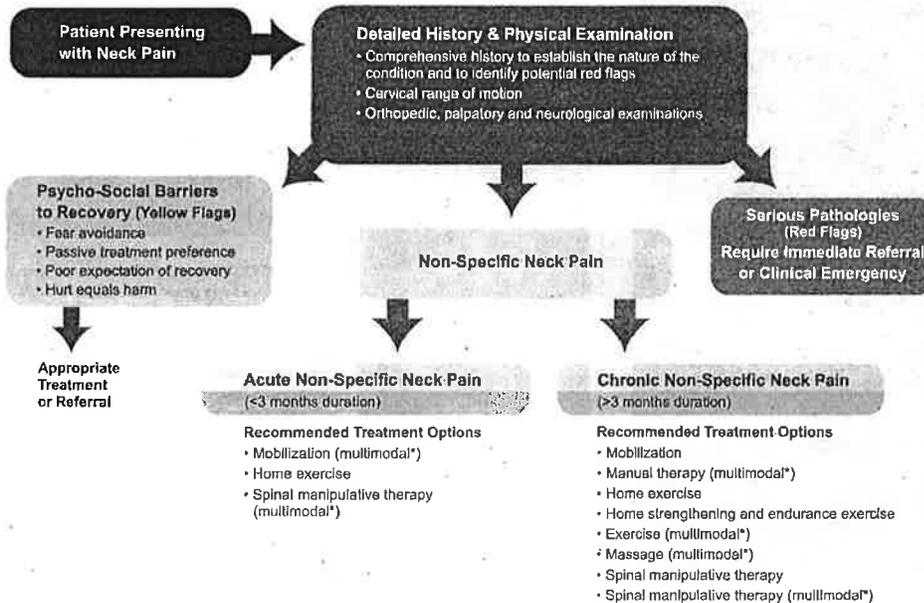
The *Clinical Practice Guideline for the Chiropractic Treatment of Adults with Neck Pain*⁵ is based on a systematic review of the most recent literature. The Guideline emphasizes that in very rare cases: "Vertebral artery dissection is known to sometimes present as neck pain. In situations where neck pain is severe or presents with a headache, the practitioner should consider all serious pathologies that may be at cause." The Guideline also highlights the importance of screening for signs of neurovascular impairment and notes that "neck pain caused by serious pathology (e.g. cervical fracture) would require immediate referral whereas signs of stroke or cervical dissection should be sent for emergency services."

The diagnosis is developed based on a thorough history and physical exam:

- 1 Ask probing questions to understand the key features of the patient's history and symptoms, and identify any red flags such as stroke risk factors.
- 2 Conduct a physical exam including range of motion, orthopedic, palpatory, and neurological tests.

An essential part of the diagnosis involves identification of potential flags and barriers to recovery such as:

- 1 Risk factors for serious pathologies (also known as red flags): history of cancer, vertebral infection, osteoporotic fractures, carotid/vertebral artery dissection, and symptoms of neurovascular impairment such as unilateral facial paraesthesia should be referred for immediate emergency care.
- 2 Psycho-social barriers to recovery (also known as yellow flags): fear avoidance, passive treatment preference, poor expectation of recovery, belief that hurt equals harm.
- 3 In the absence of any such flags or contraindications, the recommended treatment protocols for non-specific acute and chronic neck pain include a range of other treatment options, such as education, reassurance, mobilization, home exercise, as well as spinal manipulative therapy, which research has shown can be effective at relieving neck pain.^{2,3,4}



The College of Chiropractors of Ontario's Standard of Practice S-013 states that prior to administering any treatment, including manual therapy, the chiropractor must obtain informed consent from the patient.⁵ Reviewing treatment options and ensuring the patient's comfort with any care plan is fundamental to both patient safety and patient-centred care.

*multimodal: a combination of two or more treatment modalities

New series

"Chiropractic Care and Neck Pain: A Primer" is the fourth in a series of four articles focusing on chiropractic expertise in the assessment, diagnosis and treatment of LBP and MSK conditions.

For more information, please visit:

www.chiropractic.on.ca

References

1. Boyan R, Deane P, Descarreaux M, Deslauris M, Marcoux H, Polla B, et al. [2014] Clinical practice guidelines for the chiropractic treatment of adults with neck pain. Canadian Chiropractic Association.
2. Borenfort G, Evans R, Anderson A, Svendsen K, Qieba Y, and Gilman R. [2012]. Spinal manipulation, mobilization, or home exercise with advice for acute and subacute neck pain: A randomized trial. *Annals of Internal Medicine*, 156(1 Pt 1):1-10.
3. Vernon H, Hankaravys K, Hagen G. [2007]. Chronic mechanical neck pain in adults treated by manual therapy: A systematic review of change scores in randomized clinical trials. *Journal of Manipulative and Physiological Therapeutics*, 30(2): 215-227.
4. Kuntz E, Camargo C, van der Velden G, Carroll L, Nordin M, Guzman J, et al. [2008]. The treatment of neck pain: Noninvasive Interventions. *Results of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders*. *Spine*, 33(4S): S123-S152.
5. College of Chiropractors of Ontario. (2007). Standard of Practice S-013. Amended: November 24, 2009, September 30, 2013.

A physician's perspective

Dr. Tammy Hermant has been practicing as a family physician in Toronto for 20 years, and she has been referring patients to a chiropractor for at least a decade. "It's great having access to a chiropractor—he comes to our office twice a week to see patients directly and I also refer out to him at other times."

One of the greatest advantages of working with a chiropractor is the chance to learn more about the profession. "Working side by side with a chiro and seeing their approach to patient care is vital. It's so important to establish that level of comfort with any health practitioner that you are sending patients to, and it allows me to address any concerns the patient may have about working with a chiro."

Dr. Hermant refers patients with non-specific, acute or chronic neck issues to a chiropractor. "Manipulation is only one potential approach a chiropractor may have. They may also be doing active release techniques or acupuncture to relieve pain and restore function." Dr. Hermant's chiropractor also provides patients with self-management techniques and exercises as part of an overall approach to dealing with a musculoskeletal condition.

In the future, Dr. Hermant would like to include even more providers into her referral network, such as a registered massage therapist or a physiotherapist. "Having a chiropractor come in and help handle musculoskeletal cases has been a real asset. I can tell my patients that they can see a chiro tomorrow as opposed to waiting weeks or months for an MRI or to see an orthopedic surgeon."

619



Ontario
Chiropractic
Association



THE FEDERATION

CANADIAN FEDERATION OF CHIROPRACTIC REGULATORY AND
EDUCATIONAL ACCREDITING BOARDS

LA FÉDÉRATION

LA FÉDÉRATION CHIROPRACTIQUE CANADIENNE DES ORGANISMES
DE RÉGLEMENTATION PROFESSIONNELLE ET D'AGRÈMENT DES
PROGRAMMES D'ENSEIGNEMENT

NOMINATION FORM

Ontario Nominee to The Council On Chiropractic Education Canada

Nominator Statement and Contact Information

I nominate the person named below for consideration by the Federation's Nominating Committee as a candidate for appointment from Québec to the Council on Chiropractic Education Canada. (If you wish to submit more than one nomination please duplicate this form).

Name: Jo-Ann Willson

Address: 130 Bloor St. West, Ste. 902

City/Town: Toronto

Prov/Terr: ON

Postal Code: M5S 1N5

Telephone: (416) 922-6355 ext. 111

Fax: (416) 925-9610

E-mail: jpwilson@cco.on.ca

Signature:

Date: September 11, 2015

Nominee Contact Information

Name: Dr. Dennis Mizel

School of Graduation: CMCC

Address: 320 Vine St.

City/Town: St. Catharines

Prov/Terr: ON

Postal Code: L2M 4T3

Telephone: 905-938-2222

Fax: 905-934-7778

E-mail: drmizel@stcatharineschiropractic.com

Remember to include a completed Credentials Review Form (below) with this form and a current professional résumé for the nominee. Nominees will not be considered unless both of these required documents are provided.

Please complete this form and submit to: jduncan@chirofed.ca



THE FEDERATION

CANADIAN FEDERATION OF CHIROPRACTIC REGULATORY AND
EDUCATIONAL ACCREDITING BOARDS

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LA FÉDÉRATION CHIROPRACTIQUE CANADIENNE DES ORGANISMES
DE RÉGLEMENTATION PROFESSIONNELLE ET D'AGRÈMENT DES
PROGRAMMES D'ENSEIGNEMENT

CREDENTIALS FORM

Ontario Nominee to The Council On Chiropractic Education Canada

Name of Nominee: Dr. Dennis Mizel

The nominator is required to verify the following statements:

- 1 The nominee is a chiropractor registered in Ontario. Yes X No
- 2 The nominee is not employed by nor serves on the Federation's Board nor the boards of any chiropractic provincial, territorial or national association or regulatory board. Yes X No
- 3 The nominee is not now nor has been associated with any Doctor of Chiropractic Programme within the past five years. Yes X No
- 4 The nominee is not now, nor has been an elected member of the governing body of an accredited chiropractic programme within the three (3) years immediately prior to the commencement of such person's term. Yes X No
- 5 The nominee is not now, nor has been a faculty member, executive officer or other administrator of an accredited chiropractic programme for the three (3) years immediately prior to the commencement of such person's term Yes X No

Name of Nominator: Jo-Ann Willson

Signature of Nominator:

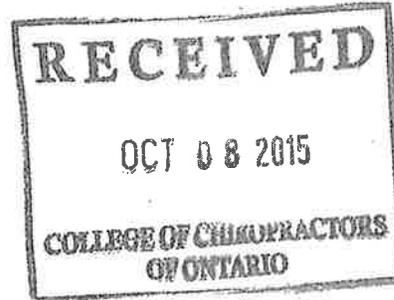
Date: September 11, 2015

Please complete this form and submit to: jduncan@chirofed.ca

ITEM 4.1.31

October 5, 2015

Ms. Jo-Ann Willson
Registrar and General Counsel
College of Chiropractors of Ontario
130 Bloor Street West, Suite 902
Toronto, ON M5S 1N5



678

Dear Ms. Willson,

I am writing to you in my capacity as Course Coordinator of CP 1102 at CMCC. This course is a foundational course dealing with Chiropractic Principles and Practice.

I am extending an invitation to you to address our Year I students in the new hybrid format which includes having an expert panel discussion after session preparations by the students.

It would involve a 12 minute presentation by you on your organization after which the floor would be open to questions from the students.

This panel is to be centered on international status, regulatory and association bodies, legislation, and professionalism and ethics.

It is to be held on Thursday, January 7, 2016, from 3:00-5:00 p.m. in Lecture Hall 1 at CMCC.

If you are agreeable to accepting this invitation and require more information, please contact me at KHammerich@cmcc.ca.

In anticipation of a positive response, I remain,

Sincerely yours,



Karin F. Hammerich DC MHS
Chair, Department of Chiropractic Principles and Practice
Faculty, Clinical Education
Vice-Chair, Faculty Council
Canadian Memorial Chiropractic College
6100 Leslie Street
Toronto ON M2H 3J1
Tel: 416-482-2340, Ext: 247

Proposition Statement for the Chiropractic Profession

CMCC Presentation
November 12, 2015

Mr. Joel Friedman, B.Sc, LL.B.
Director, Policy and Research

CCO Council, 2014-15



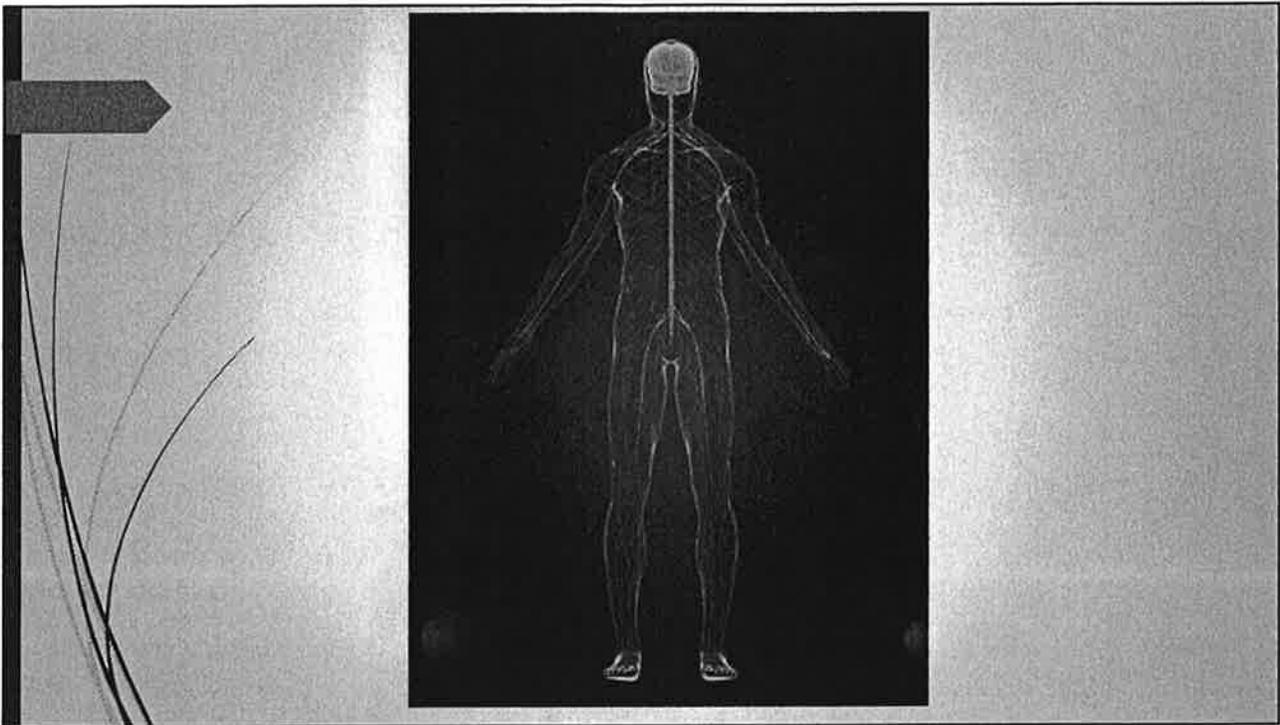
CCO Staff 2014-15



Chiropractic Act, 1991

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.



S-001: Chiropractic Scope of Practice Authorized Acts...

1. Moving the joints of the spine beyond a person's usual physiological range of motion using a fast, low amplitude thrust
2. Communicating a diagnosis related to the scope of chiropractic
3. Putting a finger beyond the anal verge for the purpose of manipulating the tailbone.

682



S-001: Chiropractic Scope of Practice Diagnostic or Therapeutic Procedures

- Used for the benefit of the patient
- Relates to the chiropractic scope of practice
- Must be taught in a core curriculum, post-graduate curriculum, or continuing education division of an accredited educational institution
- Member must have achieved, maintain and be able to demonstrate clinical competency
- Obtain informed consent
- Public Domain Activities (e.g. nutritional counseling, prescribing orthotics, advice on lifestyle and exercise, therapeutic modalities)

Section 30 the *RHPA* "Harm Clause"

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.

26 Self Governing Health Professions Under the *RHPA*

Some examples...

- Chiropractic
- Dentistry
- Medicine
- Nursing
- Optometry
- Psychology

684

Eric Hoskins, OC, MSC, MPP
Minister of Health and Long Term Care



Ontario's Health Care Action Plan

"The next step in rebuilding Ontario's health care system was to focus on the quality of care people receive. We're ensuring care is patient-centred, driven by outcomes and based on evidence."



Ontario's Health Care
Action Plan

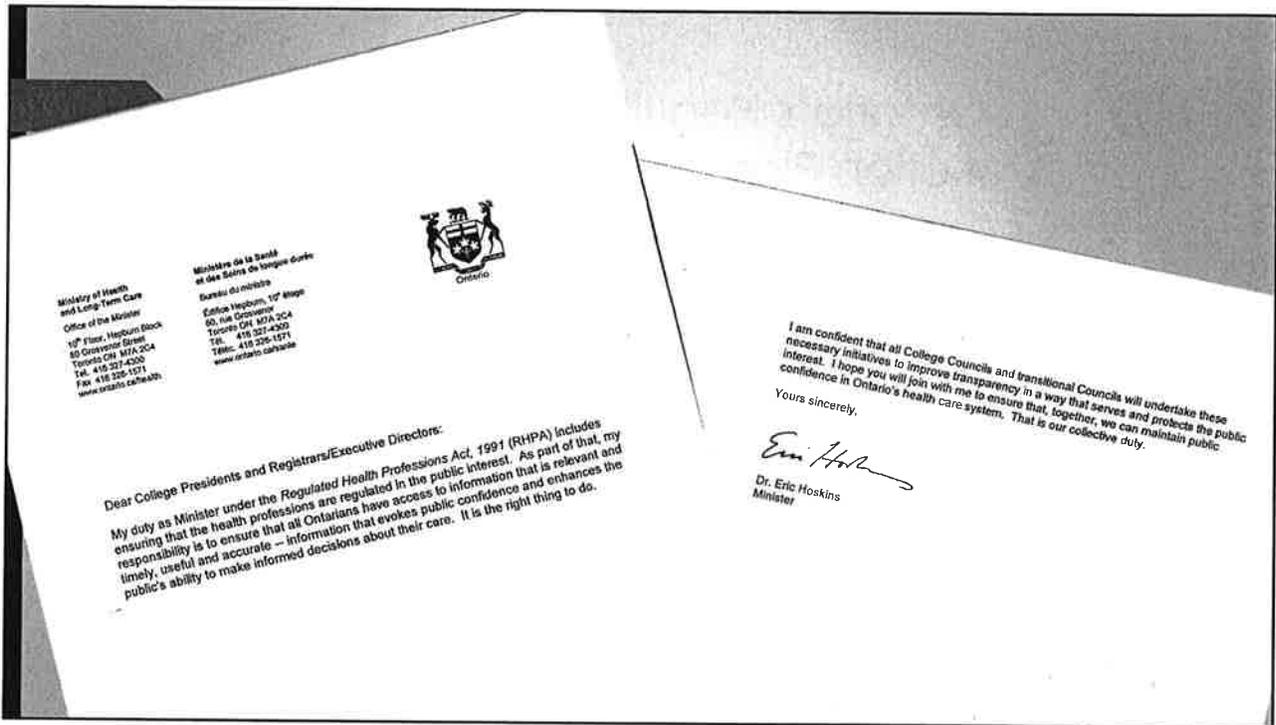
"Helping people stay healthy must be our primary goal and it requires partnership. As a government, we're increasingly putting our efforts into promoting healthy habits and behaviours, supporting lifestyle changes and better management of chronic conditions."



Ontario's Health Care
Action Plan

*"The right care...
at the right time...
and in the right place."*

686



TORONTO STAR

Ontario Health Minister orders data on clinics made public
Sunday, October 5, 2014

Province's 23 regulatory colleges scramble to meet transparency deadline
Monday, October 6, 2014

Health Ministry reviews medical secrecy
Friday, October 10, 2014

TORONTO STAR

Doctors, dentists, pharmacists: The mistakes you can't know about

Friday, January 3, 2014

"patients have no way of finding out from the colleges if their health care providers have been cautioned"

"... the balance has shifted unnecessarily away from transparency and openness."

"... privacy laws are not an excuse to promote secrecy. All too often though, that is exactly what is happening."

CCO Strategic Objectives

(Developed at the Strategic Planning Session
October 2010)

1. Improve communication of the role, mandate and mechanism of CCO to key internal and external stakeholders.

688



CCO Strategic Objectives

2. Strive for unity in the public interest, while respecting the diversity within the profession.



690



CCO Strategic Objectives

3. Optimize chiropractic services in the public interest.



CCO Strategic Objectives

4. Continue to regulate in a fiscally responsible manner: Statutory mandate met and priorities set and appropriately resourced (human and financial).

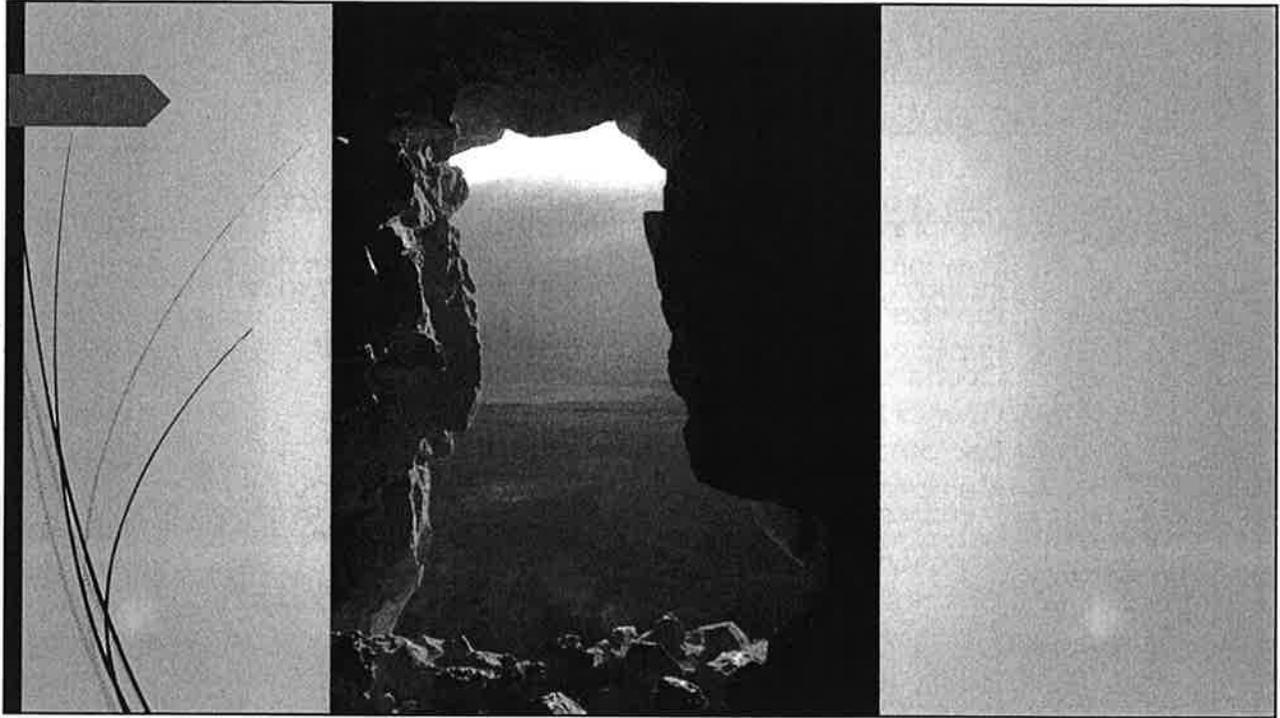
Regulatory Boards are accountable to the public in that:

1. They protect members of the public from unethical, unprofessional or incompetent practitioners;
2. They inform members of the public of their various rights, including the right to receive high quality care from all members;
3. Public members compose up to 49 % of College Councils and Committees;
4. Council Meetings are open to the public;
5. Discipline hearings are open to the public;
6. Members of the public may access information about members from the College register, including referrals to discipline, discipline findings and terms, conditions and limitations;
7. Information about discipline findings must be included in Colleges' annual reports; and
8. The Minister of Health retains ultimate authority over health regulatory colleges.

3. (2) *In carrying out its objects, the College has a duty to serve and protect the public interest*



692



From: Jo-Ann Willson
Sent: Wednesday, September 30, 2015 7:16 AM
To: Rose Bustria
Subject: FW: MSK Health Matters Update

Exec and council.

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

College of Chiropractors of Ontario
130 Bloor St. West, Suite 902
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From: Bruce Walton [bruce@n8power.ca]
Sent: Wednesday, September 30, 2015 5:33 AM
To: Jo-Ann Willson
Subject: Fwd: MSK Health Matters Update

Just FYI...

Begin forwarded message:

From: Canadian Chiropractic Association <info@chiropractic.ca>
Subject: MSK Health Matters Update
Date: September 29, 2015 at 4:38:13 PM GMT-4
To: bruce@n8power.ca

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MSK Health Matters Update

Since the election was called in early August, the CCA and CCA members have been actively working to raise awareness of MSK conditions and to obtain commitments from all four parties to work with the chiropractic profession after the election to develop a more strategic approach to MSK care, starting with soldiers and Veterans.

The CCA staff have met with the Liberal party's Issues Manager, the Director of Outreach and Stakeholder Relations for the NDP, and with the office of the Communications Director for the Green party. All of these meetings have provided an excellent opportunity for the CCA to reiterate the important burden of MSK conditions. The early meetings provided a unique opportunity for the profession to draw attention to the issue, and to raise the profile of the role Canadian chiropractors already play in the care of millions of Canadians.

To solidify commitments with all four main political parties, the CCA requested parties respond to two issues of interest:

1. How will your party recognize MSK health as an important health issue and will you commit to working with the CCA following the election to look at the kind of innovation that Canada's healthcare system requires?
2. How will your party acknowledge the importance of MSK health on the lives of Canadians, including soldiers and Veterans?

The CCA has thus far received formal responses from all but the Conservative party, with the Liberal party, NDP and Green party pledging support and commitment to work with our association following the election period. These responses can be read in full on the [CCA's website](#).

In addition, the CCA reached-out to media to attempt to gain traction on the importance of MSK health, and sent out [press releases](#) in both French and English to media outlets across the country detailing how Canada's chiropractors can play a greater role as part of the healthcare team.

While the CCA continues to directly engage with candidate and parties, you can also get involved in the conversation. Join our grassroots campaign today or join the conversation through social media. These next several weeks offer a critical time for members to speak with candidates on issues important to our organization and will pave the way for important dialogue with those elected.

If you're interested in getting involved and learning more about the CCA's grassroots candidate outreach, contact our campaign coordinator Cynthia Waldmeier at Cynthia@impactcanada.com. Stay tuned for more election updates and use the hashtag #MSKHealthMatters to have your voice heard on Twitter!



If you no longer wish to receive our emails, click the link below:
[Unsubscribe](#)
 186 Spadina Avenue, Suite 6 Toronto, Ontario M5T 3B2 Canada

Rose Bustria

From: Jo-Ann Willson
Sent: Friday, November 13, 2015 5:54 AM
To: Rose Bustria
Subject: FW: Canadian Chiropractic Association November Newsletter

695

Council.

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

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From: Bruce Walton [bruce@n8power.ca]
Sent: Friday, November 13, 2015 5:41 AM
To: Jo-Ann Willson
Subject: Fwd: Canadian Chiropractic Association November Newsletter

Interesting spins on the results of their last survey. Painting a happy picture!
Love to see the raw data.
1500 responses out of how many members???

Begin forwarded message:

From: Canadian Chiropractic Association <info@chiropractic.ca>
Subject: Canadian Chiropractic Association November Newsletter
Date: November 12, 2015 at 4:13:39 PM GMT-5
To: bruce@n8power.ca

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CCA | CONNECT

Keeping Canadian chiropractors in the loop

Canadian Chiropractic Association Newsletter, November 2015

chiropractic.ca



Message from the CEO

Each year I continue to be inspired by our membership, and 2015 has been no exception. Continued pursuit of opportunities that benefit our membership and evaluating the success of those opportunities, are of utmost importance to our staff team and Board of Directors. This past September, we launched the CCA 2015 Membership Satisfaction Survey and I am thrilled to report that over 1,500 members completed the survey, providing us with invaluable feedback on our work over the last few years. [Read more](#)



IN THIS ISSUE:

- Message from the CEO
- Tell Us Why You Became a Chiropractor!
- 2015 Federal Election Results: Changing Landscape for Healthcare
- Choose Your Own Adventure!



Tell Us Why You Became a Chiropractor!

The CCA recently distributed a 2015 Membership Satisfaction Survey – thank you to our 1,500+ members who participated! We were thrilled to hear that our membership values *BACK Matters* magazine, with over 90 percent of you reading it regularly. We listened to your feedback and will continue to tweak the content in 2016, beginning with a new feature in each issue written by one of our members about why they decided to become a chiropractor. [Read more](#)



2015 Federal Election Results: Changing Landscape for Healthcare

There is little doubt that the October 19th Federal Election results will create an important shift in the role the federal government is to play in healthcare. In fact, the new Liberal government has signaled their intention to work more closely and collaboratively with provincial governments to pursue an innovation agenda. [Read more](#)

LINKS:

[Your CCA Guidelines & Best Practice](#)
[Member Benefits](#)
[Brand Central](#)
[Announcements](#)
[Classifieds](#)

Choose Your Own Adventure!

Please register or re-visit Perkopolis.com for a chance to win a \$500 Via Travel Voucher through the Perkopolis member discount program!
[Read more](#)

Member ID: CCA16PERK



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From: Jo-Ann Willson
Sent: Thursday, October 08, 2015 3:53 PM
To: Rose Bustria
Subject: FW: CCGI 3-year report to stakeholders
Attachments: 3 yrs-Progress report CCGI-Final 6 Oct 2015.pdf

Exec and Council.

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

College of Chiropractors of Ontario
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From: Joel Friedman
Sent: Thursday, October 08, 2015 11:48 AM
To: Jo-Ann Willson
Subject: FW: CCGI 3-year report to stakeholders

Joel D. Friedman, BSc, LL.B
Director, Policy and Research
College of Chiropractors of Ontario
130 Bloor Street West, Suite 902
Toronto, ON M5S 1N5
Tel: (416) 922-6355 ext. 104
Toll Free: 1-877-577-4772
Fax: (416) 925-9610
E-mail: jfriedman@cco.on.ca
Web Site: www.cco.on.ca

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From: Heather Owens [<mailto:HOwens@chiropractic.ca>]
Sent: Wednesday, October 07, 2015 2:07 PM
To: andre.bussieres@mcgill.ca; jcorrigan@sasktel.net
Subject: CCGI 3-year report to stakeholders

Dear All,

699

We are pleased to present the 3-year report for the Canadian Chiropractic Guideline Initiative (CCGI) which you will find attached.

We would like to take this opportunity to thank you for your continuing collaboration with this important project.

Best regards,

Dr. John Corrigan, DC

Chair, CCGI Guideline Steering Committee

Dr. André Bussi eres, DC, PhD

CCGI Project Lead

Canadian Chiropractic Guideline Initiative

Advancing Excellence in Chiropractic Care

Projet Canadien des Guides de Pratique Chiropratique

Promouvoir l'excellence dans les soins chiropratiques

www.chiroguidelines.org

3-YEAR PROGRESS REPORT
Canadian Chiropractic Guideline Initiative
October 2015

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CCRF Professorship in Rehabilitation Epidemiology
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We are pleased to present this update to the Guideline Steering Committee of work undertaken from March – September 2015 by the Canadian Chiropractic Guideline Initiative (CCGI).

The mission of the CCGI is to: I) transform the culture of the profession, II) engage stakeholders, III) produce, adapt, or endorse recommendations and create, and IV) apply innovative knowledge translation strategies to influence chiropractic practice. This report reflects the progress made to date in achieving the goals set out in the Strategic Plan (revised March 2014).

The Canadian Chiropractic Guideline Initiative staff (Dr. André Bussièrès, Dr. Darquise Lafrenière, Heather Owens and Monica Slanik) met on 15 July 2015 to review and update the strategic metrics in the light of progress to date (see table 1). Whilst the vision and mission of CCGI remain the same, we would like to see the project going beyond Canada and to become a multidisciplinary, international effort.



André Bussièrès DC, FCCS(C), PhD
CCGI Project Lead

06 October 2015





CCGI Highlights: March to October 2015



Review of Neck Pain Associated Disorder and Whiplash guideline



Launch of CCGI Opinion Leader Program



Launch of Practice-based research network and seed fund competition



Development of new CCGI patient and clinician handouts



CCGI booth and workshops at CCA National Convention and Tradeshow



Translation of CCGI website into French



Hiring of part-time CCGI knowledge broker and social media consultant

Summary of progress:

After the achievement of some major milestones in 2014, including the launch of the Canadian Chiropractic Guideline Initiative (CCGI) website and the positive reception to our first webinar series on the management of neck pain, we are pleased to be able to report to stakeholders on the continued growth and expansion of CCGI in 2015. The adoption of the Evidence Informed Practice (EIP) statement by nearly all provincial associations and regulatory boards is an important step for the chiropractic profession in Canada.

We are particularly pleased to highlight the launch of the CCGI website in French. The completion of the scoping review on research utilization, evidence-based practice and knowledge translation in chiropractic, a national survey on chiropractors' attitudes, skills and use of EIP, and the new WAD recommendations approved by the Guideline Development Group are substantial steps towards our goal of adapting and adopting new guidelines. We look forward to disseminating the new recommendations on the management of neck pain associated disorders and whiplash to the profession through a new series of KT strategies in the coming months and to beginning the review of additional guidelines in 2015-16. The publication of the OPTIMa/FSCO report will be of considerable help in accelerating the process of releasing guidelines. We are planning to produce two guideline topics per year in 2016 and 2017.

We are proud of the successful launch of the CCGI opinion leader program and look forward to seeing how our investment in this strategy will help to influence the adoption of EIP across Canada. The work of the practice-based research networks is assisting clinicians to get involved in research and in the establishment of best practices.

We were proud sponsors of the CCA National Convention and Tradeshow where we met with our stakeholders and colleagues to present our work to date and discuss our plans for taking this important project forwards.

André Bussi eres, DC, MSc, PhD, FCCS (C)

CCGI Project Lead



Review of CCGI progress by strategy:

1. Transform the culture of the profession to one that is guided by evidence-based practice.

A. Consistent communication among all institutions

- ✓ Dr. Bussi eres has presented thy EIP statement at various meetings (Chiropractic Summit, President’s meeting, OCA) and conference (WFC).
- ✓ **The Evidence-Informed Practice statement** has now been adopted by nine provincial boards and regulatory bodies. A decision is pending with the Newfoundland and Labrador regulatory board, and with the Nova Scotia provincial association and regulatory board.
- ✓ Provincial Associations have been encouraged to post the EIP statement on their website and to include a link to the CCGI website.
- ✓ We would like to thank those professional associations and regulatory boards (OCA, NBCA, MCA, CAS, ACAC, BCCA) who have already posted a link to CCGI or are highlighting the work of CCGI on their websites.
- ✓ All CCGI members and collaborators were asked to sign a COI form in 2015. Structures to ensure transparency and procedures to manage conflict of interest were discussed by the GAC and GSC at the respective meeting at the CCA National Convention in September.

B. Develop stakeholder communication tool to support cultural transformation

- ✓ **Increasing engagement with stakeholders:** The Decision Maker section of the website was reorganized to ease navigation. *LinkedIn* is used to regularly inform them of available resources.
- ✓ **Increased collaboration:** We are looking into ways of working more closely with stakeholders to assist them in implementing EIP in their province, and to better understand how CCGI can be of assistance.
- ✓ **Opinion Leaders:** We encourage our stakeholders to invite CCGI Opinion Leaders to present at their AGMs and continuing education events during the year.
- ✓ **Advocate for national CE program:** discussions are ongoing with the Federation. We encourage stakeholders to inform clinicians about gaining CE hours through CCGI activities such as webinars and e-learning modules.
- ✓ **Implementation of Electronic Health Records (EHR):** The OCA is adapting OSCAR for its members and expect to have a Beta version by the end of the year. The Quebec PBRN is currently working with MediSync (owned by Telus) to pilot test an EHR over the next 6-12 months. Stakeholders will be kept informed of progress.

C. Provide leadership with learning opportunities

- ✓ **Opinion Leaders:** We are delighted that 18 Opinion Leaders are now in place across Canada and working in their different spheres of influence adoption of evidence-informed practice. Twelve

- CCGI Opinion Leaders were present at the CCA National Convention and Tradeshow in Niagara Falls. We were pleased to have their assistance in promoting the work of CCGI at the tradeshow booth and in facilitating at the CCGI workshop on the new recommendations on the management of Neck Pain Associated Disorders and Whiplash. Opinion leaders are working hard to help implement evidence-informed practice in their own provinces through continuing education activities, presentations at conferences, meetings with policy makers etc.
- ✓ A national survey of clinicians in October 2015 will help to identify new opinion leaders. We anticipate that the next round of training of new OLs will be in 2017.
 - ✓ The CCGI was a proud sponsorship of the CCA National Convention and Tradeshow (CCA NCT 2015) in Niagara Falls, ON in September 2015. This important event provided the opportunity to present the work of the CCGI and to demonstrate to clinicians important resources available on the CCGI website. CCGI staff organized a number of activities at the convention. There were opportunities for clinicians and stakeholders to engage with CCGI opinion leaders and to meet and share information at the CCGI booth on the tradeshow floor. We were especially pleased to unveil a new video introducing the CCGI website. This video, presented by Dr. Joel Weisberg, was well received by CCGI members. It is now available on the CCGI website *Home page* (<http://www.chiropractic.ca/guidelines-best-practice/>) and on YouTube. During the convention, we recorded interviews with CCGI opinion leaders and hope to release a series of videos on evidence-informed practice and the opinion leader program shortly.
 - ✓ Several meetings of CCGI groups took place (GAC, GSC, GIG, GDG) during the CCA NCT 2015. Importantly, two 90-minute workshops were offered: *a workshop on the Neck Pain Associated Disorders guideline with opinion leaders, and a workshop on practice-based research networks (PBRN)*. We are pleased to have had the opportunity to use the CCA NCT 2015 event to promote the CCGI resources at the national level.

D. Provide leadership in KT research

- ✓ **A list of publications**, conferences presentations is provided at the end of this report.
- ✓ **Building capacity:** Two implementation studies are currently underway in collaboration with graduate students from McGill University and CCGI research team members: 1) A neck pain guideline pilot implementation study with feasibility outcome measures (recruitment rate, study retention, and protocol adherence and patients pain and disability); and 2) A study examining the process of using opinion leaders to ease the implementation of recommendations.
- ✓ **O-Coast:** The Ontario Chiropractic Observational and Analysis Study (O'COAST) study documenting the reasons people seek care from Ontario chiropractors, the problems/diagnoses identified by chiropractors and the treatment they provide was completed in September 2015. A manuscript is in preparation.

2. Engage stakeholders to sustain the CCGI.

A. Develop a sustainability plan



- ✓ **Sustainability and succession plan:** Discussions continue with the GSC on the sustainability and succession plan.
- ✓ Stakeholders were asked to consider a 3-year funding. We would like to thank those who have agreed to so.
- ✓ Initial discussions took place with representatives of the American Chiropractic Association (ACA) and the Association of Chiropractic Colleges (ACC) regarding the need to avoid duplicating efforts (production of guidelines by the CCGPP and CCGI) and exploring possible collaborations. Further discussions planned before the end of the year.

B. Ensure stakeholders have opportunities to engage

- ✓ Semi-yearly reports are submitted to stakeholders, and a short 2-page summary was made available to attendees at the CCA National Convention and Tradeshow in September 2015 and will soon be published on the CCGI website.

3. Produce, adapt or endorse recommendations relevant to chiropractic practice to enhance patient care, based on the best available evidence.

A. Gap analysis on content areas

- ✓ In the light of CCGI strategic plan and the recent publication of the OPTIMa/FSCO report (June 2015), the GAC discussed methods for prioritization of future topics for 2016-2017. The GAC agreed that future topics should include thoracic spine and extremities (upper/lower to be determined). The Guideline Advisory Committee agreed in September that the GDG should continue the process of reviewing the OPTIMa systematic reviews by analysing and rating the recommendations with an internal validation process. If reviews meet all the criteria of an appropriate guideline then we would agree to adopt.
- ✓ A scoping review to report on the current state of knowledge on research utilization, evidence-based practice and knowledge translation in chiropractic care is now completed. A manuscript is expected to be submitted for publication by end of October 2015.

B. Adapt, endorse key recommendations on minor MSK reviews based on prioritization

- ✓ In June 2015, the Guideline Development Group reviewed and updated the recommendations for Neck Associated Disorders and WAD. We are currently finalizing the key recommendations and expect to provide the professions with these shortly. A manuscript is in preparation and is expected to be submitted this fall.
- ✓ We expect to review upper and lower extremities and thoracic spine in 2016.

C. Adapt, endorse ongoing LBP initiatives

- ✓ Ongoing monitoring of the Bone & Joint Canada LBP national strategy and the NICE low back pain guideline update. A systematic review of guidelines on LBP by the OPTIMa Collaboration is expected to be published soon.

4. Create and apply innovative KT strategies to influence chiropractic practice.

A. Create innovative KT strategies for chiropractic practice in Canada

- ✓ Develop tailored KT strategies and general templates
 - The webinar series and e-learning modules on Evidence-Informed Practice and the 2014 Neck Pain Guideline were very well received. With over 500 clinicians enrolled, 141 have completed the webinar series and e-learning modules, and another 157 are currently in progress. With the release of new recommendations for Neck Pain Associated Disorders and WAD in October 2015, and plans for the review of future recommendations in 2016 on the management of thoracic pain and extremity disorders. We are currently developing KT strategies in collaboration with the Guideline Implementation Group, including:
 - New handouts for clinicians and patients are currently in preparation and will be reviewed by the GIG at the CCA National Convention and Tradeshow. These will be posted on the CCGI website for download once finalized.
 - A new CCGI webinar series on Neck Pain Associated Disorders and WAD is planned for the Fall of 2015 in collaboration with CMCC. This will also serve to remind clinicians of available self-management strategies and tools.
 - Our new knowledge broker is currently developing a strategic plan for the year 2016-2017 which will highlight objectives, activities, resource need, metrics and timeline.
- ✓ Monitor and evaluate.
 - The pilot trial with feasibility outcomes on the neck pain guideline will run until December. We have recruited the pre-specified number of participant clinicians for this pilot study (n=40). Participants are currently enrolling patients for this study.
 - Pilot before and after study to explore the process of using opinion leaders to facilitate guideline uptake among peers was launched in September. The experimental groups (n=35) received the KT intervention at the CCA National Convention. Participants are now recruiting patients for this study.

B. Apply KT strategies and create infrastructure to support them



- ✓ **Infrastructure:** Apart from CCGI committees and working groups, the current infrastructure includes the CCGI website, Social media, the opinion leader program and the practice-based research network.
- ✓ **Proactive communication:** CCGI is regularly publishing articles in scientific journals, magazines, on social media, and in promoting the opinion leader profiles (see list of publications).
- ✓ **Influence adoption of EHR.** Discussions are underway regarding a future research study to assess the facilitators and barriers to adopting EHR with clinicians.
- ✓ **CCGI is pleased to announce that Dr. Darquise Lafrenière** has joined the team as part-time CCGI Knowledge Broker in July 2015. Her role is to assist clinicians and stakeholders in disseminating and implementing evidence-informed practice and creating effective KT strategies. A strategic plan for CCGI KT activities (2016-2017) is in development.

C. Create a hub for information on best practices

- ✓ The CCGI website remains a key part of our effort to disseminate clinical practice guidelines and to provide training and resources for practitioners on best practice. With an average of over 1000 views per week, and steady growth since the convention in September 2015, we are encouraged to see that this important resource is increasingly being used.
- ✓ The CCGI website is available in French since the summer.
- ✓ The website proudly hosts a range of trusted resources including the *Cochrane Corner*, providing gold-standard systematic reviews on musculoskeletal disorders. Links to abstracts of high quality systematic reviews from the *OPTIMa collaboration* are also available. Please visit this invaluable and user-friendly resource at: <http://chiroguidelines.org>
- ✓ Revisions to the website continue. Updates have been made to the Home Page, Decision Makers and GI Member's page, and include a new section for Opinion Leaders. The patient pages will also be revised in the fall and new page for posting CCGI video series will be created.
- ✓ **Social media:** CCGI now has 139 followers on LinkedIn, with our posts reaching approximately 2000 people per month. The CCGI social media consultant, Monica Slanik, is assisting CCGI to use this platform to connect with clinicians and researchers and to broaden our influence on a more international level.

D. Develop practice-based research network

- ✓ The National Chiropractic PBRN was launched in March 2015 with the setting up of the Advisory Committee. Pilot tests are starting and seed funds (total of 45,000\$) was disbursed to three successful applicants in October 2015. More than 150 practices have now been recruited across Canada. Research questions will be discussed at the CCA National Convention and Tradeshow during the CCGI workshop on PBRNs. We are looking to broaden base of support for research and recruit more clinicians to join local PBRNs.



CCGI: what to look for in 2015-2016

-  Adoption of EIP statement by all provincial associations and boards
-  Review of additional guidelines on extremities and LBP
-  Publication of scoping review and opinion leader papers
-  Release of additional CCGI patient and clinician handouts
-  CCGI funding starts for three practice-based research networks
-  Review of CCGI sustainability and succession plan by GSC
-  Creation of new incentives from CCGI for chiropractic students
-  Research study on barriers and facilitators to EHR uptake
-  New CCGI video series by clinicians on the benefits of EIP to clinical practice
-  New CCGI video series by researchers on the latest evidence
-  Dissemination of new recommendations for WAD
-  Continuing discussion of national CE program
-  Consideration of CE incentive program & certificate of EIP adherence
-  Ongoing discussions of collaboration with third party payers
-  Consideration of how to promote CCGI at the international level



CCGI Publications (2015)

1. **Bussièrès A**, Terhorst L, Leach M, Stuber K, Evans R, Schneider M. Self-Reported attitudes, skills and use of evidence-based practice among Canadian doctors of chiropractic: a national survey. *J Can Chiropr Assoc* Dec 2015 (In Press).
2. **Bussièrès AE**, Al Zoubi F, Quon JA, Ahmed S, Thomas A, Stuber K, Sajko S, French S, and members of the Canadian Chiropractic Guideline Initiative. Fast tracking the design of theory-based KT interventions through a consensus process. *Implementation Sci* 2015;10:18.
3. Blanchette MA, **Bussièrès A**, Stochkendahl JM, Boruff J, Harrison P. Effectiveness and efficiency of chiropractic care for the treatment of back pain: a systematic review protocol. *Systematic Reviews* 2015;4:30.

CCGI Manuscripts under preparation:

1. **Bussièrès A**, Al Zoubi F, Stuber K, French S, Boruff J, Thomas A. Research utilization knowledge translation and evidence-based practice in chiropractic: A scoping study (BMC Complementary & Alternative Medicine).
2. **Bussièrès A**, Maiers M, Grondin D, Brockhusen S. Identifying and training opinion leaders in chiropractic (to be submitted in: *J Alternative Complement Med*).
3. Schneider M, Terhorst L, **Bussièrès A**, Leach M. Revisiting the Evidence-Based practice Attitude and utilization Survey (EBASE): a psychometric evaluation of the dimensionality of the attitudes, skills use and barriers subscales (Submitted Aug 4, 2015: *J Alternative Complement Med*).

Magazine

1. Canadian Chiropractic Guideline Initiative Translating Evidence into Clinical Practice. *BACK Matters - Canadian Chiropractic Association*. Winter 2015: 24-7.
2. Follow the evidence – Quality care through research-based clinical practice. *Canadian Chiropractor*. September 2015: 18-20.

CCGI Platform presentations (2015 – confirmed)

1. Bussièrès A. The Canadian Chiropractic Guideline Initiative. *Opinion Leaders will be facilitating the small group session. Multimodal Care for the Management of Musculoskeletal Conditions: An Interactive. Workshop for the Practitioner*. CCA National Convention. Niagara, Ontario. September 19, 2015.
2. Bussièrès A, Quon J, French S, Stuber K. *Why should I be involved in The Chiropractic Practice-Based Research Networks?* CCA National Convention. Niagara, Ontario. September 19, 2015. (invited)
3. Bussièrès A. Treatment-based Classification Systems. CCA National Convention. Niagara, Ontario. September 18, 2015. (invited)
4. Bussièrès, Wade D, Mior S. and the CCGI. *Establishing a practice-based research network: The Canadian Chiropractic Guideline Initiative*. PriFor 2015, the 7th annual Primary Healthcare Partnership Forum. St. John's, Newfoundland, June 29–30, 2015. (Peer reviewed).



5. Bussi res A. Managing Musculoskeletal Disorders (MSD). Epidemiology, assessment and treatment of back and neck Pain in chiropractic. Canadian Arm Forces. CF Health Services Centre. Department of National Defense / Government of Canada. Ottawa, Ontario. June 5 2015. (invited - Dr. Gaurav Gupta MD)
6. Bussi res A, French S, Moore C, Wulff Christensen H. *Practice-based Research Networks*. European Chiropractic Union - Research day. Athens, Greece. May 13, 2015. (invited)
7. Bussi res A, Thomas A, French S, Stuber K, Kastner M, Boruff J, Corrigan J. *Research utilization and evidence-based practice in chiropractic: A scoping study*. World Federation Chiropractic, Athens, Greece. May 15, 2015. (peer reviewed)

CCGI Poster presentations

1. Gaid D, Ahmed S, Bussi res A. *Using Opinion Leaders to Implement Clinical Practice Guideline Recommendations on Whiplash Associated Disorders: A Controlled Before and After study*. Canadian Chiropractic Convention, Niagara Falls, September 18-20, 2015.
2. Alzoubi F, Bussi res A, Menon A. *Effectiveness of interventions designed to increase the uptake of clinical practice guidelines and best practices among musculoskeletal professionals: A systematic review*. Canadian Chiropractic Convention, Niagara Falls, September 18-20, 2015.
3. Alzoubi F, Eilayyan O, Bussi res A, Mayo N. *Evaluation of cross-cultural adaptation and measurement properties of STarT Back Screening Tool: Systematic review*. Canadian Chiropractic Convention, Niagara Falls, September 18-20, 2015.
4. Dhopte P, Quon J, French S, Ahmed S, Mayo N, Bussi res A. *Chiropractors can do: testing the feasibility of intervening to optimize chiropractic care for adults with neck pain*. KT Canada Scientific Meeting. June 11-12, 2015, Halifax, NS (submitted, peer reviewed)



Table 1: Update of CCGI Strategic Metrics

Updated CCGI Strategic Metrics July 2015		
Objectives	Groups	Date for completion
Review of Sustainability Plan	GSC	Sept 2015
Review of number of recommendations to be produced/adapted/endorsed	GAC	Sept 2015
Review of future KT strategies	GIG	Sept 2015
Completion of WAD recommendations	GDG	Sept 2015
Dissemination of WAD recommendations	GIG	Winter 2015
Consideration of EHR implementation	CCGI/PBRN/GIG	Sept 2015 (ongoing)
Consideration of collaboration with 3 rd party payers	CCGI/GAC	2015-2016 (ongoing)
Review of CE hours and incentives to adhere to EIP	CCGI/Federation	2015-16 (ongoing)
Review of Succession Plan	GSC	2016
New Opinion Leader training to expand the program	CCGI	2017



From: Jo-Ann Willson
Sent: Monday, November 02, 2015 4:27 AM
To: Rose Bustria
Subject: FW: CAC-Suggests: Chiropractic Masters Prosperity Seminar in Toronto (Nov. 6-7/15)

Council.

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

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From: Chiropractic Awareness Council [webmaster@chiropracticawarenesscouncil.org]
Sent: Monday, November 02, 2015 3:15 AM
To: Jo-Ann Willson
Subject: CAC-Suggests: Chiropractic Masters Prosperity Seminar in Toronto (Nov. 6-7/15)

CHIROPRACTIC AWARENESS COUNCIL of ONTARIO

Moving the World to Healing in a Principle-Centred, Neurologically-based Chiropractic Wellness Model.

The banner includes seven individual portraits of council members arranged horizontally below the text.

CAC-Suggests: Chiropractic Masters Prosperity Seminar in Toronto (Nov. 6-7/15)

02 - November - 2015

Greetings Ms. Willson,

If you are finding that your clinical skills are stellar but your business acumen is holding you back from the success you deserve, then you may want to attend the Chiropractic Masters Prosperity Weekend, being held at the Westin Bristol Place Airport Hotel on November 6-7, 2015.

Our good friend Dr. Mike Reid is passionate about helping chiropractors get up-to-speed on the ways and means of engaging the populous to embrace a vitalistic chiropractic lifestyle. Like us, he is frustrated that the vast majority of DC's are "getting by". Having attended one of his sessions before, I know that he will drop a ton of proven "success-nuggets": a number of various strategies that you can cherry-pick to use in your own office that will help you go from survival to thrival!

This time round he is also bringing in some big-league help, with some of his co-presenters being Mr. Chris Miles, Dr. Matt Loop, Dr. Jenna Davis, Dr. Ed Osborn, Dr. Mike Henriksen, Dr. Clayton Roach and Ms. Kimberly Goreham. That's one powerful line-up!

If this even remotely sounds interesting, it gets better. Dr. Mike has offered CAC-Ontario members the opportunity to join him for only \$297... that's \$200 off the regular price of admission! With a great rate like this, what have you got to lose?

For more info [click here](#) and to get the special CAC-Ontario rate, call 800-781-8127 ask for the **CAC "Golden Ticket" !**

A great seminar at a great price... just another GREAT reason to [join CAC-ON!](#)

Standing on Principle.
Dr. Steve

Dr. Steven J. Silk
Chairman of the Board of Directors
Chiropractic Awareness Council of Ontario

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Chiropractic Awareness Council

Principle

This is this foundation for all things we do.

Vision

Our Vision: To lead Society to a better understanding of the Chiropractic Wellness Lifestyle thereby allowing them the ability to pursue a greater quality of life through Vitalistic, Principle-Driven Chiropractic.

Leading the profession and the public in the direction that is most needed not most accepted.

Passion

Embracing the extraordinary life available to serving as a doctor of chiropractic.

Courage

Willingness to stand up and fight for the sacred trust that has been given to us.

Philosophy

Committed to continually deepening our understanding and application of the foundations that make us unique.

Certainty

Providing a community of support so no doctor feels alone in the field.

Purpose

Making our profession more than a job but a way of life so that we can provide the greatest positive impact to humanity possible.



CHIROPRACTIC
AWARENESS
COUNCIL
OF ONTARIO

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[Click Here](#) to go to our **Doctor's Site**

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PS... If you have any problems with these links please send our webmaster a note at webmaster@chiropracticawarenesscouncil.org. Just left click on this e-mail address.

715

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ONTARIO
SUPERIOR COURT OF JUSTICE
(DIVISIONAL COURT)

THE HONOURABLE JUSTICE) Tuesday, THE 27TH DAY OF
Swinton ^{-v.k.}))
) OCTOBER, 2015

BETWEEN:

COLLEGE OF NURSES OF ONTARIO

Appellant

- and -

MARK DUMCHIN

Respondent

ORDER

THIS MOTION, made by the Federation of Health Regulatory Colleges of Ontario, for an order granting the Federation of Health Regulatory Colleges of Ontario leave to intervene as a friend of the court in this appeal, was heard this day at the City of Toronto.

ON READING the Motion Record of the Federation of Health Regulatory Colleges of Ontario and on reading the consent of all parties,

1. **THIS COURT ORDERS** that leave is granted to the Federation of Health Regulatory Colleges of Ontario to intervene as a friend of the court in this appeal.

2. **THIS COURT FURTHER ORDERS** that the title of the proceedings be amended to add the Federation of Health Regulatory Colleges of Ontario as an intervener.

3. **THIS COURT FURTHER ORDERS** that the role of the Federation of Health Regulatory Colleges of Ontario on this appeal is to deliver a factum and to make oral submissions as permitted by the Court. For greater certainty, the Federation shall not introduce evidence on the appeal.

4. **THIS COURT FURTHER ORDERS** that no costs will be ordered for or against the Federation of Health Regulatory Colleges of Ontario either on this motion or in this appeal.

U. Karalus
Assistant Registrar, Divisional Court

ENTERED AT / INSCRIT À TORONTO
ON / BOOK NO: 20
LE / DANS LE REGISTRE NO.:
OCT 29 2015
PER / PAR: <i>mo</i>

COLLEGE OF NURSES OF ONTARIO
Appellant

- and -

MARK DUMCHIN
Respondent
Court File No.: 278/15

**ONTARIO
SUPERIOR COURT OF JUSTICE
(DIVISIONAL COURT)**

Proceeding Commenced at Toronto

ORDER

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Lawyers for the Federation of Health
Regulatory Colleges of Ontario

From: Jo-Ann Willson
Sent: Monday, November 23, 2015 7:16 AM
To: Rose Bustria
Subject: FW: Ontario Accepts Recommendations to Strengthen the Ontario College of Trades

Council.

Jo-Ann P. Willson, B.Sc., M.S.W., LL.B.
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From: FHRCO - Beth Ann Kenny [bakenny@regulatedhealthprofessions.on.ca]
Sent: Monday, November 23, 2015 6:08 AM
To: registrars@regulatedhealthprofessions.on.ca
Subject: FW: Ontario Accepts Recommendations to Strengthen the Ontario College of Trades

Good morning – in case you didn't see this announcement on Friday, it's being forwarded to you FYI.

Take care!
Beth Ann



Beth Ann Kenny, Executive Coordinator
Federation of Health Regulatory Colleges of Ontario (FHRCO)
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From: Ontario News [mailto:newsroom@ontario.ca]

Sent: November 20, 2015 10:18 AM

To: bakenny@regulatedhealthprofessions.on.ca

Subject: Ontario Accepts Recommendations to Strengthen the Ontario College of Trades



Newsroom

News Release

Ontario Accepts Recommendations to Strengthen the Ontario College of Trades

November 20, 2015

Province Committed to Supporting Skilled Trades

Ontario is strengthening the industry-driven governing body responsible for promoting and modernizing skilled trades in the province.

The province, in partnership with the Ontario College of Trades, has accepted the recommendations made by former Secretary of Cabinet Tony Dean, in his report, *Supporting a Strong and Sustainable Ontario College of Trades*. Ontario will bring forward proposed legislative changes in the spring legislative session and will work closely with the College of Trades to implement Mr. Dean's recommendations.

Mr. Dean's recommendations would help improve the College's processes and clarify its mandate by:

- Supporting the existing Trade Boards to update and bring consistency to all trades' scopes of practice
- Reviewing how trades are classified through establishment of an independent and evidence-based process that will use risk of harm as a key criterion
- Establishing clearer and more concise criteria on how journey-person-to-apprentice ratios are determined

- Developing an enforcement and compliance committee and appeal process to resolve potential conflicts earlier, as well as ensure enforcement activities are consistently carried out with safety and the public interest in mind.

Mr. Dean's report was informed by an open and transparent year-long review that included consultations with several hundred tradespeople, employers and industry and trade boards representing more than 70 trades.

Ontario's ongoing commitment to strengthen the skilled trades and apprenticeship system is part of the government's plan to build Ontario up. The plan includes investing in people's talents and skills, making the largest investment in public infrastructure in Ontario's history, creating a dynamic, innovative environment where business thrives, and building a secure retirement savings plan.

QUICK FACTS

- The Ontario College of Trades officially opened for membership on April 8, 2013 and provides members with benefits such as recognition as a skilled-trades professional, enforcement of trade regulations, and a mechanism to ensure public safety through a discipline and complaints process.
- There are 237,000 active members in the Ontario College of Trades in more than 150 apprenticeable trades, including the construction, industrial, motive power and service sectors.
- Ontario appointed Mr. Dean to conduct this review in October 2014.
- Tony Dean started his working life as a machine tool fitter/millwright at the Dunlop Tire Company in Birmingham, UK. Following an apprenticeship, his trade qualifications were granted by the City and Guilds of London Institute.
- Ontario is investing more than \$176 million to support apprenticeships in 2015-2016.

BACKGROUND INFORMATION

- [Supporting a Strong and Sustainable Ontario College of Trades](#)

ADDITIONAL RESOURCES

- Ontario College of Trades
- Skilled trades in Ontario

QUOTES

"I'd like to thank Mr. Dean for the consultative and tireless approach he took to develop this comprehensive report. Our government firmly believes that Ontario's skilled tradespeople deserve to have a central role in guiding the future of their own industry, and Mr. Dean's report confirms the importance of the Ontario College of Trades in supporting this important goal. We will work closely with the College over the coming months to implement these recommendations in a timely and responsible manner and help it remain strong and sustainable long into the future."

— *Reza Moridi, Minister of Training, Colleges, and Universities*

"It was a privilege to take on this review and to hear from so many people and organizations around the province. I'm grateful to Minister Moridi and officials at the Ministry of Training, Colleges and Universities, and at the College of Trades, for their support over the past year. My recommendations are designed to put the College on a stronger and more sustainable footing and I'm confident that over time they will result in even better support for skilled tradespeople across Ontario."

— *Tony Dean, Independent Reviewer*

"The Ontario College of Trades would like to thank the Premier and the Minister for agreeing to initiate this comprehensive review and for their continued support for the College's mandate. We are pleased that Mr. Dean's Report endorses the valuable work we do on a daily basis to protect the public interest and modernize and promote the skilled trades in Ontario. We are committed to working with the Ministry of Training, Colleges and Universities on the development of an implementation strategy that is effective and practical."

— *Pat Blackwood, Chair of the Board of Governors, Ontario College of Trades*

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Chair of the Board of Governors, Ontario College of Trades

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750

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Reza Moridi

Minister of Research and Innovation
Minister of Training, Colleges and Universities

Political Career

- Minister of Research and Innovation, February 2013 - present
- Minister of Training, Colleges and Universities, June 2014 - present
- Parliamentary Assistant to the Minister of Energy, November 2011 – February 2013
- Parliamentary Assistant to the Minister of Research and Innovation, September 2009 – November 2011
- Parliamentary Assistant to the Minister of Training, Colleges and Universities, October 2007 – September 2009

Education

- PhD, Brunel University
- Chartered Engineer and Chartered Physicist
- Completed *CANDU Reactor, Industrial Management and Reactor Health Physics* certificate courses

Memberships and Associations

- Vice-President and Chief Scientist, Radiation Safety Institute of Canada
- Fellow, UK Institute of Physics
- Fellow, UK Institution of Engineering and Technology

Personal and Family Life

- Married (Pari)

Honours and Awards

- Education and Communication Award, Canadian Nuclear Society
- Fellow Award, U.S. Health Physics Society

Executive Biography

Reza Moridi was first elected to the Ontario legislature in 2007 as MPP for Richmond Hill. He was re-elected in 2011 and 2014.

Moridi currently serves as Minister of Training, Colleges and Universities, as well as Minister of Research and Innovation. Moridi is an award-winning scientist, engineer, educator, business leader and community activist. He was appointed Minister of Research and Innovation in February 2013. He moved to Canada with his family in 1990, and has lived in Richmond Hill since 1991.

Moridi has served as the Parliamentary Assistant to the Minister of Energy, the Minister of Training, Colleges and Universities, and the Minister of Research and Innovation. He was the Vice-Chair of the Cabinet Committee on Jobs and the Economy, and has served on the Standing Committee on Public Accounts, the Standing Committees on General Government and on Justice Policy (as Vice-Chair).

Prior to his election, Moridi was the Vice-President and Chief Scientist of the Radiation Safety Institute of Canada. His 17-year career at this institute provided him with a thorough understanding of the nuclear industry in Canada and the application of radiation and nuclear materials in a variety of industrial and health care sectors.

For his contributions to the understanding of nuclear materials, radiation and health physics, Moridi has received the Education and Communication Award from the Canadian Nuclear Society and the Fellow Award from the U.S. Health Physics Society. He was elected as a Fellow of the UK Institute of Physics and the UK Institution of Engineering and Technology for his original contribution to physics and engineering.

Moridi has also worked as a CEO and Chair in the electrical industry. His career in academia included serving as the Dean of the School of Sciences, Chair of the Physics Department, University Chief Librarian and member of the Senate at Alzahra University in Tehran.

Moridi is an editor of *Health Physics: The Radiation Safety Journal*. And he has authored or co-authored more than 150 research papers, technical reports, training manuals and articles, and has presented at scientific conferences around the world.

Educated in the UK, Moridi obtained a PhD from Brunel University. He is a Chartered Engineer and Chartered Physicist, and has completed *CANDU Reactor, Industrial Management* and *Reactor Health Physics* certificate courses.

Moridi lives in Richmond Hill with his wife, Pari.

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755

LEARN MORE

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Supporting a Strong and Sustainable Ontario College of Trades

November 20, 2015 10:00 A.M.

To support the ongoing success of the Ontario College of Trades, the province appointed former Secretary of Cabinet Tony Dean in October 2014 to recommend improvements to key areas of the College's activities and decision-making processes.

Mr. Dean has been widely endorsed by industry and tradespeople as highly qualified to provide advice on these matters and conducted an open and consultative review, including posting monthly updates to his website, www.deanreview.com. Mr. Dean received 109 submissions and held meetings with more than 300 tradespeople, employers and industry representatives in 11 locations across Ontario.

Mr. Dean's 31 recommendations would help the College build on its strengths and ensure that the regulation of trades in Ontario is transparent, evidence-based, and driven first and foremost by the public interest.

The review's recommendations address four primary areas:

Scopes of Practice

Mr. Dean has recommended that, based on feedback gathered through consultations, there is a need to review and update trade scopes of practice - work that the College itself had already begun. Moving forward, the College would lead an open, comprehensive, industry-driven review process that would include broad and inclusive collaboration between trade boards and other stakeholders. These recommendations focus on a collaborative approach and no trade would be forced to change its scope.

The review process would provide an opportunity to clarify various functions of the College, including apprenticeship and certification, promotion of the trades, ratio reviews, and standards of practice. It would also provide an opportunity for trades to discuss and resolve issues of overlapping practice and resolve potential enforcement issues.

Trade Classification and Reclassification Reviews

Mr. Dean's report recommends changes to ensure that the process to apply for trade re-classification is transparent, inclusive, evidence-based and driven by the public interest.

The recommendation to use independent experts would ensure a strong and clear process that would yield lasting, credible decisions - while keeping the process external to government.

While more rigorous, this process would also be less rigid. For example, trades seeking a compulsory status would have the flexibility to select either specific features of their trade's scope of practice, or their full scope for review by an independent expert panel. However, the requirement to train to the full scope of practice would always remain. This change does not imply "sub-trading" or the move to a "skill sets" model.

All trades that made applications prior to Mr. Dean's review would maintain their place in the queue to apply for compulsory status under the new process. The status of existing compulsory trades would not be impacted by any changes to the classification review process.

Ratio Reviews

The Ontario College of Trades has been successful in conducting ratio reviews. However, Mr. Dean suggests that there is an opportunity for improvement. These changes would bring greater consistency and confidence in an evidence-informed, transparent and inclusive process. One recommended change, for example, would allow review panels to request their own evidence and research to inform decisions.

Enforcement

Enforcement activities are a critical function of the College's mandate and should be carried out consistently with safety and the public interest in mind. The College should work to prevent unlicensed workers from practicing compulsory trades and enforcement efforts should target high-risk activities and the underground economy.

Mr. Dean recommends that the College adopt a policy-based approach to enforcement that focuses on these objectives. He also recommends that the College's Board of Governors establish a compliance and enforcement committee to inform this policy. Collaborative College work on trade scopes of practice driven by trade boards would also help to clarify the goals of enforcement activity.

A new appeal mechanism to the Ontario Labour Relations Board would also be established to address any future cases that arise in which College of Trades enforcement clashes with the Ontario Labour Relations Board jurisprudence and workplace-based agreements.

The College would have standing before the Ontario Labour Relations Board if an appeal were made and the Board would have regard to, among other things, the *Ontario College of Trades and Apprenticeship Act 2009* when making decisions.

758

To learn more about the Ontario College of Trades, please visit:

- www.collegeoftrades.ca

To read Mr. Dean's report, please visit:

- ontario.ca/deanreport

To read Mr. Dean's biography, please visit:

- <https://news.ontario.ca/tcu/en/2014/10/tony-dean.html>

LEARN MORE

- [Ontario College of Trades](#)
- [Skilled trades in Ontario](#)

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Prepared by Richard Steinecke

In this Issue:

- *Veterinarians Act* has major re-write of its regulations, see pp. 1-2
- Consultation on new fees under the *Healing Arts Radiation Protection Act*, see p. 2
- Consultation on *Five-Year Review of the Retirement Homes Act, 2010*, see p. 2

Bonus Features:

- Detailed Guidance on Adequacy of Reasons, on the Need for Expert Evidence and on Penalty, see pp. 2-4
- Searching a Member's Personal Cell Phone, see p. 4
- College Immunity from Civil Suits, see p. 4

Ontario Bills

(See www.ontla.on.ca)

The Legislature is in summer recess.

Proclamations

(See www.ontario.ca/en/ontgazette/gazlat/index.htm)

There were no relevant proclamations.

Regulations

(See www.ontario.ca/en/ontgazette/gazlat/index.htm)

Veterinarians Act – A comprehensive revision of the general regulation for this profession includes a conflict of interest rule that prohibited veterinarians who are employed by a business from treating of patients unless the patients are owned by the employer. There were some exceptions (e.g., veterinarians employed by government).

A separate provision also included a “know-your-client” standard of practice that reads as follows:

- (a) been retained by the owner of the animal, an authorized representative of the owner or an individual who the member reasonably determines is acting in the interest of the animal;
- (b) advised the client that the member will only provide services in accordance with the standards of practice of the profession;

- (c) reached an agreement with the client as to the scope of the services to be provided by the member; and
- (d) obtained the consent of the client for each service to be provided.

(Ontario Regulations 233/15, Gazetted August 8, 2015).

Proposed Regulations Registry

(See: <http://www.ontariocanada.com/registry>)

Healing Arts Radiation Protection Act. The proposal would allow the Ministry to charge a fee for the review and approval of X-ray machine installation plans. Public hospitals and educational institutions would be exempt. Comments are due by September 28, 2015.

Five-Year Review of the Retirement Homes Act, 2010 - Consultation Paper. A comprehensive review of this legislation, as administered by the Retirement Homes Regulatory Authority, has been initiated by the issuance of a consultation paper. Comments are due by September 30, 2015.

Bonus Features

(See www.canlii.org)

Detailed Guidance on Adequacy of Reasons, on the Need for Expert Evidence and on Penalty

In *Byrnes v Law Society of Upper Canada*, 2015 ONSC 2939 a lawyer was disbarred. The lawyer's client was undergoing a matrimonial dispute. Mr. Byrnes arranged for the client to transfer his interest in his matrimonial home to the lawyer in trust and then proceeded to use it all to cover the lawyer's accounts. The lawyer spent a significant amount of time disputing the division of the family's personal items that were not worth much and on an attempt to prevent the client's wife from smoking in front of the children. The client had the accounts assessed by a court officer who directed that nothing should be paid. However, the lawyer declared bankruptcy and the client received nothing.

The first issue was whether the Court should permit the lawyer to raise new grounds of appeal that were not raised at the hearings before the Law Society. The Court stated that generally new grounds were not permitted to be raised afterwards, but indicated that there were exceptions where:

1. there is a sufficient evidentiary record to resolve the issue;
2. the failure to raise the issue at the hearing was not due to a tactical decision; and
3. the refusal to raise the new issue on appeal would not result in a miscarriage of justice.

An exception was made in this case on the issues of whether the Law Society had reversed the onus of proof and whether it gave adequate reasons for its decision. These were primarily legal issues and Mr. Byrnes had represented himself at the Law Society.

The Court then considered whether the Law Society had reversed the onus of proof when it relied on the absence of documentation by the member as part of the reason for concluding that informed consent had not been obtained and that the member had not kept the client updated on the matter. The Court concluded that it was permissible to rely on the fact that there was no record, where one would expect one to exist, along with other evidence, to support the findings. There was no reversal of the onus of proof.

The Court had an extensive discussion as to when reasons for decision were inadequate. It reviewed the leading cases on point and concluded as follows:

The reasons in *Neinstein* and *Barrington* make it clear that the reasons for decision in professional discipline cases must address the major points in issue to enable appellate review. A failure to deal with material evidence or a failure to provide an adequate explanation for rejecting material evidence precludes effective appellate review. Applying the reasoning in *Newfoundland Nurses*, if the reasons of the Hearing Panel do not explicitly make findings of credibility against Mr. Byrnes on the issues of professional misconduct, that does not end the inquiry. There is then a second step.

A recent Ontario Court of Appeal decision confirms the principles in *Newfoundland Nurses* that where the express reasons fall short, a reviewing court is obliged to discern the tribunal's implicit reasons, having regard to the context and the evidentiary record

The Court concluded that the reasons by the tribunal in Mr. Byrnes case were adequate, particularly since the findings were based on documents and admissions and were not based entirely on credibility findings.

On the issue of whether Mr. Byrnes had overcharged his client, there was no expert evidence. The Court made the usual distinction: a tribunal can use its expertise to assess the evidence, but not to substitute for expert evidence. The Court concluded that the basic facts were before the tribunal (including the number of hours spent on less important matters) and thus was in a position to use its expertise to conclude that the global fee charged was excessive. This is a somewhat surprising conclusion and should be viewed as being based on the specific facts of the case. It is doubtful that a Court would uphold a finding that a service fell below the accepted standards of practice of the profession simply because an *RHPA* discipline panel knew exactly what the practitioner had done.

The Court also upheld the order of revocation because the member had a significant prior discipline history. The Court was of the view that the tribunal's conclusion that "there is a significant risk, if not

a certainty that, at some time, at some point, Mr. Byrnes will once again take advantage of a client” was reasonable.

Searching a Member’s Personal Cell Phone

In *McLean v. Law Society of British Columbia*, 2015 BCSC 1431 a lawyer under investigation brought a complex civil action against his regulator who was conducting an investigation. He sued not only the Law Society, but also many of its employees, alleging that they conspired to harm his law practice by knowingly exceeding their investigative powers. The attempt by the Law Society to set aside the action largely failed because Mr. McLean disputed many of the facts, including whether he had given consent for the Law Society to have access to his personal cell phone.

As a preliminary matter, the Court ruled that the general power of the Law Society to have access to the member’s business premises and records did not extend to having compelled access to his personal cell phone. The Court did state, however, that the provision permitting the Law Society to obtain a court order to have access to personal, and not just business, information was available to the Law Society. That provision would provide access to the personal cell phone records of the member if the Court granted the order.

College Immunity from Civil Suits

In *Singh-Boutilier v. Ontario College of Social Workers and Social Service Workers*, 2015 ONSC 5297, a social worker, who had been disciplined, sued the College, its employees, its lawyers and the complainant and witnesses for a wide variety of causes of action.

The Court struck out the claims on various grounds including the following:

- The immunity provision precluded some claims entirely (e.g., negligence) as the College and its representatives (including its lawyers) are protected from actions taken in good faith. In addition, the College owed no duty of care to individual members; its duty was to the broader public.
- To the extent that there were some assertions of bad faith, the social worker had not provided particulars of the bad faith as required.
- The publication of the results of the discipline hearing on the College’s website was required by the legislation and therefore could not result in a breach of privacy.
- Complainants and witnesses are protected by absolute privilege for their statements including in a letter of complaints and during the investigation.
- In addition, any claims based on the College’s documents could not succeed as those documents were privileged under that College’s equivalent to subsection 36(3) of the *RHPA*.

However, the Court allowed the social worker an opportunity to try to rewrite her statement of claim on the following matters: breach of privacy, unlawful interference with economic relations, and injurious falsehood. However, particulars of the bad faith or malice would have to be alleged.

Prepared by Richard Steinecke

In this Issue:

- Bill 52, *Protection of Public Participation Act* still moving along, see pp. 1-2
- Bill 85 to give OMA immunity from civil suits, see p. 2
- Bill 113, *Police Record Checks Reform Act*, see p. 2
- Bill 122, *Mental Health Act* to be reformed for long-term detentions, see p. 2
- Bill 129 to protect genetic testing under the Human Rights Code, see p. 2
- Bill 132 provides more protection to victims of sexual violence, see pp. 2-3
- Psychotherapy misconduct regulation commencement date clarified, see p. 3
- Consultation on *Public Hospitals Act* regulation on handling critical incidents, see p. 3
- Consultation on educational qualifications of PSWs in long-term care, see p. 3

Bonus Features:

- Systemic Discrimination by a Regulator, see pp. 3-4
- Cozy Counsel, see p. 4
- Bad Faith Regulation Claim Dismissed, see p. 4
- Guidance on Unauthorized Practice Injunctions, see p. 5
- No Stay of Discipline Order Pending Appeal, see p. 5
- Going Back on an Undertaking to Resign and Never Reapply, see p. 6
- Reacting to a Difficult Member Can Impair Subsequent Proceedings, see p. 6

Ontario Bills

(See www.ontla.on.ca)

Bill 52, *Protection of Public Participation Act, 2014* (government Bill – passed Third Reading, awaiting royal assent) – Bill 52 reintroduces Bill 83 from the previous legislative sittings. It is intended to prevent the use of the legal system to stifle free speech. It allows a person to ask a court to dismiss a proceeding if it is shown that the proceeding arises from an expression made by the person that relates to a matter of public interest. Of interest to Colleges is:

- a) A provision that allows a defendant or respondent to a College-initiated court proceeding (e.g., an injunction restraining the use of a protected title and holding out) to obtain an automatic stay of the proceeding simply by bringing a motion claiming that the action involves the suppression of free speech.
- b) A provision that allows the automatic stay of a tribunal hearing (e.g., a discipline hearing) simply by filing with the tribunal notice that a motion is being brought in a related civil action to prevent the suppression of free speech. For example, if a practitioner is being disciplined for unprofessional comments made (perhaps even of a sexual nature) and sued by the complainant

at the same time, the practitioner can stay the hearing by filing a notice that a motion is being brought to dismiss the civil action. The Discipline Committee would either have to wait until the motion was determined or go to court for an order permitting it to continue with its hearing.

- c) In an unrelated section of the Bill, the *Statutory Powers Procedure Act* is being amended to require that motions for costs under the *SPPA* must be made in writing, unless a tribunal determines that to do so is likely to cause a party to the proceeding significant prejudice. It is unlikely that this amendment will apply to *RHPA* hearings as those costs motions are normally brought under the *HPPC*, not the *SPPA*.

Bill 85, *Strengthening and Improving Government Act, 2015* (*government Bill – Second Reading vote pending*) – Bill 85 provides immunity from civil suit for the good faith actions of the directors, officers, employees and other representatives of the Ontario Medical Association in their OHIP-fee negotiations with government.

Bill 113, *Police Record Checks Reform Act, 2015* (*government Bill – Passed Second Reading and referred to Standing Committee on Justice Policy*) - Bill 113 will restrict the information that police forces can release on a police record check. There will now be three categories of checks rather than the current two:

- criminal record check,
- criminal record and judicial matters check, and
- vulnerable sector check.

Non-conviction information is only authorized for disclosure in a vulnerable sector check and only in exceptional circumstances. This Bill may affect the procedure and information available to Colleges who require such checks from applicants or members.

Bill 122, *Mental Health Statute Law Amendment Act, 2015* (*government Bill – Second Reading Debate*) – Bill 122 establishes a new “certificate of continuation” approach to deal with long-term involuntary patients in psychiatric facilities. These provisions include new procedures and new remedies before the Consent and Capacity Board for such patients.

Bill 129, *Human Rights Code Amendment Act (Genetic Characteristics), 2015* (*private member’s Bill – Passed First Reading*) – Bill 129 amends the Human Rights Code to include genetic characteristics as a prohibited ground of discrimination. While perhaps of most interest to insurers, this amendment could have an impact on medical testing and treatment decisions. For example, declining genetic testing cannot result in discrimination.

Bill 132, *Sexual Violence and Harassment Action Plan Act (Supporting Survivors and Challenging Sexual Violence and Harassment), 2015* (*government Bill – Passed First Reading*) – Bill 132 provides greater protection and recourse for individuals from sexual violence and harassment. For example,

limitation periods for suing for such abuse are extended or eliminated. Post-secondary education institutions are required to develop policies to prevent and respond to sexual violence and harassment. In addition, all employers are required to address the issue more thoroughly.

Proclamations

(See www.ontario.ca/en/ontgazette/qazlat/index.htm)

There were no relevant proclamations this month.

Regulations

(See www.ontario.ca/en/ontgazette/qazlat/index.htm)

Psychotherapy Act, 2007 – The professional misconduct regulation is amended to clarify the date upon which it comes into force (*Ontario Regulation 305/15, Gazetted October 17, 2015*)

Proposed Regulations Registry

(See: <http://www.ontariocanada.com/registry>)

(Still pending) **Public Hospitals Act, 1990** – A proposal would revise the regulations under this Act to require hospitals to investigate all critical incidents, which includes interviewing patients and their personal representatives, and to explain to patients and their personal representatives the cause of the critical incidents, where possible. Comments are due by November 2, 2015.

Long-Term Care Homes Act, 2007 – A proposal would revise the regulations under this Act in a number of areas including the educational qualifications for personal support workers. Comments are due by November 20, 2015.

Bonus Features

(See www.canlii.org)

Systemic Discrimination by a Regulator

In *Brar and others v. B.C. Veterinary Medical Association*, thirteen Indo-Canadian veterinarians succeeded in their human rights complaint against the British Columbia Veterinary Medical Association (now called a “College”).

In its 491-page decision, the Tribunal concluded that the College engaged in systemic discrimination against the veterinarians on the basis of race, colour and place of origin alleging that the College targeted Indo-Canadian practitioners for inspections, investigations and advertising scrutiny. In addition, the Tribunal found that the English language fluency test was designed to exclude members of this group from registration in the profession. For one of the veterinarians, the College was found

to have discriminated on the ground of mental disability. In addition, the Tribunal stated that the College retaliated against the veterinarians after they filed their complaints with the Human Rights Tribunal.

The Tribunal ordered the College to pay between \$2,000 and \$35,000 to each of the 13 veterinarians for “injury to dignity, feelings and self respect”, which totalled \$219,500. In addition, the College was ordered to pay approximately \$45,000 for lost wages and expenses. The Tribunal also ordered non-monetary remedies: the College was required to cease the discrimination and to refrain from committing the same or a similar contravention, and to take specified steps to address the effects of its discriminatory practices. The case is not yet on CanLII but can be found at: <http://www.bchrt.bc.ca/decisions/2015/oct.htm>.

Cozy Counsel

In *DeMaria v Law Society of Saskatchewan*, 2015 SKCA 106, the issue was an appearance of bias where counsel to the College appears before adjudicative committees. While the Court said that counsel could fulfill both roles, it was important that a suitable professional distance be maintained. The Court was concerned about evidence that committee panel members had breakfast with prosecuting counsel before the hearing and that counsel stayed in the room with the panel for at least ten minutes after the hearing ended. However, the Court concluded that these unfortunate circumstances did not amount to a reasonable appearance of bias. The Court was not concerned with a committee panel member being friends with prosecuting Council on Facebook as this, on its own, only indicated that they knew each other. Additional details of this case are found in the October issue of *Grey Areas*, attached for quick reference.

Bad Faith Regulation Claim Dismissed

Dr. Venneri is a chiropractor who owns a hyperbaric oxygen chamber. Federal rules require that its operation be administered by a physician. Dr. Venneri hired five physicians to operate the chamber. The College of Physicians and Surgeons of Ontario investigated concerns about the conduct of those physicians when operating the chamber. During the investigation, all five physicians resigned from Dr. Venneri’s business and undertook not to return to it. Dr. Venneri sued the College for intentional interference with economic relations and misfeasance of public office, alleging that the College acted in bad faith to protect physician turf. He sought access to the College’s files to demonstrate this bad faith. The College refused to produce its files and moved to dismiss Dr. Venneri’s lawsuit.

In *Hyperbaric Oxygen Institute of Canada Inc. v College of Physicians, et al.*, 2015 ONSC 6208, the Court dismissed the action. It found that Dr. Venneri had not established bad faith. In addition, subsection 36(3) of the *RHPA* protected the College’s investigation files from being produced in the civil action.

Guidance on Unauthorized Practice Injunctions

In *Law Society of Saskatchewan v Mattison*, 2015 SKQB 323, the regulator sought an injunction against a former member with a long discipline history who appeared to be continuing to provide professional services. The Court made the following points:

- The fact that clients of the unregistered individual know his or her status is irrelevant. The issue is the present and anticipated illegal conduct.
- The discipline history provides good evidence as to the individual's likely future lack of willingness to comply with the law.
- The existence of a provision authorizing the issuance of the restraining order removes the need for the regulator to prove irreparable harm (which must usually be proved for civil injunctions).
- The balance of convenience generally does not weigh in favour of the individual since the injunction only requires him or her to comply with a law that already applies.
- The wording of the order should not simply follow the language of the legislation as that makes contempt proceedings more difficult to establish. Rather, the order should be specific as to the actual things that the individual must not do.

No Stay of Discipline Order Pending Appeal

The Dr. Noriega saga is well known and often reported in the media. He has a history of findings of sexual abuse. He also breached an undertaking designed to protect his pediatric patients. Most recently, the Discipline Committee revoked his certificate of registration for sexual abuse. In *Noriega v College of Physicians and Surgeons of Ontario*, 2015 CanLII 67141 (ON SCDC), he sought to stay that order pending his appeal (which is scheduled to be heard in three months). The Court found that the financial impact of the order is not irreparable harm even though his financial circumstances are reportedly dire. The Court also doubted that his practice would be destroyed as it appears to have remained viable after previous suspensions. The Court also did not accept the argument that he was the only Spanish speaking pediatrician still accepting new patients in the area as irreparable harm.

In terms of balance of convenience, the Court was particularly concerned that Dr. Noriega's breach of his previous undertaking demonstrated a significant risk to the public. The Court was also concerned about the impact of any stay of the order on public confidence in the regulation of the profession.

The Court refused to order a stay of the order, except that the costs order need not be paid until after the appeal had been determined.

Going Back on an Undertaking to Resign and Never Reapply

In *Stelmaschuk v. The College of Dental Surgeons of B.C.*, 2015 BCSC 1766, the dentist resigned and undertook never to reapply after multiple complaints had been made against him. Three years later he sought judicial review of the College's acceptance of his resignation on the basis that he resigned under duress when he was, to the knowledge of the College, suffering from bi-polar affective disorder.

The Court ruled that a settlement agreement cannot be the subject of judicial review as it was not a statutory decision. However, the dentist could sue the College in civil court for abuse of process. The matter would proceed as a civil action.

Reacting to a Difficult Member Can Impair Subsequent Proceedings

In *D’Mello v The Law Society of Upper Canada*, 2015 ONSC 5841, there is no doubt that Mr. D’Mello was a difficult member. While investigating a complaint from a bank about a mortgage transaction, Mr. D’Mello insisted on disclosure of an electronic version to a letter because he believed it was concocted by the Law Society and the bank. For a time, Mr. D’Mello refused to cooperate with the investigation until he received the electronic copy. Eventually no action was taken on the original complaint, but the Law Society proceeded on the failure to cooperate matter, making a finding against Mr. D’Mello and imposing an order that included a reprimand and one month suspension as well as a costs order.

Mr. D’Mello appealed. The Court upheld the finding of non-cooperation stating that, even though there had been a delay in initiating the investigation on the original complaint and even though Mr. D’Mello had concerns, he was not entitled to disclosure of the electronic copy of the letter during the complaints stage. Mr. D’Mello clearly refused to cooperate and turn over his files.

However, the Court found that the order was unfair. In part, the tribunal had unfairly said that Mr. D’Mello’s conspiracy theories were irrelevant to his duty to cooperate and then went on to find, during the penalty hearing, that his conspiracy theories were unfounded. In addition, the tribunal misused the lack of remorse by Mr. D’Mello, stating: “Remorse may be a mitigating factor, and the lack of remorse may mean that there are no mitigating factors, but lack of remorse is not an aggravating factor.” The Court said that the suspension was unwarranted and, since Mr. D’Mello had already served part of it, that no further order (e.g., reprimand, costs) should result.

**College of Chiropractors of Ontario
Advertising Committee Report to Council
Friday, December 4, 2015**

Members: Dr. Bruce Lambert, *Chair*
Dr. Lawrence McCarthy, *non-Council member*
Ms. Patrice Burke
Dr. Reginald Gates

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

The Advertising Committee continues to fulfill its mandate of reviewing submitted advertisements and providing feedback to members within ten business days. The Advertising Committee met in person on October 29th, 2015 to review Standard of Practice: S-016, Guideline G-016: Advertising and Policy P-016: Public Display Protocol.

Recommendation 1

The Advertising Committee recommends amendments to Standard of Practice S-016: Advertising for distribution and feedback.

Recommendation 2

The Advertising Committee recommends amendments to Guideline G-016: Advertising for distribution and feedback.

The committee reviewed its decision making process leading to the S-016: Advertising recommendation to Council at the June 2015 meeting. The June 2015 Council meeting minutes, the close “straw vote” where some Council members were “on the fence,” Council feedback and stakeholder feedback were analyzed to determine future recommendations regarding testimonials, websites and the Public Display Protocol.

The first topic was the use of testimonials in advertising. The CCO is an outlier from the majority of regulated health colleges in that S-016 allows the use of testimonials while the other colleges do not. When considering this fact, it is important to note that the CCO is an outlier in another important way. The CCO is the only Ontario College that has an Advertising Committee whose role is to review advertisements submitted by its members. The committee believes that the proposed changes for utilizing testimonials in advertisements is in the public’s best interests. The inclusion of patient consent that is to be maintained in the patient’s health record creates a mechanism to validate testimonials and provides a tool that allows an audit of the testimonials being used by members. The required documentation would be available for review in a Peer and Practice Assessment or on a case by case basis if required.

The second topic pertained to S-016 excluding chiropractors' websites from the advertising standard. It was suggested at the June Council meeting that this be reviewed in light of current technologies having advanced significantly the past ten years. Internet search engines may now take the public deep into a chiropractor's website which the committee believes nullifies the previous stance that a person had to click to enter the website in a way similar to stepping through the front door of the office. The committee concluded that websites need to be considered as advertising.

The committee discussed at length the ramifications of changing S-016 and the potential challenges that might arise. Would the committee be responsible for reviewing each website? Should the CCO expect an increase in costs associated with website inclusion in advertising? Will members consider legal challenges for their right to free speech? The committee is recommending that the standard consider websites and electronic communications as advertising and that compliance with the new standard of practice be the member's responsibility. The Advertising Committee does not have the resources or staffing capacity to review every chiropractor's website. The change will require members to update their electronic presence, and if communicated correctly to ensure compliance, will not add increased costs in the operation of the Advertising Committee. The Quality Assurance Committee may wish to incorporate a review of the website during peer assessments to monitor compliance. The committee recommends distributing the proposed changes to S-016 for stakeholder feedback.

The third point of discussion at the last Advertising Committee meeting was regarding suggestions to change the Public Display Protocol. The Committee understood that the suggested change state that during a public display, any diagnostic process be demonstrated on staff or a person affiliated with the display, and not on members of the public. As the Committee began scrutinizing the Public Display Protocol, it became evident that this change would be a massive restructuring of the document and be a significant change in policy. The Committee asked that I as Chair receive specific direction from a majority of Council voices before undertaking this significant endeavor, keeping in mind that the objective of the policy is to protect the public.

I wish to thank Dr. Lawrence McCarthy, Ms. Patrice Burke and Dr. Reginald Gates for their commitment, insight and focus. I wish to also thank Mr. Joel Friedman and Ms. Andrea Szametz for their excellent work in support of the committee.

Respectfully submitted,

Dr. Bruce R. Lambert,
Chair, Advertising Committee

Advertising Committee
Approved by Council: September 7, 1996
Amended: September 21, 2002, June 22, 2007, November 29, 2007,
September 24, 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 provide members with advertising guidelines to ensure all advertisements serve the public interest.
- To educate the public on what is available for their chiropractic care.
- To ensure, as much as possible, that the public has the information to make rational choices for their care.
- To assist the public in obtaining the services of members of their choice.
- To maintain a professional image.

Advertising Definition for the Purpose of Standard of Practice S-016: Advertising

Advertising is any message communicated outside a member's office through a public medium that can be seen or heard by the public at large with the intent of influencing a person's choice of service or service provider. This standard applies equally to members acting individually, as a group, or as a professional health corporation.

DESCRIPTION OF STANDARD

1. An advertisement must be:
 - (a) accurate, factual and contain information that is verifiable; and
 - (b) readily comprehensible by the persons to whom it is directed.
2. An advertisement may:
 - (a) name a specific service, technique and/or product but cannot claim superiority or endorse the exclusive use of such services, techniques or products. References to specific diagnostic or therapeutic procedures must comply with Standard of Practice S-001: Chiropractic Scope of Practice;

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- (b) make reference to the member being a specialist, provided the member is recognized pursuant to CCO's policy as a specialist, and the specialty is disclosed. Refer to Policy P-029: Chiropractic Specialties, for the list of specialties currently recognized by CCO;
 - (c) make reference to the member being affiliated with any professional association, society or body, other than CCO, only on a curriculum vitae, business stationery and recognized public displays;
 - (d) allow an individual or organization to endorse a member provided:
 - (i) the individual or organization proposing the endorsement has sufficient expertise, according to CCO, relevant to the subject matter being endorsed; and
 - (ii) the member has been appropriately assessed as providing the subject matter being endorsed; and
 - (e) offer an initial complimentary consultation¹.
3. Any advertisement with respect to a member's practice must not contain:
- (a) anything false or misleading;
 - (b) a guaranteed success of care;
 - (c) any comparison to another member's or other health care provider's practice, qualifications or expertise;
 - 2 (d) any expressed or implied endorsement or recommendation for the exclusive use of a product or brand of equipment used to provide services;
 - (e) testimonials that refer to a particular member or office²; and
 - (f) material that, having regard to all the circumstances, would reasonably be regarded as disgraceful, dishonourable or unprofessional.
4. A member may advertise his/her fee for chiropractic services provided:
- (a) the advertisement contains accurate, complete and clear disclosure of what is and what is not included in the fee;

- (b) there are no hidden fees/costs;
 - (c) the member does not bill a third-party payor for the complimentary portion of the diagnostic or treatment service;
 - (d) the advertisement expressly states the timeframe to be honoured for any complimentary or discounted diagnostic or treatment service;
 - (e) the advertisement does not limit the offer to a certain number of participants;
 - (f) no obligation is placed on the patient for follow-up appointments as a result of the complimentary or discounted diagnostic or treatment service; and
 - (g) the advertisement is presented in a professional manner that maintains the dignity of the profession.
5. A member advertising the exchange of products/services for proceeds/donations to a charity may do so as follows:
- (a) the proceeds/donations are being collected for a registered charity, school or other organization that, in the opinion of the Advertising Committee, serves the public's interest ("charity");
 - (b) the charity is disclosed in the advertisement;
 - (c) the member discloses the part of the proceeds/donations to be given to the designated charity and if he/she is taking any proceeds/donations to cover his/her expenses;
 - (d) the member may not bill any third-party payor for the diagnostic or treatment services provided in exchange for the charitable proceeds/donation; and
 - (e) the member providing diagnostic or treatment services in exchange for the charitable proceeds/donation must comply with all CCO standards of practice.
6. Public presentations or displays³ are permissible provided:
- (a) a member adheres to CCO's regulations and standards of practice (e.g., consent, record keeping);

- (b) professional conduct is maintained at all times;
 - (c) material distributed complies with the advertising standard⁴;
 - (d) assessment(s) performed comply with CCO's Public Display Protocol (Policy P-016) and are for educational purposes;
 - (e) no controlled acts of diagnosis and/or adjustments are performed; and
 - (f) no coercion or pressure tactics are used⁵.
7. (a) Banner advertising on the Internet must comply with CCO's advertising standard of practice;
- (b) A member's website is considered an extension of the member's office. Information on a member's websites must be informative, educational and professional;
- (c) Information on a member's website must comply with CCO's standards of practice, except S-016: Advertising⁶.
8. A member must not:
- (a) advertise or permit advertising with respect to his/her practice in contravention of the regulations or standards of practice; and
 - (b) contact or communicate with or allow any person to contact or communicate with potential patients via telemarketing or electronic methods.

LEGISLATIVE CONTEXT

It is an act of professional misconduct to contravene or fail to maintain a standard of practice.

For additional information regarding billing procedures, please refer to Regulation R-008: Professional Misconduct (Business Practices section) and Guideline G-008: Business Practices.

¹ A consultation is a meeting to discuss how chiropractic may benefit the patient. A consultation does not include examination procedures, diagnostic tests (e.g., x-rays) or treatment services.

² Testimonials that refer to the benefits of chiropractic and not to a particular member/clinic are permissible provided they are not false or misleading. A member shall comply with the current privacy legislation and obtain the patient's consent prior to using his/her testimonial.

³ "Displays" include presentations or other visual material to members of the public, in a place normally frequented by the public, by a person or persons who are physically present when such material is disturbed or presented.

⁴ It is strongly recommended that material to be distributed be pre-approved by the Advertising Committee.

⁵ Voluntary appointments are permitted - i.e., if potential patients ask for the member's business card or request an appointment.

⁶ With the exception of banner advertising, a member's website is considered an extension of the member's office in that the public must choose to enter the website.

Advertising Committee
Approved by Council: January 13, 1996
Amended and Approved by Council: September 21, 2002, June 22, 2007,
November 29, 2007, and September 24, 2009

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

INTENT

The advertising guideline is designed to detail Standard of Practice S-016: Advertising, and to give members guidance when educating members of the public. Advertisements should help the public make informed choices regarding their health care. To assist members of the public in making knowledgeable choices, advertisements must be informative and maintain a professional image.

DESCRIPTION OF GUIDELINE

1. An advertisement must be:

- (a) accurate, factual and contain information that is verifiable;

Providing the public with accurate, factual, objective and verifiable information to make an informed choice in health care is in the public's best interest. Subjective opinions may cause confusion and lack of trust.

- (b) readily comprehensible by the persons to whom it is directed.

Advertisements should be readily understandable so the general public is not confused by the message.

2. An advertisement may:

- (a) name a specific service, technique and/or product but cannot claim superiority or endorse the exclusive use of such services, techniques or products. References to specific diagnostic or therapeutic procedures must comply with the Standard of Practice S-001: Chiropractic Scope of Practice;

Such references assist the public in finding a particular type of chiropractic care and allow an informed choice.

Members may advertise services (e.g., acupuncture, ultrasound, x-rays), adjustive techniques, and other procedures within the public domain (e.g. orthotics, nutritional products). Members should understand exhaustive lists of everything possible may confuse the public and are not advised.

- (b) make reference to the member being a specialist, provided the member is recognized pursuant to CCO's policy as a specialist, and the specialty is disclosed. Refer to Policy P-029: Chiropractic Specialties, for the list of specialties currently recognized by CCO;

Members may only use terms such as "specialist" and "specializing in" in reference to the specialties recognized by CCO. A member cannot advertise a specialty in area(s) not recognized by CCO. A member may express an "interest in" or "focus on" an area of practice.

- (c) make reference to the member being affiliated with any professional association, society or body, other than CCO, only on curriculum vitae, business stationery and recognized public displays;

Advertising a member's affiliations in any other medium may confuse the public and may cause comparisons to other members, which is not permitted.

- (d) allow an individual or organization to endorse a member, provided:

An unqualified endorsement from a source with little or no expertise is not in the public's best interest and undermines the public's trust.

- (i) the individual or organization proposing the endorsement has sufficient expertise, according to CCO, relevant to the subject matter being endorsed;
- (ii) the member has been appropriately assessed as providing the subject matter being endorsed;

- (e) offer an initial complimentary consultation.¹

Members may advertise complimentary/courtesy initial consultations. Members may not bill any third-party payors for complimentary/courtesy consultations.

3. Any advertisement with respect to a member's practice must not contain:

- (a) anything false or misleading;

False or misleading statements undermine public trust in the profession and may result in a complaint to CCO by a colleague or a member of the public.

- (b) a guaranteed success of care;

Claims and guarantees of success are often not verifiable and may appear unprofessional. Members should not use expressions such as "will help" and "does relieve" which imply a guarantee. Members may use expressions such as "may be able to help" or "has been shown to relieve."

- (c) any comparison to another member's or other health care provider's practice, qualifications or expertise;

Comparison to any facet of another member's practice is unprofessional. The public and the profession are better served by positive and generic chiropractic facts.

Members should not use adjectives with comparatives (e.g., "more" or "better") in their advertising because they imply a comparison. Members may use words such as "safe" and "effective" to describe the chiropractic profession in general.

- (d) any expressed or implied endorsement or recommendation for the exclusive use of a product or brand of equipment used to provide services;

Exclusive endorsements of products suggest superiority and imply a comparison, which is not permitted.

- (e) testimonials that refer to a particular member or office;

Testimonials that refer to the benefits of chiropractic and not to a particular member or office are permissible. Testimonials must be truthful and verifiable, and must meet all other elements of CCO's advertising standard.

- (f) material that, having regard to all the circumstances, would reasonably be regarded as disgraceful, dishonourable or unprofessional.

All advertisements must maintain professional integrity and serve the public's best interest.

It is an act of professional misconduct to engage in conduct or perform an act that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

4. A member may advertise his/her fee for chiropractic services provided:

- (a) the advertisement contains accurate, complete and clear disclosure of what is and what is not included in the fee;

The public is entitled to full disclosure of what is and what is not included in the advertised fee.

- (b) there are no hidden fees/costs;

The public is entitled to full disclosure of what is and what is not included in the advertised fee.

- (c) the member does not bill a third-party payor for the complimentary portion of the diagnostic or treatment service;

A member is not permitted to bill any third-party payor for complimentary diagnostic or treatment services as this practice is unethical and may be professional misconduct.

- (d) the advertisement expressly states the timeframe to be honoured for any complimentary or discounted diagnostic or treatment service;

To ensure there is no confusion or misunderstanding, the advertisement must indicate the exact timeframe in which the complimentary or discounted diagnostic or treatment services apply.

- (e) the advertisement does not limit the offer to a certain number of participants;

Members of the public must all be given an equal opportunity to obtain the advertised complimentary or discounted diagnostic or treatment services. An advertisement that limits an offer to a certain number of participants may be misleading.

- 4 (f) no obligation is placed on the patient for follow-up appointments as a result of the complimentary or discounted diagnostic or treatment service;

A member may not use an advertisement for complimentary or discounted diagnostic or treatment services to pressure or coerce a member of the public to return for follow-up appointments.

- (g) the advertisement is presented in a professional manner that maintains the dignity of the profession.

All advertisements must be presented in a professional manner, maintain professional integrity, and serve the public's best interest.

5. A member advertising the exchange of products/services for proceeds/donations to a charity may do so as follows:

An advertisement that encourages philanthropy, if done professionally and ethically, serves the public's interest.

- (a) the proceeds/donations are being collected for a registered charity, school or other organization that, in the opinion of the Advertising Committee, serves the public's interest ("charity");

The charity or organization must serve the public interest.

- (b) the charity is disclosed in the advertisement;

The public is entitled to full disclosure regarding the charity or organization for which proceeds are being collected.

- (c) the member discloses the part of the proceeds/donations to be given to the designated charity and if he/she is taking any proceeds/donations to cover his/her expenses;

The public is entitled to full disclosure regarding how the proceeds will be divided.

- (d) the member may not bill any third-party payor for the diagnostic or treatment services provided in exchange for the charitable proceeds/donation;

A member is not permitted to bill any third-party payor for complimentary diagnostic or treatment services as this practice is unethical and may constitute an act of fraud.

- (e) the member providing diagnostic or treatment services in exchange for the charitable proceeds/donation must comply with all CCO standards of practice.

Members must comply with all CCO standards of practice. If the member is uncertain if the proposed advertisement is appropriate, he/she is encouraged to submit it to the Advertising Committee for review prior to publication. Turnaround time for a response is approximately 10 business days.

6. Public presentations or displays² are permissible provided:

The advertising standard permits public presentations for educational or informational purposes. Being intrusive to the public within a public place, harassing the public or

using pressure tactics are unprofessional and undermines the public's trust.

- (a) member(s) adhere(s) to CCO's regulations and standards of practice (e.g., consent, record keeping);
- (b) professional conduct is maintained at all times;
- (c) material distributed complies with the advertising standard;⁴
- (d) assessment(s) performed comply with CCO's Public Display Protocol (Policy P-016) and are for educational purposes;

Assessment procedures, as listed in CCO's Public Display Protocol (Policy P-016), are permitted, provided the protocol is followed and consent is obtained.

- (e) no controlled acts of diagnosis and/or adjustments are performed;

Since a complete history and examination are inappropriate at a public display, making a diagnosis or performing an adjustment is not permitted. Adjustments at a public display may alarm the public when observing an adjustment procedure without a proper explanation.

- (f) no coercion or pressure tactics are used.⁴

7. (a) Banner advertising on the internet must comply with CCO's advertising standard of practice.

With the exception of banner advertising, a member's website is considered an extension of the member's office in that the public must choose to enter the website.

- (b) A member's website is considered an extension of the member's office. Information on a member's website must be informative, educational and professional.
- (c) Information on a member's website must comply with CCO's standards of practice, except S-016: Advertising.

8. A member must not:

- (a) advertise or permit advertising with respect to his/her practice in contravention of the regulations or standards of practice; and

A member is responsible for all advertising that is directly or indirectly controlled by

that member.

- (b) contact or communicate with or allow any person to contact or communicate with potential patients via telemarketing or electronic methods.

It is not professional to harass the public with solicitous contacts, intrusion and disturbance of privacy.

LEGISLATIVE CONTEXT

Proposed advertising regulation pursuant to the *Chiropractic Act, 1991*. It is an act of professional misconduct to contravene or fail to maintain a standard of practice. For additional information regarding billing procedures, please refer to Regulation R-008: Professional Misconduct (Business Practices section) and Guideline G-008: Business Practices.

¹ A consultation is a meeting to discuss how chiropractic may benefit the patient. A consultation does not include examination procedures, diagnostic tests (e.g., x-rays) or treatment services.

² "Displays" include presentations or other visual material to members of the public, in a place normally frequented by the public, by a person or persons who are physically present when such material is distributed or presented.

³ It is strongly recommended that material to be distributed be pre-approved by the Advertising Committee.

⁴ Voluntary appointments are permitted - i.e., potential patients ask for the member's business card or request an appointment.

Advertising Committee
Approved by Council: June 22, 2007
Amended: September 13, 2008, September 24, 2009, December 1, 2011

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 chiropractic is consistently promoted in a professional manner with personal accountability. This protocol provides members with some practical approaches to community event planning and implementation.

DESCRIPTION OF POLICY

Displays include presentations of printed or other visual material to members of the public, in a place normally frequented by the public, by a person or persons who are physically present when such material is distributed or presented. They do not include signage, billboards, or other forms of visual advertising that do not ordinarily require that the person advertising be physically present.

Public display is a type of community service that includes educational sessions and/or public health screenings. These public events are used to encourage and promote chiropractic in a positive and professional manner.

An educational session is a live communication to a group, organization or the public at large. This may include a formal lecture, informal discussion or presentation. Professional accountability is imperative as these sessions are usually performed in the absence of formal evaluations.

A public health screening is an assessment procedure to identify possible chiropractic/health concerns that may require attention. Members may only perform a screening assessment on willing participants.

Members may conduct a public display/health screening only at the following events - health fairs and trade shows.

Health fair is a community event focused on the promotion of health.

Trade show is an exhibition for people or companies in a specific industry to demonstrate products and services.

Educational sessions provide an excellent opportunity to promote chiropractic, and to inform and educate the public.

Public health screenings that stress the importance of preventative health strategies are used in health professions and are widely recognized to promote public health.

Public displays and public health screenings are of value to the public because they may identify early signs of potential health problems and educate the public about chiropractic. They can be used to help build a stronger chiropractic presence in the professional and public communities. These events are intended to promote chiropractic as a legitimate, safe and effective health care choice.

Set-up/Presentation

All aspects of public displays/health screenings will be evaluated by the participating public and other professions and, for that reason, must remain professional.

Signs, communication, marketing material, and professional appearance are all important factors to consider when planning the set-up and delivery of a public display/health screening.

Signs should state the purpose and intent of the event (e.g., chiropractic talks, spinal evaluation, postural evaluation, etc.). Members may have signage listing their affiliation with groups, societies or associations, provided that the affiliated group officially recognizes the event.

CCO requires notification, in writing, informing of a public display/health screening at least 10 business days prior to the event. The notification must include the names of participating member(s) and the event's date, time and location.

2

Chiropractic Representation

CCO requires that at least **one licensed member** be present at a public display/health screening at all times.

Information for Distribution

The distribution of all chiropractic information and communication materials (e.g., pamphlets, posters, handouts, video/audio materials, etc.) at public displays/health screenings shall comply with Standard of Practice S-016: Advertising. CCO recommends that such materials be forwarded to CCO for pre-approval.

Turnaround time for approval is approximately **10 business days**.

Screening Procedures

The primary purpose of a public display/health screening is to educate the public. A member should not pressure or aggressively solicit any potential participant. Participation must be voluntary.

For the purpose of the public display protocol, "fully informed" means the participant understands that the purpose of the screening is not to diagnose but to screen him/her for potential problems that may require further investigation in a formal office setting. A member must provide the participant with a description and explanation of the purpose of the screening procedure. Prior to performing any assessment 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 his/her consent at any time;
- offer the participant the option of having the assessment performed in a private area (e.g., separated or sectioned off with a curtain); and
- perform a screening in compliance with the current privacy legislation.

A member shall not:

- disrobe or gown any participant at a public display/health screening;
- use a method of assessment 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
- perform therapeutic interventions, e.g., soft tissue therapy or massage, stretching, mobilizations, manipulation or adjustment (manual/instrumented).

A members is reminded:

- if a fee is charged for the screening procedure, the fee must be disclosed to the participant before the service is provided;
- to comply with section 4 of Standard of Practice S-016: Advertising;
- to be sensitive to the fact that he/she may be screening a participant who is already receiving chiropractic care; and
- to not compare their services to any other chiropractor, directly or indirectly.

If it is deemed appropriate that a participant requires any follow-up chiropractic care, the member should recommend that the participant visit a chiropractor of his/her choice.

It remains a participant's choice to follow up with a more complete evaluation at a chiropractic office.

Screening Equipment

Assessment procedures may include computerized testing, simple functional testing (with no equipment) and/or questionnaires.

Assessments currently accepted:

- questionnaires
- postural evaluation - computerized, plumb lines or manual
- hands-on procedures (e.g., range of motion, flexibility, static/motion palpation)
- dual or four quadrant weight scales
- surface electromyography (sEMG)** (cervical spine only, when appropriate)
- thermography/thermal scanning (to already exposed spinal areas only, no clothing is to be shifted/moved)**

** sEMG, thermography/thermal scanning and computerized spinal analysis must follow generally accepted protocols.

A member is reminded that he/she represents a profession with high standards and, when performing any of the above assessments, he/she may be compared to other professions.

Professional Conduct

A member shall adhere to CCO regulations and standards of practice (including, but not limited to, consent and record keeping) at all times. 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.



CCO PUBLIC DISPLAY STATEMENT

851

- ✓ The College of Chiropractors of Ontario (CCO) is the self-governing body of the chiropractic profession, established by the provincial government
- ✓ CCO is committed to improving the health and well-being of Ontarians by informing the public and assuring them of competent and ethical chiropractic care
- ✓ CCO's mandate is to regulate chiropractors in Ontario and protect the public interest
- ✓ Every chiropractor practising in Ontario must be a member of CCO and is listed on the public register of CCO's website
- ✓ Chiropractors are accountable to the public

For more information about the regulation of chiropractors in Ontario, please visit www.cco.on.ca.

College of Chiropractors of Ontario
Patient Relations Committee Report to Council
December 4, 2015

873

Members: Ms Judith McCutcheon, *Chair*
Dr. Daniela Arciero, *non-Council member*
Dr. Lisa Cadotte, *non-Council member*
Ms Patrice Burke
Dr. Pat Tavares

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

Report

Since the last Council meeting the committee has had one meeting on October 7, 2015.

The committee continued to approve funding for patients sexually abused by members, consistent with CCO's policy.

At this time the committee recommends the following to Council:

Recommendation 1

Approval of Guideline G-001: Communication with Patients.

Recommendation 2

That, upon approval of Guideline G-001: Communication with Patients, the current Guideline G-001: Prevention of Sexual Abuse of Patients be revoked.

Recommendation 3

That CCO proceed with a public education campaign consistent with the strategy prepared by Mach One (680 News Marketing Proposal).

Recommendation 4

That the script for the radio ads be as follows:

Did you know that every chiropractor in Ontario is regulated and is a member of the College of Chiropractors of Ontario? The CCO sets entry-to-practice requirements, establishes standards of practice and requires chiropractors to participate in continuing education. The CCO regulates in the public interest and is here for you. If you have questions about the profession, contact the CCO or visit its web-site at www.cco.on.ca.

Radio 680 is an all news radio station that is a dominant radio presence in the Greater Toronto Area.

At a future meeting, the committee will be examining the issue of the appropriate handling of therapy dogs who attend at the office with a patient/owner. CCO has a standard of practice for animals but it covers the chiropractic treatment of animals. The rights of individuals who have therapy dogs is covered under the *Accessibility for Ontarians with Disabilities Act*.

I would like to thank the members of the committee, Drs Arciero, Cadotte and Tavares and Ms Burke, for their hard work as well as our staff support of Ms Willson, Mr. Friedman, and Ms Szametz.

Respectfully submitted,

Ms Judith McCutcheon
Chair, Patient Relations

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 CCO's commitment to zero tolerance of sexual abuse of patients, as defined below. CCO has in place supportive standards of practice, policies, procedures, practices, and educational programs to accomplish this goal.

OBJECTIVES

A member should be able to:

- describe the principles of zero tolerance; and
- define sexual abuse, including abusive verbal and physical behaviours.

DESCRIPTION OF GUIDELINE

Zero Tolerance

No act of sexual abuse, as defined by the *Regulated Health Professions Act, 1991 (RHPA)*, is acceptable. Sexual abuse must never be tolerated. According to section 85.1 (1) of the Health Professions Procedural Code, Schedule 2 to the *RHPA*, members of regulated health professions must report a member of their own or a different regulated profession if they believe that person has sexually abused a patient.

Zero tolerance recognizes the seriousness and extent of injury sexual abuse causes the victim and others related to the victim. Zero tolerance does not preclude professional behaviours, such as physical contact, that are helpful and, therefore, acceptable to the patient. A member must provide a satisfactory explanation of a procedure to a patient prior to conducting any examination or treatment procedure that could reasonably be misinterpreted by the patient as being sexually abusive.

Principles for Members

All members should:

- seek opportunities to learn about appropriate attitudes and behaviours so sexual abuse does not occur out of ignorance;

- encourage health care recipients to report allegations of sexual abuse to the appropriate health regulatory college;
- support sexual abuse victims by encouraging them to seek appropriate professional help;
- recognize that words can be as demeaning as actions to a sexual abuse victim;
- understand that behaviour that causes other discomfort of a sexual nature will not be tolerated; and
- understand that the above principles underlie all professional tasks undertaken by a member.

Guidelines for Talking with Patients

Remarks of a sexual nature are a common form of sexual abuse of patients. Always speak in words that patients can understand.

Words

A member should pay attention to the way he/she conveys information and to the words he/she selects when speaking to patients by:

- employing the correct vocabulary for body parts and procedures;
- being particularly sensitive to words that could cause misunderstandings; and
- knowing when to call an interpreter.

2

Dealing with Language or Conceptual Difficulties

Many patients may have language or conceptual difficulties. A member shall be aware that the use of charts and diagrams enhances the communication process. Because how a member says something is as important as the choice of vocabulary, he/she needs to:

- use fact and consideration when explaining procedures to patients to avoid causing anxiety;
- not talk about him/herself or his/her problems to patients, this being

considered unprofessional;

- be honest and straightforward, and demonstrate respect and concern for patients;
- legitimize patients' fear and embarrassment, which are natural emotions when submitting to chiropractic procedures;
- reassure patients by demonstrating respect and empathy;
- provide patients with an opportunity to ask questions;
- provide patients with answers within the chiropractic scope of practice;
- talk directly to patients when working with interpreters or members of their support networks; and
- verify understanding of the intended message by rephrasing the message and, if necessary, asking patients to repeat it.

Benefits associated with these principles of communication include:

- confidence in the member as a professional;
- relaxed and cooperative patients who will make the member's role easier;
- patients who are unlikely to become angry or abusive;
- a greater understanding of patients' reactions to procedures; and
- informed patients who are able to make informed decisions.

Body Language

Body language, the non-verbal component of language, will convey as much or more to patients as words. Patients may distrust the message if body language contradicts what is being said. Always remember the importance of:

- maintaining appropriate eye contact;
- adopting an appropriate facial expression to convey concern and proficiency;
- being careful in the use of physical gestures; and

- respecting the patient's personal sense of space.

Careful use of body language can greatly enhance communication, leading to better understanding and trust between the member and the patient. Since the main goal of communication is mutual understanding, listening is just as important as speaking. The member shall learn to communicate with your entire being, to listen and carefully observe patients.

By learning to listen effectively, a member can learn to modify your speech to match the needs of the patient. The benefits of listening and observing include enriched communication and patients who are dignified partners in their own care.

Principles of Communication Relating to Touching

A member shall:

- obtain the patient's consent;
- acknowledge that patients have the right to change their minds about consenting to procedures;
- avoid causing unnecessary distress or embarrassment to the patient by inappropriate touching;
- show respect by maintaining the patient's dignity;
- respect, as much as possible, the patient's personal sense of space;
- use firm and gentle pressure when touching the patient to give reassurance and produce a relaxed response;
- avoid hesitant movements by being deliberate and efficient;
- understand when to use gloves for reasons relating to quality assurance; and
- in the case of touching sexual areas, understand that the use of gloves decreases intimacy that might be interpreted as sexual.

Consent to Touch

A member shall recognize the patient controls consent and:

- the patient is entitled to know why, where and when he/she is to be touched;
- consent may be withdrawn at any time during a procedure;
- agreement, acquired verbally or non-verbally, is required before a patient may be touched;
- if a sensitive area is involved (e.g., breast, gluteal and inner thigh), a member must recognize that the patient controls consent and when appropriate, palpate carefully with the patient's guidance, participation and consent;
- special situations must be identified and possible options anticipated; and
- patient concerns must be addressed first.

Privacy

A member shall:

- make the patient, who must necessarily be partially unclothed, as comfortable as possible;
- give patients clear instructions about how to wear the gown;
- allow patients independence, and enough time and privacy while disrobing;
- touch only those areas needed to facilitate removal of clothing when providing assistance to disrobe; and
- request the patient's permission for students or staff to observe.

Communication Skills Relating to Touch

To avoid perceptions of sexual abuse, a member must make touching an acceptable encounter by:

- providing reassurance and explanations throughout the procedure;
- involving patients in some aspects of procedures, such as moving themselves in response to clear instructions;
- encouraging patients to identify affected areas or landmarks when possible; and

- constantly checking for the level of understanding and consent by the patient.

Procedures requiring touching of the patient are open to misinterpretation. Ensuring that the patient understands at all times what is being done and why will greatly reduce the risk of offense. Considerate touching will encourage the patient to relax and cooperate in ways that will save time and produce better results.

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.

Statement of purpose, sexual abuse provisions

Section 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. Encouragement of the patient by the member to masturbate in the presence of the member.

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: Prevention of Sexual Abuse of Patients should be read in conjunction with:

- The sexual abuse provisions of the *RHPA*
- Standard of Practice S-014: Prevention of Sexual Abuse of Patients
- Policy P-003: Principle of Zero Tolerance

**College of Chiropractors of Ontario
Quality Assurance Committee Report to Council
Friday, December 4, 2015**

Members: Dr. Brian Gleberzon, *Chair*
Ms Georgia Allan
Ms Judith McCutcheon
Dr. Bryan Wolfe
Dr. Joel Weisberg, *non-Council member*

Staff Support: Mr. Joel Friedman, *Director, Policy and Research*
Dr. Bruce Walton, *Director of Professional Practice*
Ms Jo-Ann Willson, *Registrar and General Counsel*
Ms. Andrea Szametz, *Recording Secretary*

Chair's Report

I Introduction and Recommendations

Since the last meeting of Council, the Quality Assurance (QA) Committee has met twice on October 21, 2015 and November 20, 2015.

Recommendation 1

That Council approve minor amendments to Standard of Practice S-009: Chiropractic Care of Animals

The Committee has a minor amendment to recommend to Standard of Practice S-009 to clarify that a member may only transfer the record of care to the veterinarian with the consent of the owner of the animal. This is consistent with standards of the College of Veterinarians of Ontario, which prevent the transfer of records from one veterinarian to another without the consent of the animal owner.

II QA Initiatives

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

In addition to the amendments recommended to Standard of Practice S-009: Chiropractic Care of Animals, the Committee identified a possible need for clarification in Standard of Practice S-013: Consent. There was discussion by the Committee if the requirement to document consent to examination, in addition to consent for care, was adequately communicated in the standard and if this was the usual practice for members. There was also discussion about the importance of

having a consistent message regarding consent to examination in relation to a past communique from CCO (included in the Council package). The Committee considered the idea of separating the requirement for consent to examination and care into two separate sections to clarify the requirement, but would like the direction of Council before proceeding.

B Record Keeping Workshops (RKW)

The Committee continues to offer the RKW at least three times a year or more on an “as requested” basis. The RKW material continues to be updated consistent with CCO standards of practice.

C Peer and Practice Assessment

The 2014-15 round of assessments, which was divided into two phases, is almost complete. Peer assessors have been and will continue to be working diligently, in the coming months, to conduct assessments and deserve our appreciation for all their efforts. We are closing in on the scheduled completion of the first assessments on all members, save for those just starting into practice, which will be an ongoing project. A big thank you goes to staff members Madeline Cheng and Sarah Oostrom for their help in conducting the internal portion of the peer and practice assessment process.

The next Peer Assessor Workshop, has been scheduled for Saturday, January 23, 2016, following the QA meeting, Friday, January 22, 2016.

The Committee put a call out for new peer assessors, back in August, and received many good applications from interested members. On November 19, a sub-group of the QA committee conducted 12 phone interviews and subsequently selected 9 candidates to recommend as new peer assessors. These new assessors will undergo an orientation training January 22, 2016 and also attend the Peer Assessor Workshop on January 23, 2016. The interview team deserves many thanks for spending the time sifting through applications, conducting all the interviews and making the tough final decisions. The entire QA Committee welcomes all the new peer assessors.

The Committee continued the discussion related to the development of PPA 2.0 including:

- The importance of rolling out the program in a controlled, measured and fiscally responsible way;
- Perhaps only rolling out one phase at a time; and
- The utilization of workshops;

The Committee will continue to work on refining PPA 2.0 and plans, as its next step, to “test-run” the process at the upcoming Peer Assessor Workshop.

D Communication with Members and Stakeholders

896

The QA Committee continues to respond to inquiries from members and other stakeholders. These inquiries include matters related to delegation and billing practices, scope of practice, and continuing education.

III Acknowledgements

I am pleased to report that these meetings of the QA Committee were successful, and there is every reason to believe PPA 2.0 will be fully developed. I would like to thank Committee Members Dr Brian Wolfe (past Chair), long-time non-Council member Dr Joel Weisberg, and public members Judith McCutcheon and Georgia Allen for their thoughtful insights and contributions. I would also like to thank Dr Bruce Walton and Joel Friedman for their institutional knowledge and expertise.

Respectfully Submitted,

Dr Brian Gleberzon, Chair
Quality Assurance Committee

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 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 their obligations relating to the chiropractic care of animals.
- To ensure appropriate coordination and consultation between members 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 College of Veterinarians of Ontario (CVO), who are responsible for appropriate history taking, comprehensive examination, including clinical pathology, 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 registrants are required to comply with all standards of practice and applicable legislation relating to chiropractic.

903

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;
- provide, upon request, 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 chiropractic¹; and
- ensure that the owner of the animal(s) is fully informed about the member's insurance coverage².

Exemption

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

2

- is enrolled and participating in a 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 program in animal chiropractic within two years of his/her enrolment;
- provides chiropractic care to animals within the parameters of his/her course of study; and
- informs the owner of the animal(s) that he/she has enrolled and is participating in but has not yet graduated from a 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 Health Professions Procedural Code, Schedule 2 to *RHPA*:

(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.

905

(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.
- 4 (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.

-
- ¹ Maintenance of separate office space is a minimum requirement for health and sanitation reasons, particularly in light of the various communicable diseases common to humans and animals.
 - ² 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.

Quality Assurance Committee
Approved: November 30, 2002
Amended: November 24, 2004,
September 20, 2013

ITEM 4.4.3

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 obligations relating to consent for examination, care and plans of care.

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 of 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

A member is to obtain patient consent to an examination, 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; and
- evidenced in a written form signed by the patient or otherwise documented in the patient health record.

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.

Emergency Care

A member may administer care without consent, in accordance with section 25 of the *Health Care Consent Act, 1996 (HCCA)*, if:

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

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."

Appropriate Discussion and Dialogue

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 or care or plan of care?
- What are the alternatives to the examination or 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.

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.

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 treatment.

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.

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.

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.

910

- (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.¹ This information should be communicated to the patient in a manner the patient is best able to understand; and
- Relevant information related to a determination of incapacity and a patient's substitute decision-maker must be documented in the patient health record.

4

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 Treatment 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.

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 a member shall ensure that the patient consent is fully informed and voluntarily given before the patient is 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.

914

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).

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 health record:

- S-001: Chiropractic Scope of Practice
- S-002: Record Keeping
- S-005: Chiropractic Adjustment or Manipulation
- S-006: Technical and Interpretative Components for X-ray
- 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: Prevention of Sexual Abuse of Patients
- G-009: Code of Ethics

¹ 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.

CCO COMMUNIQUÉ

January 2009



Mr. Richard Steinecke

Mr. Richard Steinecke is a partner in the law firm Steinecke Maciura LeBlanc and author of *A Complete Guide to the Regulated Health Professions Act*. This article provides general information only. For legal advice, please speak to your own lawyer.

Informed Consent

Maria arrives for her first appointment since the accident. She has already been shown to an examination room and asked to undress to her underwear and to put on a paper gown. The chiropractor, Joe, enters the room and says "Let's see what we have here." Joe opens the gown slightly and starts examining Maria, being careful at all times to keep Maria draped as much as possible. On the way out of the clinic, Maria complains to the receptionist that she had not given permission for Joe to examine her. Does Maria have a legitimate complaint?

The principle of informed consent is one of those rules that is honoured more in its breach than in its compliance. Chiropractors know they are supposed to obtain informed consent and probably believe that they generally do obtain it, but some objective observers might disagree that patients have truly given an informed consent.

There are a number of reasons for this discrepancy in perception:

- **Chiropractors assume a level of sophistication** that often does not exist. In the above example, the chiropractor might assume that Maria knew when she was asked to disrobe that she was going to be physically examined by the chiropractor she had made an appointment to see. Most of the time that assumption would be correct. However, it is possible that Maria is not familiar with this routine



(which Joe has followed hundreds of times). In addition, Maria may have assumed that the examination would not be as intrusive as the chiropractor planned it to be.

- **Chiropractors are rushed.** In today's environment of cutbacks and downsizing, there is tremendous pressure to "get through" patient visits.
- **Poor communication skills.** In the above example, Joe made a statement; he did not ask a question. Out of deference to the authority of the chiropractor, compliant patients will often not express their surprise as to what is happening at the time.
- **Ignorance of the requirements of informed consent.** While all chiropractors know that they need "informed consent," they may not always appreciate all that this entails. In the above example, Joe might be surprised that informed consent is needed for assessments as well as treatments.

While most of the court decisions on informed consent relate to surgery, consent is needed for all assessments and treatments. Often, consent can be quite informal. For example, when chiropractors ask a patient a question about their medical history, the patient generally consents by answering the question. However, whenever a chiropractor touches a patient, or orders or administers a treatment, more formal steps must be taken.

A patient is entitled to know the following before any assessment or treatment is given:

- **The nature of the treatment or assessment.** Chiropractors must be careful not to assume that patients know what will happen next. While not always necessary, it is generally prudent to explain the nature of the assessment and the manner or mechanism by which any treatment works. It is in this area where Joe failed in his duty to Maria.
- **Who will be providing the procedure.** The patient will generally see who is administering the treatment. However, the patient should know whether the person is registered or not. It would also be prudent to tell the patient who will be administering the treatment ahead of time because some patients may feel uncomfortable in telling the person to stop the treatment and get someone else to do it. For some procedures, it is also prudent to communicate the gender of the person as well.
- **The reasons for the procedure.** The patient should understand the expected benefits of the procedure.
- **The material effects, risks and side-effects of the procedure.** One court has described a material risk in the following way: *a risk is thus material when a reasonable person in what the [chiropractor] knows or ought to know to be the patient's position would be likely to attach significance to the risk or cluster of risks in determining whether or not to undergo the proposed therapy.* Thus, remote risks that are a mere possibility usually need not be disclosed unless the consequence is significant (e.g., death, paralysis, stroke).



- **The alternatives to having the procedure.** Often there is more than one option available. While the other options may not be preferred by the chiropractor, it is ultimately up to the patient to decide. For example, some options may be more intrusive, painful or expensive than others, which could influence the patient's choice. It is acceptable to explain why the chiropractor does not recommend the other options. The material effects, risks and side-effects of the alternative should also be explained in a general way. It is not acceptable to just provide the options the chiropractor is able to offer.
- **The consequences of not having the procedure.** Not having the procedure is an alternative to all patients. Therefore, patients should have an opportunity to consider the advantages and disadvantages of that option as well. This discussion should not create the impression, however, that the chiropractor is attempting to coerce patients to undergo the procedure.

In addition to the general aspects of an informed consent listed above, chiropractors should be sensitive to any particular concerns that an individual patient might have. If the chiropractor knows that the procedure could offend a religious, ethical or personal belief of the patient, that should be communicated as well.

For repetitive matters, it is acceptable to give patients a written description of the information the patient needs to know. This will often save considerable time. However, there should

always be some individual discussion with the patient after they have read the description to ensure that the patient understands the information and appreciates the consequences of each option. Some patients are functionally illiterate and hesitant to disclose this fact. The discussion with the patient should be sufficient to ensure that the information was comprehended. Simply asking "did you understand what you read?" is generally not sufficient.

Consent need not be obtained in writing from the patient. In many circumstances, such as a routine physical examination, a written consent is impractical. However, if a particularly risky procedure will be done, or if the patient appears unreliable, a written consent can help the chiropractor prove that he or she did obtain a proper consent. The consent form should be simple and easy to understand.

Written consent forms are not a complete defence to an allegation of failing to obtain an informed consent. The patient can still assert that the form was not clearly explained before his or her signature was obtained or that he or she did not understand what was signed. Therefore, the written consent should not be obtained in a rushed or routine fashion and should never be obtained at the time of the patient's initial registration with the office or clinic. However, a clear and simple consent form signed by the patient and witnessed by the chiropractor or another person places a heavy onus on the patient to explain why he or she signed the form without obtaining the explanation referred to.



If a written consent is not obtained, chiropractors should document in the chart that an informed consent was obtained verbally for particularly risky procedures or where the patient appeared unreliable.

If a patient does not understand any aspect of the informed consent process or does not appreciate the consequences of their choice, then the patient is said to be incapable. Where a patient is incapable, the chiropractor needs to obtain consent from a substitute decision maker. These are listed in priority order in the *Health Care Consent Act*, as follows:

1. The incapable person's court appointed 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 Consent and Capacity Board if the representative has authority to give or refuse consent to the treatment.
4. The incapable person's spouse or partner (which need not be a sexual 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 does not include a parent who has only a right of access and is not lawfully entitled to give or refuse consent

to treatment. 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.
9. As a last resort, the Public Guardian and Trustee.

In general, the highest ranked substitute who is willing and able to provide consent becomes the decision maker. Chiropractors are generally able to rely upon the statements of friends and family members as to who is the appropriate substitute.

Consent to treatment is just one of three areas where chiropractors must be careful to have consent. Similar principles apply to the collection, use and disclosure of personal health information by chiropractors and to the billing of patients. Generally, patients have the right to know all material information and to make voluntary and informed choices about their personal health information and about the billing for the services provided to them.

CCO reminds members to review the consent standards of practice, including S-013: Consent, S-012: Orthotics, and S-017: Acupuncture.



Quality Assurance Committee
Approved by Council: February 8, 2011
Amended: April 16, 2013, June 17, 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 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 POLICY

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 with 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*;
- CCO randomly selects members to participate in the program and matches the selected member with a peer assessor;
- members may volunteer to participate in the program before being chosen through random selection; and
- information gathered during the peer and practice assessment is only shared with the members of the Quality Assurance Committee. No other committee will have access to this information.

1

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 his/her professional portfolio and a cover letter outlining the reason(s) he/she is interested in being appointed or re-appointed as a peer assessor.

Procedures for Appointing, Re-appointing, Discharging and Thanking Peer Assessors

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 years;
- has been peer assessed;
- practises primarily in Ontario;
- 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 against him/her in the preceding three years;
- has not been disqualified from Council or a committee of CCO in the previous three years;
- is not a member of the Council of a college of any other health profession; and
- is not currently or has not been a member of the CCO's staff at any time within the preceding three years.

Procedures For Appointing and Re-Appointing 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 he/she is appointed.

- 2 A peer assessor may request a deferral for appointment and/or leave of absence for up to one year if he/she provides the Quality Assurance Committee with reasons for the request that are satisfactory to the Committee

When the member's three-year appointment nears its completion, the member may apply for re-appointment.

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 he/she 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
- 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 he/she:

- 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;
- is absent from two consecutive CCO peer assessor training days¹; or
- fails to discharge properly or honestly any office to which he/she has been appointed, in the opinion of the Quality Assurance Committee.

Completion of Appointment

A peer assessor will be considered to have completed his/her appointment and thanked for his/her services if he/she does any of the following:

- resigns in writing;
- requests an extended leave of absence as a peer assessor;
- completes his/her term of service and is not re-appointed; or
- completes nine consecutive years of three consecutive terms.

¹Extenuating circumstances may be reviewed by the Quality Assurance Committee.

**College of Chiropractors of Ontario
Registration Committee Report to Council
Friday, December 4, 2015**

Members: Dr. David Starmer, *Chair*
Mr. Shakil Akhter
Dr. Bruce Lambert

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

Introduction and Recommendations

Since the last meeting of Council, the Registration Committee has met by teleconference on October 13 and November 10, 2015. The Committee continues to review referrals of applicants for registration. Monthly teleconference meetings have been scheduled until April 2016 to ensure a timely response to all applicants that apply for registration.

Recommendation

That Council approve minor amendments to Policy P-053: Returning to the General Class of Registration.

Policy P-053 identifies what measures the Registration Committee uses to assess competency to practise when a member has been out of the General class for more than two consecutive years.

The first proposed amendment involves deleting the requirements for members who have been out of the General class for less than two years, which is consistent with CCO practice, the registration regulation, and the recent amendments to CCO's inactive and retired forms.

The second proposed amendment involves adding to the possible actions that the Registration Committee may require of an applicant to demonstrate competency who has been out of the General class for a period of 2-5 years. This action would be for a member to complete an in-person workshop or course on the controlled acts authorized to chiropractors in Ontario. The Registration Committee is of the opinion that it is in the public interest for an applicant who has been out of practice for this period of time to refresh his/her skills in the controlled acts and has been consistently applying this requirement to such members. Typically the requirement workshop or course would be a minimum 6 hours in length.

The Committee encourages council members to forward recommended changes to the Registration renewal form that is distributed to members in October of every year, for the renewal the following year. Typically the form is approved at the September Council meeting. The 2017 renewal form will change the reference to the specialties to be consistent with the name change for one of the specialties, but if there are other amendments, we would be pleased to incorporate these into the recommendations to Council for the next renewal year.

Current Member Status

Chart 1: Membership Statistics as at November 20, 2015

Status	Total
Active	4325
Active w/ Terms	0
Active-Non Resident	43
Inactive – Resident	128
Inactive – Non Resident	66
Retired	128
All categories	4690

Chart 2: Change in Registration statistics for August 25, 2015 – November 20, 2015

Description	Total
New registrants	20
Female	11
Male	9

Chart 3: Colleges of Graduation for New Registrants

CMCC	17
NYCC	1
UQTR	2

I would like to thank the members of the registration committee and the support staff for their time and commitment: Dr. Bruce Lambert, Mr. Shakil Akhter, Mr. Joel Friedman, Ms Maria Simas, Ms Andrea Szametz and Ms. Jo-Ann Willson.

Respectfully submitted,

Dr. David Starmer,
Chair, Registration Committee

**POLICY
P-053**

Registration Committee
Approved by Council: December 1, 2011
Amended: September 20, 2013

**Returning to the General
Class of Certificate of
Registration
928**

ITEM 4.5.2

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 the 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 follow:

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 members 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 she or she 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, and 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 on what may be required for a member to satisfy the Committee that he or she is competent to practise.

Inactive

If a member has been inactive for a specified period of time, and not registered in a regulated jurisdiction outside of Ontario with an equivalent license 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 a member who intends 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 regulated jurisdiction outside of Ontario with an equivalent license 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 practice of chiropractic in Ontario.

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 less than 2 years

- submit a professional portfolio within a specified period of time as determined by the Registration Committee;
- attend a record keeping 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; and
- otherwise satisfy the Registration Committee that the member is competent to practise in Ontario.

Inactive for 2 to 5 years

- submit a professional portfolio within a specified period of time as determined by the Registration Committee;
- attend a record keeping 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; and
 - otherwise satisfy the Registration Committee that the member is competent to practise in Ontario.

Inactive for more than 5 years

- submit a professional portfolio within a specified period of time as determined by the Registration Committee;
- attend a record keeping 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; and
- otherwise satisfy the Registration Committee that the member is competent to practise in Ontario.

AUTHORIZATION TO WORK IN CANADA

You must be authorized to work in Canada by one of the following provisions. Please indicate which provision applies to you.

- Canadian citizen
- Permanent resident
- Engage in the practice of chiropractic profession under the *Immigration and Refugee Protection Act, 2001*
- If no category applies, provide explanation: _____

PROFESSIONAL MISCONDUCT, INCOMPETENCE AND INCAPACITY

Has a regulatory body made a finding against you or are you currently facing a regulatory proceeding of professional misconduct, incompetence or incapacity, since the date of your most recent renewal with CCO. Check the appropriate box(es) below:

- 1. In Ontario as a chiropractor YES NO
 - 2. In another jurisdiction as a chiropractor YES NO
 - 3. In another profession YES NO
- If YES to any question, please provide details on a separate sheet of paper, including the nature, description, and date of any finding.

SELF REPORTING

As a chiropractor, you are required to report to CCO information about any guilty finding made by a court related to an offence, professional negligence or malpractice (the duty to report offences and findings is found in section 85.6.1 and 85.6.2 of the *Health Professions Procedural Code* as enacted by the government).

Check the appropriate box(es) below of any findings that have occurred since the date of your most recent renewal with CCO.

- 1. Have you been found guilty of an offence? YES NO
 - 2. Has there been a finding of professional negligence or malpractice made against you which has not been reversed on appeal? YES NO
- If YES to any question, please provide details on a separate sheet of paper, including the nature, description, date of any finding, name and location of the court, and any appeal status relating to the finding.

ACKNOWLEDGEMENT OF COMPETENCE AND GOOD CHARACTER

(If you answer NO to either question, please provide a written explanation on a separate sheet of paper)

- 1. I confirm that I am mentally and physically competent to practise chiropractic. YES NO
- 2. I confirm that I will practise chiropractic with professionalism, decency, integrity, honesty and in accordance with the law. YES NO

PROFESSIONAL LIABILITY PROTECTION INFORMATION

Please indicate and confirm carrier and coverage: _____

(By-law 16 requires a minimum amount of \$1,000,000 per occurrence and a minimum aggregate amount of \$3,000,000 per year)

CHIROPRACTIC SPECIALTY INFORMATION ON RECORD

Please indicate if you have any of the following specialty designations and the date obtained: _____ Date: _____

- FCCO(C) – Fellow of the College of Chiropractic Orthopedists (Canada): _____
- FCCR(C) – Fellow of the Chiropractic College of Radiologists (Canada): _____
- FCCPOR(C) – Fellow of the Canadian Chiropractic Specialty College of Physical and Occupational Rehabilitation (Canada): _____
- FCCS(C) – Fellow of the College of Chiropractic Sciences (Canada): _____
- FRCCSS(C) – Fellow of the Royal College of Chiropractic Sports Sciences (Canada): _____

REGISTRATION PAYMENT INFORMATION

Please make cheque(s) payable to College of Chiropractors of Ontario. Credit card payments not accepted. Registration renewals must be received by **January 1, 2016**, or be subject to a late payment fee.

General (Active) Certificate Members

- enclosed is my full fee payment of \$1050, payable January 1, 2016
- enclosed are my two payments of \$550 each, payable January 1, 2016, and June 1, 2016
- \$100 late payment fee (if applicable)

First Renewal General (Active) Members (Registered for first time in 2015)

- enclosed is my full fee payment of \$525, payable January 1, 2016
- \$100 late penalty fee (if applicable)

Inactive Certificate Members

- enclosed is my full fee payment of \$475, payable January 1, 2016
- \$20 late payment fee (if applicable)

Retired Certificate Members

- enclosed is my full fee payment of \$100, payable January 1, 2016
- \$20 late payment fee (if applicable)

CCEB Examiner

I served as a CCEB examiner for the year 2015: 1 sitting 2 sittings

Please note: if you served as a CCEB examiner for one sitting, you must pay half of the General registration fee. If you served as a CCEB examiner for two sittings, you are exempt from paying the full General registration fee.

Payment enclosed: \$525 Fee exempt

NOTE: This renewal form must be completed in full, signed and dated before it can be processed. Incomplete forms will not be considered to have met the due date and will be returned to the member, which may result in the member being charged a late fee. Cheques that are returned N.S.F. or are non-negotiable (i.e., misdated, not signed or otherwise miswritten) will be returned to the member and a \$50 charge will be levied in addition to the late fee, if applicable.

I declare the information as recorded on this registration form to be true and complete and undertake to advise CCO immediately if there is any change in the information provided on this form. I understand it may be considered an act of professional misconduct to provide false information to CCO.

Date: _____ Signature: _____

**POLICY
P-029**

Chiropractic Specialties

934

Executive Committee
Approved by Council: September 7, 1996
Amended: November 1, 1997, April 20, 2002,
June 22, 2012
Re-affirmed: June 18, 2014
Amended: 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 Canadian Federation of Chiropractic Regulatory and Educational Accrediting Boards.

Ministry of Citizenship,
Immigration and International Trade

Deputy Minister

400 University Ave. 6th Floor
Toronto ON M7A 2R9
Tel.: 416 325-6210
Fax.: 416 325-6196

Ministère des Affaires civiques,
de l'immigration et du
Commerce international

Sous-ministre

400, avenue University, 6^e étage
Toronto ON M7A 2R9
Tél. : 416 325-6210
Télec. : 416 325-6196



Ontario

September 21, 2015

Dear Colleagues,

I'm pleased to announce that Mary Shenstone will serve as Interim Commissioner of the Office of the Fairness Commissioner (OFC), effective September 21, 2015. Mary will take on this new role for a period of up to six months, while a mandate review for the agency is being completed.

The Office of the Fairness Commissioner is valued and respected in this province. I know Mary will continue to promote transparency, objectivity, impartiality and fairness in Ontario's regulated professions and trades.

The OFC has accomplished a great deal since it was created and is recognized as a leader around the globe. Our fair access legislation was the first of its kind in Canada and is now being replicated in other jurisdictions.

We want to ensure that success continues. I know that Mary will help the OFC move forward and will continue to work collaboratively with Ontario's regulatory bodies.

Sincerely,

Helen Angus
Deputy Minister
Citizenship, Immigration and International Trade

From: Jo-Ann Willson
Sent: Monday, September 21, 2015 3:29 PM
To: Rose Bustria
Subject: FW: Dear Colleagues / Chères collègues et chers collègues - Mary Shenstone (Interim Commissioner of the Office of the Fairness Commissioner / Commissaire intérimaire du Bureau du commissaire à l'équité
Attachments: Letter from DM Helen Angus 20150921.doc; Lettre Sous-ministre Helen Angus 20150921.doc; Lettre du Sous-ministre Helen Angus 20150921.pdf; Signed version Letter from DM Helen Angus 20150921.pdf

Registration and Council.

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

College of Chiropractors of Ontario
130 Bloor St. West, Suite 902
Toronto, ON M5S 1N5
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From: Bowskill, Sofi (MCIIT) [<mailto:Sofi.Bowskill@ontario.ca>]
Sent: Monday, September 21, 2015 3:19 PM
Subject: Dear Colleagues / Chères collègues et chers collègues - Mary Shenstone (Interim Commissioner of the Office of the Fairness Commissioner / Commissaire intérimaire du Bureau du commissaire à l'équité

Sofi Bowskill

Scheduler to Deputy Minister Helen Angus
Ministry of Citizenship, Immigration and International Trade
and Deputy Minister Responsible for Women's Issues and Seniors Affairs
Deputy Minister's Office
400 University Avenue, 6th Floor
Toronto ON M7A 2R9
Telephone: 416-325-6181
Email: sofi.bowskill@ontario.ca;

Sofi Bowskill

Secrétaire exécutif du Sous-ministre Helen Angus
Ministère des Affaires civique, de l'Immigration et du Commerce International
400 avenue Université, 6^e étage
Toronto, ON M7A 2R9
Tél : 416-325-6181
Télééc. : 416-325-6196

Courriel : sofi.bowskill@ontario.ca;

937

From: Jo-Ann Willson
Sent: Wednesday, November 18, 2015 10:17 AM
To: Rose Bustria
Cc: Joel Friedman; Maria Simas
Subject: FW: Invitation to Orientation to the new FRP Reports

Registration and Council.

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

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

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This e-mail including any attachments may contain confidential information and is intended only for the person(s) named above. Any other distribution, copying or disclosure is strictly prohibited. If you have received this e-mail in error, please notify me immediately by reply e-mail and delete all copies including any attachments without reading it or making a copy. Thank you.

From: Office of the Fairness Commissioner (MCIIT)
[mailto:OfficeoftheFairnessCommissioner@ontario.ca]
Sent: Wednesday, November 18, 2015 10:11 AM
Cc: Vanin, Sharon (MCIIT) <Sharon.Vanin@ontario.ca>; Cavaco, David (MCIIT) <David.Cavaco@ontario.ca>; Jafri, Nuzhat (MCIIT) <Nuzhat.Jafri@ontario.ca>
Subject: Invitation to Orientation to the new FRP Reports

Dear Colleagues,

The OFC is pleased to launch a revised Fair Registration Practices (FRP) reporting approach starting this December. We have significantly amended the reporting template and questions, as well as the online reporting site. We hope you are as excited about the changes as we are. The site will be available to you starting December 16, 2015 (the report is due March 1st, 2016). To prepare you for the new approach and the new reporting site, you are invited to an orientation session that will provide:

- an overview and rationale for the new approach;
- hands-on training with an opportunity to walk through the new site in real time; and
- technical trouble-shooting advice from the website developers who will be on site to answer your questions.

Details:

You may register for one of four available sessions:

1. Monday December 7th 10:00 am – 12:00 pm, Sky Room, 11th floor, 595 Bay Street
2. Monday December 7th 2:00 pm – 4:00 pm, Sky Room, 11th floor, 595 Bay Street
3. Wednesday December 9th 10:00 am – 12:00 pm, Earth Room, 11th floor, 595 Bay Street

939

4. Wednesday December 9th 2:00 pm – 4:00 pm, Earth Room, 11th floor, 595 Bay Street

We are able to accommodate two people from each organization.

Please bring a laptop or other personal computing device so you can connect to the online FRP reporting site via wifi.

RSVP to David Cavaco at david.cavaco@ontario.ca with your preferred time slot by **Thursday November 26, 2015**. We will try our best to accommodate your preference. If you are not able to attend one of the orientation sessions, your adviser will be happy to provide you with assistance as required. Please contact them directly.

Thank you and we look forward to seeing you in December.

Nuzhat Jafri
Executive Director
Office of the Fairness Commissioner
416-325-9651
www.fairnesscommissioner.ca

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COLLEGE OF RESPIRATORY THERAPISTS OF ONTARIOTitle: **CRTO Social Media Policy**Number: **PR – Social Media - 103**Date originally approved:
May 24, 2013Date(s) revision approved:
N/A**POLICY****Policy Statement**

It is the policy of the CRTO to encourage clear and effective communication with all Members, Stakeholders and members of the public using a variety of accepted tools, including social media. College use of social media must, like all other forms of communication, meet tests of credibility, privacy, authority and accountability.

Definitions

SOCIAL MEDIA - Social media means the online technologies and practices that are used to share information and opinions and build relationships. It can involve a variety of formats, including text, pictures, video, audio and real-time dialogues. It includes, but is not exclusive to, such things as social networks, discussion forums, blogs, wikis and Twitter.

MODERATED - Moderated means technical and monitoring measures that prevent, or ensure the timely removal of, any defamatory or objectionable submissions.

REASONABLE COMMUNICATIONS PRACTICES - Reasonable communications practices include practices that help assess potential audience, the costs and benefits to the CRTO and to the health, safety and well-being of the public, public service needs, and other factors associated with a communication plan prepared by CRTO staff.

Policy Objectives

The objectives of this policy are to:

- encourage the safe, creative and effective use of social media by CRTO designated spokespersons.
- provide a framework for the application of the policies and guidelines that oversee social media use, such as the Social Media Terms of Use and the Foundations and Resources for a Best Practices Approach to Social Media.
- enable social media use in communicating overall CRTO themes and policy directions.
- ensure the use of social media by CRTO designated spokespersons complies with all applicable laws, and all College policies and procedures, including those related to protection of privacy, retention of records, security, code of conduct, confidentiality and Internet/e-mail use.

This policy applies to all social media communication by all CRTO designated spokespersons, Council and Committee Members.

Policy Directives

- CRTO designated spokespersons using any social media are governed by all CRTO policies and procedures including those related to the protection of privacy, records retention and website/Internet use.
- All CRTO designated spokespersons using social media shall comply with the Social Media Terms of Use and the Foundations and Resources for a Best Practices Approach to Social Media.
- Blogs, discussion forums or other social media initiated and/or created by, and within the control of the CRTO must be moderated.
- CRTO-hosted social media services must include Terms of Use Guidelines for users.

Accountability

ALL CRTO DESIGNATED SPOKESPERSONS

- CRTO designated spokespersons are responsible for understanding and following all CRTO policies affecting use of social media, including but not exclusive to the Social Media Terms of Use, the Foundations and Resources for a Best Practices Approach to Social Media and procedures affecting protection of privacy, records retention and website/Internet use.
- ensuring that social media services initiated and/or created by and within the control of CRTO are moderated;
- ensuring that appropriate Terms of Use Guidelines are posted, whenever possible, for all CRTO-operated social media initiatives; and
- ensuring that appropriate records management policies are implemented for all CRTO-operated social media initiatives.

REGISTRAR

- is responsible for administering and ensuring implementation of the policy;
- will determine that each new social media venture initiated or created by the CRTO has plans that are based on reasonable communications practices and include technical and monitoring measures which prevent, or ensure the timely removal of, any defamatory or objectionable submissions; and
- is responsible for ensuring the appropriate criteria required for moderation of social media is created.

References

- Social Media Terms of Use
- Foundations and Resources for a Best Practices Approach to Social Media
- Confidentiality Policy
- Website Design and Content Standards
- Privacy Policy
- CRTO Records Management Policy

COLLEGE OF RESPIRATORY THERAPISTS OF ONTARIOTitle: **CRTO Social Media Terms of Use Policy**Number: **PR – Social Media Terms of Use Policy - 102**Date originally approved:
May 24, 2013Date(s) revision approved:
N/A**POLICY****Social Media Terms of Use Guidelines for Designated Spokespersons**

College of Respiratory Therapists of Ontario (CRTO) designated spokespersons use the internet in the course of their work as well as during their private time. Social media – blogs, twitter, public wikis and social networking sites such as Facebook – provide useful means for use in communicating with each other, with Members, stakeholders and the public.

The following policy is meant to assist designated spokespersons in making appropriate, trouble-free use of social media at home and at work.

What is social media?

Social media refers to online technologies and practices that are used to share information and opinions, host conversation and build relationships. It can involve a variety of formats, including text, pictures, video, audio and “live,” real-time dialogues of a few, or thousands of participants.

Examples of social media include discussion forums, blogs, social networks, webinars, wikis, podcasts, Google Wave and vlogs (video blogs).

Benefits of social media

Social media can help the CRTO to better understand, respond to and attract the attention of specific audiences. It enables interactive communication – the exchange of information, perspective and opinion – among multiple audiences, effectively, efficiently, and in places where those conversations are already taking place. Social media can:

- increase the CRTO’s access to audiences and improve the accessibility of communication and engagement efforts;
- enable the CRTO to be more active in its relationships with Members, stakeholders and the public;
- offer greater scope to adjust or refocus communications quickly, when necessary;
- enhance the credibility of the CRTO’s initiatives or proposals through non-traditional channels;
- increase the speed of public feedback and input;
- reach specific audiences on specific issues; and
- reduce the CRTO’s dependence on traditional media channels and counter any inaccurate press coverage, in a more timely manner.

Official Use of Social Media

The College can make use of social media in two ways:

- by contributing to existing platforms operated by outside organizations or individuals, or
- by setting up its own discussion forums or other online communication platforms. These may be ongoing or may be established for a specific time-limited proposal or initiative. They may be open to the public or access may be confined to a particular group of stakeholders.

When considering launching a social media initiative, designated spokespersons should be clear about the purpose and the resource implications that maintaining and monitoring the effort will entail.

Guiding Principles for Designated Spokespersons Use of Social Media

The CRTOs Confidentiality, Privacy, Employee and Conflict of Interest policies ([K:\Policy Procedures\](#)) apply to on-line communication as fully as they do to activities in any other circumstance or venue.

Professionalism

Social media is chatty and informal so, by all means, be chatty and informal online. But if you're participating as a CRTO employee, don't compromise on professionalism. Designated spokespersons who engage in social media must:

- maintain a respectful, constructive, professional tone that maintains the brand consistency of the CRTO;
- stick to the facts and refrain from debates over matters of strict opinion;
- never launch personal attacks or make defamatory or offensive (racist, sexist, lewd etc.) statements;
- refrain from making partisan, political comments while speaking as a CRTO employee;
- not criticize policies of the CRTO; and
- maintain the integrity and values of the CRTO's designated spokespersons.

In other words, use common sense.

Confidentiality

This is covered in the CRTOs Confidentiality policy, ([K:\Policy Procedures\Council\Final&PDF\Confidentiality\Policy CP-Confidentiality-10.2012-October-25.pdf](#)) but it's worth special mention here. Many of us are privy to confidential and sometimes sensitive information in our work. It is every bit as important to protect confidential information when posting comments online as anywhere else. If you wouldn't say it to a reporter, don't say it in a blog or discussion thread.

Authorization

Before granting an interview to a reporter or agreeing to appear on the evening television news, you are required to make contact with the Registrar or President to discuss the request. Unless otherwise authorized the Registrar and president are the only ones authorized to talk to media on behalf of the CRTO. The same authorization applies to online communications. If you are thinking about posting to a social media site on a work-related matter, have a chat with Communications staff first. The public is not well served if different sources within the CRTO are saying different things.

Any work-related, external social media initiative must be approved by the Registrar who is responsible for ensuring appropriate awareness and agreement with the initiative.

For further details please see the CRTOs Confidentiality policy
(K:\Policy Procedures\Council\Final&PDF\Confidentiality\Policy CP-Confidentiality-10.2012-October-25.pdf)

Self-Identification

If you want to speak or write online about something connected with your job or the work of your department – even something so simple as to correct a mistake made by someone else – you should identify yourself as a CRTO employee. This applies whether you're posting from your desk during office hours or from your cell phone on the weekend. Doing so will probably add a little more weight to what you say in your post; more importantly, though, it will prevent situations from developing where you, or the CRTO, could be accused of covertly attempting to influence free discussion.

Personal Use of Social Media During Work Hours

Some CRTO designated spokespersons have legitimate, business-related reasons to make use of social media in the course of doing their jobs; others do not. It's not a good idea for anybody to be regularly updating their Facebook status, or otherwise spending significant amounts of time with social activity when they're on the job. Everybody in their network knows what they're doing or not doing. Use the same common sense with the social part of social media activity that you would with coffee breaks.

Personal Use of Social Media Outside of Work Hours

All Employees

As a member of the public, as well as an employee, you can, of course, use social media in all the same ways as anyone else outside of work hours. It is important to recognize however, that what you publish on the Internet may reflect on your employer. Employees who use social media for personal purposes should:

- use a disclaimer anywhere there may be uncertainty about the capacity in which they are acting. A disclaimer, such as: "The postings on this site are my own and do not represent the views or opinions of my employer" can help protect you;
- recognize that anything posted on the Internet is there for good. Even if you attempt to delete the post, photo, comment, etc., it is likely that it has been stored in any number of other places. Content posted to the Internet should be thought of as permanent;
- avoid sharing CRTO material in a personal space. Try and keep your personal online presence and your work online presence separate;
- respect copyright and fair use;
- recognize that if you publish inappropriate comments that reflect badly on your employer in your personal space, on your personal time, that disciplinary action could follow;
- above all, use common sense.

For Individuals who hold senior positions, or who work in sensitive areas, a disclaimer does not by itself exempt them from special responsibility when posting online. By virtue of their position, these individuals should consider whether personal thoughts they publish may be misunderstood as expressing the positions or opinions of the CRTO. For individuals in positions like this, caution is advisable, and check with the Registrar when in doubt.

The College of Physicians and Surgeons of Ontario

950Site Search

Social Media

Share

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The College of Physicians and Surgeons of Ontario (“CPSO”) uses Facebook, Twitter, LinkedIn and other social media tools to share information about CPSO and to communicate with our stakeholders. CPSO makes reasonable efforts to ensure that content it posts comes from official and approved sources. CPSO welcomes all commentary, opinions, questions and responses which relate to CPSO or the issue being discussed, and which comply with these ‘Terms of Use’. CPSO endeavours to read all comments posted and to respond where appropriate during its regular business hours (Monday to Friday, 8 am to 5 pm). If you ask CPSO a question, CPSO will endeavour to respond within one to two business days.

Rules for posting content

- CPSO will allow comments and other content from users to appear on or through its social media sites, tools or channels, including without limitation comments and content submitted or posted by any means and in any media (“posting”) unless CPSO determines in its sole discretion that the comments and content:
 - provide information or opinions that are unrelated to CPSO or the issue being discussed;
 - provide personal information or information that may identify a third party;
 - discuss complaints or compliments about a specific physician;
 - relate to a specific individual;
 - discuss an ongoing investigation;
 - make false or unsubstantiated allegations;
 - are or may be aggressive, abusive, obscene, profane, hateful, harassing or threatening;
 - may abuse or infringe any intellectual property right;
 - are or may be defamatory, slanderous or libelous;

951

- constitute spam;
- advertise or solicit business;
- breach or may breach any CPSO by-law, policy or terms of use (including these Terms of Use);
- breach or may breach any law, statute, regulation, order, code, standard or rule;
- are or may be unlawful, misleading, malicious, or discriminatory.

CPSO may move to restrict a user's use of its social media sites, tools or channels if CPSO determines in its sole discretion that the user is:

- impersonating another person;
- allowing any other person to use the user's identification for posting or viewing comments or content;
- breaching or may breach any CPSO by-law, policy or terms of use (including these Terms of Use);
- breaching or may breach any law, statute, regulation, order, code, standard or rule;
- is engaging, or may engage, in activity which is unlawful, misleading, malicious, or discriminatory.

Content removal and other remedies

- CPSO reserves the right at any time to refuse to post comments and content or to remove comments or content, in whole or in part, which CPSO determines, in its sole discretion, does not comply with these Terms of Use.
- Violation of any element of these Terms of Use can lead to restrictions regarding use of CPSO's social media sites, tools or channels, including without limitation blocking a user from posting to CPSO's social media sites, tools or channels.
- No remedy herein conferred upon or reserved in favour of CPSO shall exclude any other remedy existing at law or in equity or by statute, but each shall be cumulative and in addition to every other remedy given hereunder or now or hereafter existing.
- Please notify CPSO if you see a comment, content or a use that you think does not comply with these Terms of Use.

Disclaimers and Agreements

- All comments posted are the opinion of the writer, not CPSO.
- You agree not to upload viruses or other malicious code.

- You agree not to facilitate or to encourage any violations of these Terms of Use.
- By posting comments or content, you are giving CPSO permission to use and distribute those comments and content. For any comments or content you post that is covered by intellectual property rights (“IP Content”), you specifically grant CPSO the non-exclusive, transferable, sub-licensable, royalty-free, worldwide license to use IP Content in any manner (including without limitation the right to copy, distribute and make derivative works). You confirm, represent and warrant that you have the right without restriction to post all comments and content (including without limitation all links) posted by you.
- The submitter of comments and content is fully responsible for the comments and content posted; CPSO is in no way responsible for such comments and content nor for any information, references, links, opinions, claims, or advice in such comments and content, nor to collect, review, use, update, edit, retain, return, dispose of, share, circulate, act on, consider, or respond to, any such comments and content.
- CPSO in no way verifies or confirms the accuracy of user comments or any aspect of posted content. CPSO does not review any references or links in any content and is not responsible for any content of any document referred to or site linked.
- Spelling and grammatical errors will not be corrected.
- CPSO will not automatically ‘friend you’ or ‘follow’ you back. A decision to ‘friend’ or ‘follow’ a user does not constitute endorsement of comments, content, position, or perspective.
- Any sharing or re-tweeting of links on the part of CPSO does not equate to endorsement.
- Social media sites, tools or channels are or involve third-party service providers for CPSO which are not affiliated with CPSO. Users are encouraged to read the terms and conditions of use and the privacy policy of each relevant social media site, tool or channel.
- By using any of CPSO’s social media sites, tools or channels (including without limitation by posting any comment or content), each user agrees to indemnify CPSO regarding and to hold CPSO harmless from any liability, loss, damage or expense, including without limitation professional and other fees and expenses, arising out of such user’s use of any CPSO social media site, tool or channel and any comments or content posted.

Social Media - Appropriate Use by Physicians

Share

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The term ‘social media’ refers to web and mobile technologies and practices that people use to share content, opinions, insights, experiences, and perspectives online. There are many prominent examples of social media platforms, including Facebook, Twitter, YouTube, LinkedIn, and blogging sites, among many others.

Social media can be used for both personal and professional purposes. Many physicians are now using social media in their practices to interact with colleagues and patients, to seek out medical information online, and to share content with a broad audience.

Whether engaging in social media for personal or professional use, the nature of these platforms, which are highly accessible, informal, and public, raise important questions about the steps physicians should take to uphold their important professional obligations while online.

Purpose

This document provides guidance to physicians about how to engage in social media while continuing to meet relevant legal and professional obligations.

This document is not a policy, nor does it establish any new expectations for physicians that are unique to social media. Rather, this document clarifies how existing professional expectations can be met in the social media sphere.

College position on social media

The College’s position is that physicians are expected to comply with all of their existing professional expectations, including those set out in relevant legislation, codes of ethics, and College policies, when engaging in the use of social media platforms and technologies.

If physicians do so, the College recognizes that social media platforms may present important opportunities to enhance patient care, medical education, professional competence, and collegiality, among other potential benefits.

Legal and professional expectations that govern medical practice are set out in the College's Practice Guide, policies, and relevant legislation. A number of these obligations are relevant to the use of social media by physicians, and are articulated below. These obligations are not unique to social media, but apply to medical practice in general, and must be met by all physicians.

They are as follows:

- Comply with all legal and professional obligations to maintain patient privacy and confidentiality.¹
- Maintain appropriate professional boundaries with patients and those close to them.²
- Maintain professional and respectful relationships with patients, colleagues, and other members of the health-care team.³
- Comply with relevant legislation with respect to physician advertising.⁴
- Comply with the law related to defamation, copyright, and plagiarism when posting content online.⁵
- Avoid conflicts of interest.⁶

Guidelines

In order to satisfy the above professional expectations while engaging in social media, it is recommended that physicians:

1. Assume that all content on the Internet is public and accessible to all.
2. Exercise caution when posting information online that relates to an actual patient, in order to ensure compliance with legal and professional obligations to maintain privacy and confidentiality. Bear in mind that an unnamed patient may still be identified through a range of other information, such as a description of their clinical condition, or area of residence.⁷
3. Refrain from providing clinical advice to specific patients through social media.⁸ It is acceptable, however, to use social media to disseminate generic medical or health information for educational or information sharing purposes.
4. Protect their own reputation, the reputation of the profession, and the public trust by not posting content that could be viewed as unprofessional.

5. Be mindful of their Internet presence, and be proactive in removing content posted by themselves or others which may be viewed as unprofessional.⁹
6. Refrain from establishing personal connections with patients or persons closely associated with them online, as this may not allow physicians to maintain appropriate professional boundaries and may compromise physicians' objectivity.¹⁰ It is acceptable to create an online connection with patients for professional purposes only.
7. Refrain from seeking out patient information that may be available online without prior consent.¹¹
8. Read, understand, and apply the strictest privacy settings necessary to maintain control over access to their personal information, and social media presence undertaken for personal purposes only.
9. Remember that social media platforms are constantly evolving, and be proactive in considering how professional expectations apply in any given set of circumstances.

Endnotes

1. *Personal Health Information Protection Act, 2004*, S.O. 2004, c. 3, Schedule A (hereinafter PHIPA), the CPSO's Confidentiality of Personal Health Information policy.
2. For more information please see the CPSO's Maintaining Appropriate Boundaries and Preventing Sexual Abuse and Treating Self and Family Members policies.
3. The duty of physicians to maintain professional and respectful relationships is set out in the CPSO's Physician Behaviour in the Professional Environment policy, and the Practice Guide.
4. For more information on physician advertising, please see Part II of O.Reg., 114/94, enacted under the *Medicine Act, 1991*, S.O. 1991, c. 30.
5. For example, *Copyright Act*, R.S.C. 1985, c. C-42.
6. For more information on conflicts of interest, please see Part IV of the General, O. Reg., 114/94, and the CPSO's Practice Guide.

956

∴ A breach of confidentiality may be deemed to have occurred if the facts available are sufficient for the patient to be identified, even if only by themselves. This is consistent with the definition of “identifying information” in section (4)2 of PHIPA.

8. Clinical advice is defined as advice of a clinical nature that is directed toward a specific individual to address a medical concern. It is distinct from general health information that is not patient-specific, but disseminated to a general audience for education or information sharing purposes.

9. Be mindful that once information has been posted online, it may be difficult or impossible to remove. Reasonable steps should be taken to remove information that has been posted by one’s self or others.

10. Some physicians may find it preferable to maintain a separate online presence for their personal and professional networks. For more information on maintaining appropriate professional boundaries, please see the CPSO’s Maintaining Professional Boundaries and Preventing Sexual Abuse policy, Treating Self and Family Members policy, and *Dialogue* article “Maintaining Boundaries.”

11. Patients are entitled to a reasonable expectation of privacy. While physicians are expected to adhere to all of their relevant legal obligations under PHIPA with respect to the collection of personal health information, they should also refrain from seeking out other types of non-protected information online without prior consent.

Related Links

Social Media FAQ

- [available here](#)

UNDERTAKING TO THE CCO REGISTRAR FROM CANDIDATE

College of Chiropractors of Ontario (CCO)

January 2015

This document is part of and must be received with nomination papers at CCO by 4 p.m. on February 12, 2015.

Note to Candidates: Initial the box/boxes that apply. Leave blank box/boxes that do not apply and provide an explanation on a separate page.

I, _____, candidate for election to CCO Council in District _____, undertake to the Registrar as follows:

1. (a) My **primary practice of chiropractic** is located in the electoral district for which I am nominated.

– OR –

OR

(b) I am not engaged in the practice of chiropractic and my **primary residence** is located in the electoral district for which I am being nominated.

2. I am **not**:

- in default of payments 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.
- in default in completing and returning any form required by the College.
- the subject of a disciplinary or incapacity proceeding.
- an employee, officer or director of any professional chiropractic association such that a real or apparent conflict of interest may arise, including but not limited to being an employee, officer or director of the OCA, CCA, CCPA, CAC, CCEB, CSCE or the Council on Chiropractic Education (Canada) of the CFCREAB¹.
- an officer, director, or administrator of any chiropractic educational institution, including but not limited to, CMCC and UQTR, such that a real or apparent conflict of interest may arise.
- a member of the Council or of a committee of the college of any other health profession.

3. If applicable, I have attached to this undertaking a copy of all letters of resignation from my position as an employee, officer or director of any professional chiropractic association or an officer, director or administrator of any chiropractic educational institution such that a real or apparent conflict of interest may arise.

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

ITEM 5.4

COLLEGE OF CHIROPRACTORS OF ONTARIO

965

UNDERTAKING TO MAINTAIN CONFIDENTIALITY

FOR COUNCIL MEMBERS

I, _____, Council member of the College of Chiropractors of Ontario (“CCO”), undertake to preserve secrecy with respect to all matters that come to my knowledge in the course of my duties as a Council member of the CCO and further undertake not to communicate any information concerning such matters to any person except as required by law.

I acknowledge and agree that all records, material and information (including but not limited to all minutes of meetings) and copies thereof obtained by me in the course of my duties on behalf of CCO are confidential and shall remain the exclusive property of CCO and I undertake to take all reasonable steps to protect the confidentiality of such records, material and information.

I understand that a breach of my duty of confidentiality will result in my removal from council.

I understand that CCO’s Privacy Code approved in principle by Council on November 28, 2003 imposes strict requirements on the retention, disclosure and use of any information in my possession or control, and I agree to comply with these obligations.

I further acknowledge and agree that my obligations regarding confidentiality continue beyond the expiration of my term as a Council member of CCO.

I have read and understood sections 36 and 40 (4) of the *Regulated Health Professions Act, 1991* copies of which are annexed hereto, which outline my duty of confidentiality and the consequences for a breach of confidentiality under the legislation.

Signature

Witness

Date:

CCO CODE OF CONDUCT**Executive Committee****Approved by Council: September 28, 2012**

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

1. be familiar and comply with the provisions of the *Regulated Health Professions Act, 1991 (RHPA)*, its regulations and the *Health Professions Procedural Code*, the *Chiropractic Act 1991*, its regulations, and the by-laws and policies of the College;
2. diligently take part in committee work and actively serve on committees as elected and appointed by the Council;
3. regularly attend meetings on time and participate constructively in discussions;
4. offer opinions and express views on matters before the College, Council and committee, when appropriate;
5. participate in all deliberations and communications in a respectful, courteous and professional manner, recognizing the diverse background, skills and experience of members on Council and committees;
6. uphold the decisions made by Council and committees, regardless of the level of prior individual disagreement;
7. place the interests of the College, Council and committee above self-interests;
8. avoid and, where that is not possible, declare any appearance of or actual conflicts of interests;
9. refrain from including or referencing Council or committee positions held at the College in any personal or business promotional materials, advertisements and business cards;¹
10. preserve confidentiality of all information before Council or committee unless disclosure has been authorized by Council or otherwise exempted under s. 36(1) of the *RHPA*;

¹ This section does not preclude the use of professional biographies for professional involvement.

967

11. refrain from communicating to members, including other Council or committee members, on statutory committees regarding registration, complaints, reports, investigations, disciplinary or fitness to practise proceedings which could be perceived as an attempt to influence a statutory committee or a breach of confidentiality, unless he or she is a member of the panel or, where there is no panel, of the statutory committee dealing with the matter;
12. respect the boundaries of staff whose role is not to report to or work for individual Council or committee members; and
13. be respectful of others and not engage in behaviour that might reasonably be perceived as verbal, physical or sexual abuse or harassment.



✉ dnevin@proskauer.com

968



Social media e-discovery: its time is here

There's a treasure trove of important evidence to be gained from apps and online posts.

By Dera J. Nevin

Social media is an important source of discovery in an increasing range of cases and can often yield the most important evidence. Social media and its derivatives are prevalent with many people using social media as their dominant communications channel, preferring some in-app messaging tools to e-mail. Corporations, too, are using these media to target and communicate with their customers. Ignore these sources and you leave potentially game-changing evidence on the table.

Early social media case law largely addressed whether privacy concerns mitigated the obligation to identify, review, and produce social media communications. It was thought that accessing these sources of information was too intrusive. In all jurisdictions in Canada, those questions seem to be settled, largely as social media has become familiar even to judges.

Social media is, without doubt, discoverable and producible if relevant, not only because courts have understood that the point of social media is the erosion of privacy, but also because courts have largely adopted the view that privacy will not trump discoverability of evidence as long as there isn't an impact on third-party interests. Also, redaction tools have improved.

A quick review of recent discovery case law shows that social media is used as evidence in all manner of cases, but

it is particularly prevalent in personal injury, employment, family, criminal, and theft of IP or unfair competition matters. And that makes sense: These are primarily personal tools. Furthermore, social media are frequently pictographic or representational: Shorter text accompanies pictures, but this text is economical and direct. It is compelling evidence.

Social media are today's e-mail of yesterday: It's where people display their emotions and thoughts, communicate

in real time, and exchange important collateral information, such as photographs, videos, and voice recordings. Moreover, since many people access their social media accounts on mobile devices (such as their phones) and either turn "geolocation" services on within social media apps or have otherwise poor privacy practices, collection of social media yields valuable meta-data including date and time stamps for posts.

Embarking on social media discovery is a bit like going on a safari: Everyone knows of and wants to see the Big Five (LinkedIn, Facebook, Twitter, Instagram, Pinterest), but if you look closely, there is an abundance of channels in the social media ecosystem. Spend time early in fact discovery identifying potential sources of social media and custodian interviews. My standard form custodian interviews include developed scripts for social media investigation, tied closely to my scripts on mobile devices and cloud computing.

Many corporations have dedicated teams for their corporate social media accounts. Companies troll LinkedIn for candidates or have writers developing content. Companies tweet and have Facebook and Instagram profiles. A quick Google search (or a search within an app) can help you identify any accounts held by a corporation.

The same searching techniques are available to identify social media accounts for individuals, except a search alone is not conclusive because individuals can both implement privacy settings on their accounts to screen them from search and create profiles using a name other than their legal name. I always directly ask my opponents about their social media activities whether in oral examinations or written interrogatories.

Beware of your ethical responsibilities when working online and ensure you are avoiding behaviour that regulators

have identified as irresponsible or unethical. This is particularly important when using social media against an individual litigant, represented or otherwise. Regulators that have issued opinions on the ethical use of social media have noted that “friending” someone in order to gain access to their profile information is never appropriate. It is also not appropriate to invent a fictitious profile to lurk on opposing litigants’ pages. Generally, I stop at Google and in-app searches for public information and then ask opposing parties for information from the accounts I have uncovered.

Once you have identified target social media, you need to develop a plan for its collection. For public accounts (and by this I mean accounts where the entire profile is made public and visible over the Internet), it is possible to collect the information by using a collection tool. The one I use most frequently is X1 Social Media because it can defensibly capture and reassemble most public social media channels. While I always recommend electronic (native) capture

of social media, there are times when I have captured screen shots or print-outs of postings — particularly where I have been concerned an opposing party would disable or hide an account. The screen captures (with date stamps) have been helpful in proving the existence of the account and content at the time of the screen capture.

Where accounts are subject to privacy settings, access to the account may be required, and collection will fall to the account holder to implement. Some apps, such as Facebook and Google+, have developed in-app collection capabilities. There are excellent guides available about how to use these tools, and I frequently use Google Takeout to collect anything on Google Drive. I always ask my client to temporarily change the password to something innocuous before turning over the account to me or a third party for collection, and then immediately re-change the password after collection.

The value of a proper collection is that metadata is preserved. The meta-

data might include information to align the elements of social media with each other (re-aggregating the page or reassembled after collection). However, many social media have geolocation or geotagging capabilities and the metadata can reveal a lot about the post and where the user was at the time of the post. This information will not be available if social media is not collected electronically.

There are additional and idiosyncratic challenges associated with social media collection. For example, Twitter can “cap” the number of tweets it retains, meaning the longer you leave collection of Twitter, the more likely it is that “older” messages will be difficult to retrieve. However, social media collection is becoming increasingly documented and is currently a hot topic in the CLE circuit, so there’s no longer any reason to avoid this valuable source of evidence. **CL**

Dera J. Nevin is the director of e-discovery services at Proskauer Rose LLP. The opinions in this article are entirely her own.

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From: Jo-Ann Willson
Sent: Thursday, September 24, 2015 4:58 PM
To: DrLIZ
Cc: Rose Bustria
Subject: RE: FYI info

Thank you Liz - we'll include it for both Exec and Council.

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

College of Chiropractors of Ontario
130 Bloor St. West, Suite 902
Toronto, ON M5S 1N5
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Web Site: www.cco.on.ca

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From: DrLIZ [drliz@drliz.ca]
Sent: Thursday, September 24, 2015 4:56 PM
To: Jo-Ann Willson
Subject: FYI info

I thought the piece on Orthotics/proprioception was most interesting perhaps for council and wanted to forward the email in it's entirety.

Liz

Sent from my BlackBerry 10 smartphone on the Rogers network.

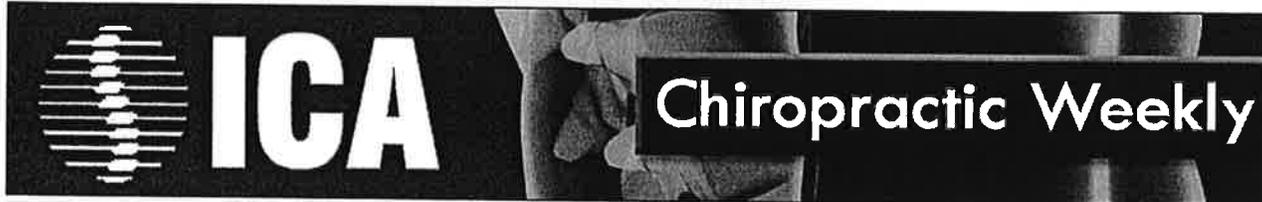
From: ICA Chiropractic Weekly <icaorg@multibriefs.com>
Sent: Thursday, September 24, 2015 4:10 PM
To: drliz@drliz.ca
Reply To: icaorg@multibriefs.com
Subject: ICA Pediatrics Program offers vital new clinical insights

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LEADING CHIROPRACTIC TECHNOLOGY FOR YEARS

Expand your clinical skills with excellent workshops and more at the Chiropractic Pediatrics Super Conference

International Chiropractors Association

The ICA Council on Chiropractic Pediatrics has included two excellent three-hour workshops at its Super Conference to be held Dec. 11-13 at the Hyatt Regency in New Orleans.

These workshops will provide DCs with practical skills they can use in the care of their pediatric patients. One is focused on pediatric conditions



of the upper and lower extremities taught by Tracey Littrell, DC, DACBR, DACO, CCSP and James Rizer, DC, CCSP; the other is focused on kids with neurodevelopmental problems taught by Dr. Laura Hanson who has developed several effective programs for kids with neurobehavioral problems. These expert instructors will teach how to assess and manage, including hands-on adjusting techniques. There are many more excellent presentations on topics designed to keep chiropractic practitioners on the cutting edge of their clinical skills and knowledge. CE is administered by Palmer College and 16 hours have been pre-approved in 25 states and applied for in others. Don't miss this opportunity to learn from the best about chiropractic pediatric care. Register today at www.icapediatrics.com.

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CDC Guidelines Include recommendation for 'non-pharmacological therapy' as 'preferred' for certain cases

Pain News Network

New draft guidelines by the Centers for Disease Control and Prevention would — if adopted — sharply reduce the prescribing of opioids for both chronic and acute pain in the U.S. The CDC draft includes a recommendation for "non-pharmacological therapy" as "preferred" for certain health issues. The proposed guidelines may also trigger a turf battle between the CDC and the Food and Drug Administration over which agency has primary responsibility for the safe prescribing of medication. The CDC does not normally get involved in setting guidelines for prescription drugs, a responsibility that falls on the FDA — which regulates drugs and determines which ones can be used to treat which conditions.

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Dynamic spine brace in development for children with scoliosis

Columbia University School of Engineering and Applied Science News-Medical.net

The typical spine brace used with children in an attempt to stabilize scoliosis is made of rigid plastic. But the rigid braces have numerous shortcomings, and they "freeze" the child's body and limit movement. Having the flexibility to move when wearing a spinal brace that fits around the trunk and hips to apply corrective counter-pressure on spinal curvatures could provide important features, including the ability to adapt as the child grows. Three researchers — Sunil Agrawal, professor of mechanical engineering and of rehabilitation and regenerative medicine at Columbia Engineering, David P. Roye, St. Giles Foundation Professor of Pediatric Orthopedic Surgery at the Columbia University Medical Center, and Charles Kim, professor of mechanical engineering at Bucknell University — are developing a dynamic spine brace that is more flexible than the rigid braces now in use. "If we can design a flexible brace that modulates the corrective forces on the spine in desired directions while still allowing the users to perform typical everyday activities, we will bring revolutionary change to the field," Agrawal says.

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Research review: Orthotics and proprioception findings

Dynamic Chiropractic

Numerous clinical research studies have been investigating roles that orthotics might specifically play in muscle function, injury prevention and other parameters — and some findings specifically point to a specific factor: proprioception. An analysis reviews how orthotics are able to effectively manage a wide range of musculoskeletal disorders not because they alter the overall range of pronation, but because they decelerate the velocity of pronation, improve moment arms, distribute force over a broader surface area and improve sensory input to the plantar surface of the foot thereby enhancing proprioception. Orthotic intervention affected muscle activity and increased it not because the orthotics altered motion, but because they improved sensory input to the plantar surface of the foot. As it turns out, orthotics are able to effectively manage a wide range of musculoskeletal disorders not because they alter the overall range of pronation, but because they decelerate the velocity of pronation, improve moment arms, distribute force over a broader surface area and enhance proprioception.

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The future is here: Shifts underway towards 'value-based' reimbursement

Chiropractic Economics

New models of reimbursement are on the way. Do you understand how they're about to affect your practice — and your income — in the near future? Medicare and the major insurance companies have been conducting trials over the past few years and have recently announced they intend to roll out new payment models across the country, in less than two years' time. As doctors and small-business owners, nothing gets our attention as much as major changes in how healthcare

practitioners get paid—and this time, if we are alert for and can adapt to the coming changes, it can be to our benefit.

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Anti-addiction groups seek details on probe into ties between painkiller manufacturers, providers

The Associated Press via Modern Healthcare

Anti-addiction activists are calling on a Senate committee to release findings from a 3-year-old investigation into links between painkiller manufacturers and not-for-profit medical groups. In a letter, a coalition of groups asks the Senate Finance Committee to make public information from the probe, which was launched in May 2012. Several of the companies targeted by the probe are also named in closely watched lawsuits in Chicago and California, where local governments are seeking to recover millions of dollars spent on treating opioid addictions and overdoses. The lawsuits allege that opioid drugmakers misled doctors and patients about the risks and effectiveness of their medications in treating chronic pain.

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Does your team increase your STRESS or SUCCESS?

Assistants for Chiropractic Excellence

De-stress your practice for more success. That really is the first step. Chiropractic practices can experience all different types of stress: the doctor wanting to completely overhaul the entire practice the day after attending a seminar, running out of necessary office supplies, staff turnover, miscommunications, dropped balls, computer malfunctions, staff errors and mishaps, team conflict, excessive waits that cause angry patients, uncollected fees and more.

It doesn't matter if the cause of the problem stems from the doctor or the CA. Stress increases negative energy and creates chaos that repels patients. Stress sabotages your success.

I can help you implement office systems that will enable you to get more of what you want in your practice: September's A.C.E. Program chiro-team course is Office Systems that Maximize Flow of Patients and Profits. This one-hour presentation is available online in both video and audio format, so your entire team can access it however and whenever it's convenient for them as often as they need 24/7 from now until the end of the month.

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TRENDING ARTICLES

Missed last week's issue? See which articles your colleagues read most.

[Chiropractic Profession and Patients Celebrate Founder's Day \(International Chiropractors Association\)](#)

[5 common causes of neck pain \(and how chiropractic can help\) \(To Your Health\)](#)

[One symptom in new ICD-10 coding: Anxiety \(The New York Times\)](#)

[Meta-analysis of studies: steroid shots offer little relief for radiculopathy or spinal stenosis \(Medscape\)](#)

[ICD-10's potential effects on your revenue cycle \(Diagnostic Imaging\)](#)

Don't be left behind. [Click here](#) to see what else you missed.

980

Chiropractic Weekly

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EDUCATION

B.C. ramps up plan for new chiropractic school

BRITISH COLUMBIA may soon become the site of a new academic institution for chiropractic. The new Pacific Academic Institute of Chiropractic (PAIC) has released a progress report that outlined recent developments about the planned chiropractic academic institution, which will include a chiropractic school, a research program and a multidisciplinary primary care clinic.

The PAIC is currently exploring the possibility of collaborating with a U.S.-based university. The details of this potential partnership is yet to be finalized.

The PAIC is projecting an intake of 100 new students once the school becomes operational. Historically, about 75 per cent of new chiropractic registrants in western Canada graduate from U.S. institutions, George Eisler, CEO of PAIC said. The intent is to capture students from western Canada who would otherwise go to the U.S. for chiropractic education.

Educating future chiropractors within Canada has been a long-standing goal of B.C. chiropractors. This led the profession in 2009 to create a special fund – which chiropractors in the province contribute to – administered by the College of Chiropractors of B.C. The goal is to raise \$6 million by 2018. This money will be used to fund the establishment of a new health education, research and community primary care in B.C. – which now form part of the newly established PAIC.

In addition, the profession



also spearheaded the establishment of the Pacific Spine Research and Education Foundation, a charitable organization tasked to develop and implement fundraising strategies for the PAIC. The foundation hopes to raise an additional \$24 million.

PAIC will be building the 100,000 square-foot academic and research facility on Simon Fraser University (SFU) property in Burnaby, B.C. under a lease agreement.

In addition to the education component, progress is also being made in the research and clinic fronts. The PAIC plans to open up a multidisciplinary primary care clinic inside SFU's UniverCity – a sustainable community development project in Burnaby.

Eisler said the planned primary care clinic will be located within UniverCity, in response to current demand for physicians, chiropractic and other health care services in the new mountaintop community. It was an opportunity that PAIC was not going to pass up.

"We are looking to lease a

space and develop what will essentially be a satellite clinic to our institution," Eisler said. The PAIC hopes to open the clinic by January 2016.

In addition to the clinic, PAIC is also in talks with SFU about potential research collaboration projects, Eisler said. While no concrete strategy is in place yet, a joint research seminar was held on September 11 involving chiropractic researchers and SFU scientists to discuss opportunities for establishing potential research initiatives.

The collaboration with SFU is an important aspect of the development of the academic institute, according to Eisler, particularly in pursuing the ultimate goal of integrating the PAIC with the public post-secondary education system.

"The interest for just another private school was not that high, but the opportunity to be close to and be well-integrated with the public system was attractive. Our long-term goal is to essentially become as integrated as possible with the SFU system."

There are currently more

than 1,000 registered chiropractors in B.C. Most recent data has revealed chiropractic utilization rate in B.C. – the percentage of the population who are under chiropractic care – is at 24 per cent. This figure is significantly higher than utilization rate in Ontario at 11 to 12 per cent, and where more than 4,000 chiropractors currently practice.

According to Dr. Don Nixdorf, co-founder of the Pacific Spine Foundation and a big proponent of establishing a chiropractic education program in B.C., annual licensing of chiropractors in western Canada has remained steady for the last 15 years, with no significant surge in the numbers.

"The B.C. school is designed to have intake which represents the historical growth and aging demographic of DCs in western provinces," Nixdorf said.

He said having a chiropractic school in B.C. would "significantly contribute to public and stakeholder awareness when utilizing chiropractic doctors."

Mari-Len De Guzman



COLLEGE OF DENTURISTS OF ONTARIO

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November 6, 2015

ANNOUNCEMENT**DR. GLENN PETTIFER APPOINTED REGISTRAR, COLLEGE OF DENTURISTS OF ONTARIO**

Hanno Weinberger, President of the College of Denturists of Ontario (CDO), is pleased to announce the appointment of Dr. Glenn Pettifer, as the new Registrar of the CDO.

Glenn brings to the CDO a breadth of knowledge and direct experience in professional regulation in Ontario, that well positions him for the role of the new Registrar of the College of Denturists of Ontario. He has demonstrated experience in regulatory governance, policy development, program development and administration, strategic planning and working with Council and its committees.

Glenn joins us from the College of Veterinarians of Ontario (CVO) where he is the current Deputy Registrar and Senior Partner, Quality Practice. He is a Doctor of Veterinary Medicine, and worked both in private practice and as a member of the faculty at the College of Veterinary Medicine at the University of Guelph before joining the CVO. Glenn's current role at the College of Veterinarians of Ontario has provided the opportunity for him to work under a regulatory framework different from, but modelled in many respects, after the Regulated Health Professions Act (RHPA). He has worked extensively with colleagues from health as well as non-health regulatory Colleges in Ontario on a number of initiatives of mutual interest, and for the past three years, has served as Co-Chair, of the Quality Assurance Working Group of regulated health and non-health professions.

"I am very excited to join the College of Denturists and look forward to working with Council, the administrative team, and all members of the profession, as the College continues with its work related to the regulation and governance of the profession of Denturism in the public interest " said Dr. Pettifer.

President Weinberger added "On behalf of all members of our College Council, I am delighted to welcome Glenn to the College of Denturists of Ontario as our new Registrar. We are looking forward very much to working with him in the years to come, building on the many positive initiatives already in place."

Dr. Pettifer will assume his position as Registrar of the College of Denturists of Ontario on December 7, 2015.

As self-regulated health care professionals, members of the College are to demonstrate ethical conduct and integrity, whether in professional practice or their personal conduct. That is stated explicitly in the Standard of Practice for Core Competencies. The same standard says that the competent ND must understand and comply with the regulations governing the profession, as well as all rules of the College of Naturopaths of Ontario.

There is a simple way to describe how NDs should behave, be it with patients or in any dealings as an ND – with professionalism. This advisory is to remind members of that expectation regarding their contact with the College.

On July 1, 2015, the *Naturopathy Act, 2007* was fully proclaimed and the College of Naturopaths of Ontario became the regulatory authority for the profession. Also at that time, the profession's regulatory framework moved from the *Drugless Practitioners Act* to the *Regulated Health Professions Act*.

The College regulates the profession in the public interest. It is the College's responsibility to ensure that Ontarians have access to safe, ethical, competent care from members of the profession. In so doing, the College performs four key functions:

1. Ensure that individuals entering the practice of the profession meet the entry-to-practice requirements.
2. Develop, monitor and maintain standards of practice of the profession, which are the rules by which naturopaths practice.
3. Help naturopaths remain current in their competency through the Quality Assurance program, a program of continuing education, professional development and peer assessment.
4. Hold naturopaths accountable for their conduct by receiving and investigating complaints or concerns surrounding their competence, capacity and compliance with the standards of practice of the profession.

To meet this mandate, the staff of the College will often be in contact with members of the profession. Most members of the profession are respectful in their interactions with the College and its staff. However, a small number of members have not been.

Therefore, all members are advised that all interactions with the College and its staff must remain professional, respectful and courteous. At no time is it acceptable to disparage, swear at, or be rude to staff, either by phone, in person or in any written form.

The Professional Misconduct Regulation, Ontario Regulation 17/14, further relates to the topic of this advisory. It identifies the conduct of a naturopath that would be considered unprofessional and includes the following provisions:

- It would be professional misconduct to engage in conduct which, having regard to all of the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional (section 46); and

- It would be professional misconduct to engage in conduct that would reasonably be regarded by members as conduct unbecoming a member of the profession (section 47).

985

Members should also be aware that it is professional misconduct to fail to reply appropriately and within 30 days to a written inquiry or request from the College (section 44).

The need to send an advisory of this nature is extremely concerning to the College. We understand that with the new regulatory framework, members have faced much change. That can cause strain and frustration. While the College is sympathetic, this is not and cannot be a rationale for denigrating, insulting or otherwise demeaning the staff at the College.

The staff can and will be understanding of your situations. However, they are obligated to apply the rules established in the legislation, regulations, policies and by-laws – which form the regulatory framework – in a manner that is fair, objective, transparent and impartial. The College and its staff strive to perform their roles in the most professional way possible; members of the College should and must act professionally in turn.

College of Naturopaths of Ontario

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From: Jo-Ann Willson
Sent: Thursday, November 05, 2015 9:34 AM
To: Rose Bustria
Subject: FW: iNformed - CONO Newsletter

Council.

Jo-Ann Willson, B.Sc., M.S.W., LL.B.
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From: College of Naturopaths [<mailto:info@collegeofnaturopaths.on.ca>]
Sent: Thursday, November 05, 2015 9:23 AM
To: Jo-Ann Willson <jpwillson@cco.on.ca>
Subject: iNformed - CONO Newsletter

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The College of Naturopaths of Ontario
NEWS BULLETIN

The College of Naturopaths of Ontario is happy to announce the release of the first edition of the CONO newsletter, **iNformed**. This quarterly newsletter includes an overview of the first 100 days of the College, questions and answers from our Practice Advisor, discipline decisions, a volunteer spotlight and a list of news and upcoming events.

987

If there is a specific item you would like to see in a future edition of iNformed, please email us.

The November 2015 issue can be found here.

College of Naturopaths of Ontario

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Table of Contents

President's Message	1
Registrar's Message	2
The First 100 Days	3
What Could Clinic Regulation Mean To You	9
Ask The Practice Advisor	10
ICRC Corner	12
Discipline Decisions	15
Specimens and Lab Tests	18
Learn About The MLT Role	23
Volunteer Spotlight	24
Keeping In Touch	25
Suspended Members	27
News and Events	28

989

President's Message



This is my last official duty as President of the Council (and of the former transitional Council) of the College of Naturopaths of Ontario. It is quite fitting for me to add a message to this newsletter, which comes out nearly six

years to the day since the transitional Council started its work. We've come a long way.

In November 2009, the transitional Council was tasked with establishing the regulations, by-laws, standards of practice and business operations for a new college to regulate the profession of naturopathic medicine. This meant working closely with the Ministry of Health and Long-Term Care, within the scope of the Naturopathy Act, 2007.

The transitional Council maintained a careful watch over the development of the new regulatory framework. Full proclamation of the Naturopathy Act and the launch of the College has been a milestone for the well-being of Ontarians. NDs have joined some 300,000 practitioners who fall under

the Regulated Health Professions Act. All of them are accountable for their conduct and practice, and for meeting high standards and public expectations of their professions. We're proud to be part of this community.

Our past work assured that the College had the policies, procedures and programs in place to be the trusted source of information and authority for naturopaths. Soon, the torch of governing this institution will be passed to the new Council.

Our mandate – to protect the public interest, and ensure that Ontarians who seek naturopathic services receive safe, ethical, competent care – must remain front and centre for the incoming Council and the College. As a new College, we must not only fulfill this mandate but be seen to be fulfilling it. Transparency and commitment to public protection cannot be overstated.

On behalf of the former transitional Council and the first Council of the College, I wish the new elected members and public appointees every success. May wisdom and patience be your guide.

Dr. Tom Ellis, ND

President, 2012-2015

"NDs have joined some 300,000 practitioners who fall under the Regulated Health Professions Act."

Registrar's Message

Welcome to the inaugural edition of iNformedD, the quarterly newsletter of the College of Naturopaths of Ontario.

This publication is part of our effort to help NDs stay up-to-date on the issues that affect them, their practice and their involvement with the College. As our vibrant lineup shows, we plan to do that in many ways. In this edition, you'll find:

- A feature on the first 100 days of the new College. Learn more about what we have already accomplished.
- A review of a discipline finding, a scenario based on a complaint received, and questions to our Professional Practice Advisor.
- A look at collecting specimens and ordering lab tests, to clarify what is currently permitted in Ontario.
- News and information about the College, about initiatives that relate to the ND's workplace, and about other regulated health care professionals.
- A profile of a volunteer, to capture why people are engaged with the College and what they gain from the experience.

As we produce more editions of this newsletter, we'll discuss what College programs and policies mean in practice. We'll also continue to touch on several major themes, like serving the public interest, the roles of NDs in the health care system, inter-professional collaboration, and the College's transparency.

While iNformedD is designed for members of the profession, we hope it appeals to other audiences who are interested in the profession of naturopathic medicine and in health care regulation.

This newsletter fits with broader efforts by your College to add to our members' body of knowledge. We'll continue to release regular News Bulletins to augment the information we cover, as well as producing website content that looks at issues in more depth.

In keeping with the nature of those resources, we'll deliver this newsletter in an electronic format only. That helps us get the publication to you in a timely way, when and where it's convenient for you to use. Eliminating printing and mailing also allows us to keep the costs of producing iNformedD as low as possible.

Andrew Parr, CAE
Registrar & CEO

991

The First 100 Days

It was 100 days that were half a decade in the making. After five-plus years of hard work, the Naturopathy Act, 2007 was proclaimed on July 1, 2015. On October 8, the new College of Naturopaths of Ontario marked its 100th day of operations.

Much has happened in the first 100 days, since the profession moved from operating under the Drugless Practitioners Act to the regulatory umbrella of the Regulated Health Professions Act.

The College of Naturopaths of Ontario became the province's 26th health regulatory college. When people seek the services of any regulated health professional, they can do so with confidence. That's because each college sets strict standards to enter and practice the profession, ensures they're met, and regulates their profession in the public interest.

The first 100 days of the College capture many of the ways that happens.

Council elections

Council is responsible for overall governance of the organization. On July 1, the former transitional Council members automatically became the Council of the College. One of the College's first steps was to launch an election process for a new Council.

In health care in Ontario, self-regulation is a partnership between the profession and the public. That's why Council has an appropriate balance of elected naturopathic doctors and appointed public members.

"NDs who run for Council do so because they want to make a positive contribution to how the profession is regulated," says Andrew Parr, the College's Registrar. "Elected Council members understand the importance of rising above the interests of the profession, to make reasoned judgments that serve the public."

A field of 29 candidates covered the eight electoral districts. Each district had a contested election, and by October 1 over 51% had voted. "That's an impressive turnout for initial elections, and shows the high degree of interest our members have in sound governance," says Parr.



Registration and examinations

The College ensures that only qualified people can practice naturopathic medicine in Ontario. It does that by issuing certificates of registration to NDs who've met the requirements.

On July 1, all registrants of the former Board of Directors of Drugless Therapy – Naturopathy (BDDT-N) became members of the new College. The College fees due allowed members to complete their membership year and practice until the March 31, 2016 renewal. Notices of membership fees went out June 30, with a payment deadline of August 14. For 90% of members, fees were collected on time.

“We register individuals who demonstrate the required knowledge, skill and judgement”

For the first time as part of registration, photos were required from all members of the profession. These are to be posted as part of the member's profile on the Naturopathic Doctor Register (on the College website).

“That reassures Ontarians that the person they're seeing is in fact registered with the College,” says Nadja Gale, Director of Registration. “Having photos on the register, along with information about the member, is another way to protect the public.”

The College followed up with members who didn't pay their fee or provide their photo on time. Members were advised that failure to meet all registration requirements by the deadline would result in suspensions.

The Registration Regulation under the Naturopathy Act, 2007 provides the legal foundation for College requirements for education, examinations, professional liability insurance, currency, and information to be collected and reported. The College has been diligent in keeping members (including all inactive members, inside and outside Ontario) aware of the requirements under the new legislative framework.

“We register individuals who demonstrate the required knowledge, skill and judgment,” says Gale. “Examinations are another critical part of ensuring that individuals have those requirements to practice the profession.”

To date, the College has:

- offered three Prescribing and Therapeutic Examinations (with a fourth in November) to 334 people;
- held its first Ontario Clinical Examination (in August) as part of the entry-to-practice process, where 104 individuals sat; and
- continued to plan and develop the Intravenous Infusion Therapy Examination.

Unauthorized practitioners

Without being registered with the College, it's illegal for someone to hold themselves out to be qualified to practice naturopathy. That's true no matter their education, experience or memberships with other regulatory bodies in Ontario or other jurisdictions.

Anyone found using a protected title in Ontario (including ND, naturopath and naturopathic doctor) without belonging to the College is considered to be engaged in unauthorized practice. When that happens, the College takes action to stop those individuals from using the title or performing certain procedures.

In the first 100 days, the College sent six cease and desist letters to unauthorized practitioners. Five signed back, agreeing to stop. The one remaining file remains under discussion by the Registrar and the College's legal counsel.

If someone doesn't cease their activities, the College's next step is to seek a court injunction. Once that's granted, further unauthorized action by the individual could result in contempt of court charges and serious fines or imprisonment.

"The ability to use a protected title is a privilege and a matter of public protection," says Jeremy Quesnelle, Director of Professional Practice. "The title signifies that the individual belongs to and is accountable to a regulatory body."

"The ability to use a protected title is a privilege and a matter of public protection."

In other cases, an organization or corporation holds themselves out to be a regulatory authority over the profession. These cases are much more complex. Already, two such cases have come to College's attention. The Registrar is currently making inquiries.

Complaints and discipline

The College holds members accountable in several ways. One key is reviewing complaints or concerns surrounding an ND's conduct or practice.

On July 1, the College inherited eight complaint files that were in process under the BDDT-N. In the first 100 days, the College received three additional complaints, which are under investigation by the Inquiries, Complaints and Reports Committee (ICRC).

The BDDT-N took great steps to complete all active discipline cases before winding down. One file was outstanding and remains under active review by the College; a hearing is expected shortly.

Under the new regulatory framework, the Registrar also has the authority to review and refer matters to the ICRC even when a formal complaint has not been received. The Registrar has initiated three such investigations with the approval of the ICRC.

"The College takes any concerns and complaints about an ND seriously," says Quesnelle. "The work of the ICRC and, if needed, the Discipline Committee, is a vital part of our mandate. In looking into these matters, the goal is always to protect and promote public safety, while enhancing the practice standards of the profession."

Fitness to Practice

Complaints generally deal with alleged incompetence or unprofessional conduct. However, the College also has obligations to review concerns about the possible incapacity of its members.

What does "incapacitated" mean? The Health Professions Procedural Code defines it as a physical or mental condition or disorder "that makes it

"The work of the ICRC and, if needed, the Discipline Committee, is a vital part of our mandate."



desirable, in the interest of the public, that the member's certificate of registration be subject to terms, conditions or limitations or that the member no longer be permitted to practice."

When such information comes to the College's attention, the Registrar is obligated to initiate an informal review. Currently, three are underway.

If the circumstances suggest that incapacity exists, the Registrar will forward a report to the ICRC. It's up to the ICRC to refer the matter, if needed, to the Fitness to Practice Committee for a hearing.

Website and communications

During the first 100 days, communications has been an important element of the College's work. Numerous bulletins, advisories and notices kept members apprised of the changes affecting them, the roles of the College, and dealing with the College.

"Access to clear information allows members and the public alike to understand the profession's obligations and accountabilities"

Leading up to and immediately following proclamation, the website was a major focus. New information was added regularly, in particular to the Professional Practice area.

For health regulatory colleges, the public register enables anyone to determine whether a person is a member of the profession and has been subject to discipline. Recent by-law changes have increased the information available on most public registers, part of efforts across colleges to boost transparency. This College launched its fully operational public register on July 1, fulfilling these responsibilities to Ontarians.

"Our focus is communicating in a timely, open and comprehensive manner," says John McCracken, Manager, Corporate Services. "Access to clear information allows members and the public alike to understand the profession's obligations and accountabilities."

The College continues to develop valuable communication tools for the profession's use. Work on these was initiated in the first 100 days and will be finalized in spring 2016.

One of these tools is a video series called "The College and You". Last spring, in the run-up to proclamation, the transitional Council mounted

educational sessions across Ontario. Now, to reach 100% of membership (and future members), the College has created five videos. They cover the role of the College, registration, QA, professional misconduct and complaints, and controlled acts.

The series answers the most pressing questions of NDs regarding regulation, and can be accessed through the College website. Another video geared to the public will be available on the website shortly.

Organizational management

Finally, the College of Naturopaths of Ontario is also a corporate entity, which triggered a number of necessary administrative functions in the first 100 days:

- applying for and being granted corporation status, including an Ontario Corporation number;
- applying for and being granted a business number and taxation number from the Canada Revenue Agency;
- closing the accounting books for both the BDDT-N and transitional Council; and
- establishing a new set of books and chart of accounts to reflect the broader business purposes of the College.

“The first 100 days have been busy, exciting and productive.”

These behind-the-scenes activities have been essential to creating proper management systems. With the end of the transitional Council as an entity, final reports are due to the Ministry of Health and Long-Term Care, including an annual report to be filed this fall.

“The activities we have undertaken since July 1 underscore the scope of the critical roles of the College,” says Parr. “The first 100 days have been busy, exciting and productive. We have laid a good foundation for the development of the College and the regulation of the profession in the public interest.”

997

What Could Clinic Regulation Mean To You

Health regulatory colleges have a mandate to protect the public. Achieving that can be a challenge in a system that regulates individual professionals, but not necessarily their workplaces. CONO is among a group of colleges exploring whether a new model for regulating clinics would serve the public and strengthen our health care system.

Ontarians receive health care services through a range of settings. Some, such as hospitals and long-term care homes, are governed by legislation. Certain types of clinics (like pharmacies and some physician and dental clinics) are also regulated. Yet many clinics currently have no oversight.

Clinic regulation would achieve several goals. It would hold clinic owners accountable for acting in patients' best interests. It would minimize the chance of fraud and other inappropriate business practices. And it would increase transparency by providing a public register of clinics.

The proposed model of the college group would also help health care professionals to meet their obligations. Those who work in a clinic could expect to see:

- Safeguards to prevent your credentials from being misused by clinics without your knowledge.
- Adequate records for patients, and appropriate access to those records to facilitate care.
- The ability to notify the clinic regulator, without fear of reprisal, if you have concerns about clinic practices.

The group of colleges have updated the Government of Ontario, which is ultimately responsible for deciding whether to establish a clinic regulation model.

To further explore the viability of this approach, we want to hear from you. During consultation this fall and winter, we will be seeking views from members, patients, other health professionals and businesses on a draft model. Your feedback will help us refine and improve a potential model – one that enhances public protection and provide better health care to all Ontarian's.

- Billing that accurately reflects the services provided.

From: Jo-Ann Willson
Sent: Wednesday, September 23, 2015 11:53 AM
To: Rose Bustria
Subject: FW: College of Nurses of Ontario: Proposed by-law amendments re: when to remove info from the Register

Exec and Council.

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From: Bylaws [mailto:Bylaws@cnomail.org]
Sent: Tuesday, September 22, 2015 10:52 AM
To: Bylaws <Bylaws@cnomail.org>
Subject: College of Nurses of Ontario: Proposed by-law amendments re: when to remove info from the Register

The College is proposing amendments to its Register By-Laws that will guide when information can be removed from the College's register: Find A Nurse.

In accordance with the requirements of the *Health Professions Procedural Code*, the proposed amendments are being circulated to members for 60 days. You are welcome to review and comment on the proposed by-law amendments.

You may send your comments by:

Email:

bylaws@cnomail.org

Fax:

416 928-5916

The deadline for sending comments is **midnight, Wednesday, November 18, 2015.**

A summary of feedback will be presented to Council in December 2015.

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Merci

For feedback: When to remove info from Find a Nurse

Following feedback from members, Council approved the publication of cautions and remedial activity outcomes on Find a Nurse at its September meeting. Information posted on [Find a Nurse](#), the College's public register, helps the public make informed decisions about their care provider.

Council also approved circulating for member feedback, proposed changes to College by-laws that would result in cautions and remedial activities being automatically removed from Find a Nurse. This removal would happen three years after the nurse meets all requirements set by the Inquiries, Complaints and Reports Committee (ICRC). If no further concerns arise during the three years, the College would be confident that the member has learned from the remedial activity.

Not all cautions and remedial activity would be automatically removed. Exceptions would be made for possible sexual abuse or boundary violations, or if other relevant information comes to the attention of the College about the nurse. In such situations, before removing information, the College would assess each case to make sure the nurse no longer poses a risk to the public.

The ICRC imposes cautions and remedial activities when it believes doing so will help nurses improve their practice. A caution requires a nurse to appear before a panel of the ICRC to hear concerns about her or his practice. A remedial activity is an educational requirement the ICRC orders.

You can read the proposed by-law changes below and send your comments to the College by emailing bylaws@cnomail.org. **The deadline for feedback is Wednesday, Nov. 18, 2015.**

1001

Removal of cautions

44.1.08.1

Subject to Article 44.1.08.2, information placed in the register as a result of paragraph 8.01 of Article 44.1.06, shall be automatically removed once three years has expired since the member attended the Inquiries, Complaints and Reports Committee and received the caution;

44.1.08.2

Information shall not be removed pursuant to Article 44.1.08.1 if

- i) in the opinion of the Executive Director, the caution was, related to conduct involving sexual abuse or a boundaries violation with a patient or former patient; or*
- ii) since the decision was made by Inquiries, Complaints and Reports Committee requiring the member to attend to receive a caution, the College has received information relating to the member's conduct which is of concern to the Executive Director, including but not limited to a complaint or mandatory report under the Code.*

44.1.08.3

Information placed in the register as a result of paragraph 8.01 of Article 44.1.06 and not removed pursuant to article 44.1.08.2, shall be removed if

- i) the member has made a written request to the Executive Director to remove the information;*
- ii) at least three years has expired since the member attended the Inquiries, Complaints and Reports Committee and received the caution; and*
- iii) the Executive Director is satisfied, having considered all information in the College's possession related to the member, including the member's history with the College, that there is no public benefit to maintaining the information on the register.*

Removal of SCERPs

1002**44.1.09.1**

Subject to Article 44.1.09.2, information placed in the register as a result of paragraph 8.02 of Article 44.1.06, shall be automatically removed once three years has expired since the member successfully completed all of the requirements of the specified continuing education or remediation program;

44.1.09.2

Information shall not be removed pursuant to Article 44.1.09.1 if

i) in the opinion of the Executive Director, the specified continuing education or remediation program was related to conduct involving sexual abuse or a boundaries violation with a patient or former patient; or

ii) since the decision was made by Inquiries, Complaints and Reports Committee requiring the member to complete a specified continuing education or remediation program, the College has received information relating to the member's conduct which is of concern to the Executive Director, including but not limited to a complaint or mandatory report under the Code.

44.1.09.3

Information placed in the register as a result of paragraph 8.02 of Article 44.1.06 and not removed pursuant to article 44.1.09.2, shall be removed if

i) the member has made a written request to the Executive Director to remove the information;

ii) at least three years has expired since the member successfully completed all of the requirements of the specified continuing education or remediation program; and

iii) the Executive Director is satisfied, having considered all information in the College's possession related to the member, including the member's history with the College, that there is no public benefit to maintaining the information on the register.

From: Jo-Ann Willson
Sent: Monday, November 09, 2015 5:18 PM
To: Rose Bustria
Subject: FW: Information: Regulators' Nursing Exam
Attachments: NCLEX - Briefing Note - OTHER STAKEHOLDERS - FINAL.pdf

Council.

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From: Caruso, Laura [lcarus@cnomail.org]
Sent: Monday, November 09, 2015 3:21 PM
To: Caruso, Laura
Cc: 'boriordan@casipo.com'; Smith, Felicia; Jo-Ann Willson; 'ltaylor@cdho.org'; 'jrigby@cdto.ca'; Fefergrad, Irwin; 'abuahene@denturists-cdo.com'; 'melisse.willems@collegeofdietitians.org'; 'brenda.kritzer@coko.ca'; 'corinne.flitton@cmt.com'; Wilkie, Kathie; Gough, Linda; Adams, Deborah; 'elarney@coto.org'; 'fkhan@coptont.org'; 'PGarshowitz@collegeoptom.on.ca'; 'mmoleschi@ocpinfo.com'; Gerace, Dr. R.; 'stanchak@collegept.org'; 'rmorris@cpo.on.ca'; 'taylor@crto.on.ca'; 'cristina.decaprio@ctcmpao.on.ca'; 'Basil.ziv@collegeofhomeopaths.on.ca'; 'andrew.parr@collegeofnaturopaths.on.ca'; 'j.rowlands@crpo.ca'; 'bpatterson@cou.on.ca'; 'sdeluca@fanshawec.ca'
Subject: Information: Regulators' Nursing Exam

Please see the e-mail below sent on behalf of Anne Coghlan, Executive Director and CEO of the College of Nurses of Ontario:

I am writing to provide you with information about the regulatory exam being used by the College of Nurses of Ontario (CNO). Misinformation is circulating in parts of the nursing community about the exam – known as the NCLEX-RN – which is used by CNO and other provincial and territorial nursing regulators as part of their assessment of applicants to the nursing profession.

The attached document provides you with background on the purpose of this exam, and how and why it was selected. The document corrects the misinformation around the use of this exam and the exam's

1004 content. In particular, it addresses the misconception that the exam content is "American," clarifies the content being tested, and explains the process by which the exam is translated into French.

The document also discusses the role of the CNO in testing applicants and its accountability to the public to ensure nurses are safe to practice.

This information has also been provided to the Ministry of Health and Long Term Care, the Ministry of Training, Colleges and Universities, and the Office of Francophone Affairs.

As regulators, we look for opportunities with government, educators, employers, nursing associations, students, and the public to share knowledge and collaborate to improve public safety as it relates to nursing care.

Please contact me if you have any questions about the exam or require further information.

Sincerely,

Anne L. Coghlan, RN, MScN
Executive Director & CEO
College of Nurses of Ontario
101 Davenport Road
Toronto, Ontario M5R 3P1
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Thank you.

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Merci

INFORMATION:

Regulators' Nursing Exam



COLLEGE OF NURSES
OF ONTARIO
ORDRE DES INFIRMIÈRES
ET INFIRMIERS DE L'ONTARIO

THE STANDARD OF CARE.

1005

SUMMARY

- As the province's nursing regulator, the College of Nurses of Ontario (CNO) is accountable to the public to ensure that nurses have the knowledge, skill and judgment to practise safely. As part of a robust set of requirements an applicant must meet to become a nurse in Ontario, CNO requires those applying to practice to have passed a regulator-selected and approved exam.
- In January 2015, CNO and other provincial/territorial Registered Nurse (RN) regulators began using the National Council Licensure Examination for Registered Nurses (NCLEX-RN). The decision to use this exam was based on extensive research on the requirements needed by RNs entering the profession, a thorough business case and a reviewed RFP process.
- The NCLEX-RN is a computer-adaptive test (CAT) which replaced a pen-and-paper exam. A CAT exam provides more rigour and security in our testing process. Also, it is offered throughout the year, allowing those who pass to obtain results quickly and therefore begin their nursing careers sooner.
- As the regulator, our requirement for this entry-to-practice exam is not to test all that educators have taught in their 4-year curriculum. The NCLEX-RN is an accurate and valid test for basic skills, knowledge and judgment needed by RNs in the first year of their career. These competencies are neither "American" nor "Canadian." The exam is not testing the writer's knowledge of a particular health care system, history or legislation. Testing for such knowledge is not the purpose of the NCLEX-RN.
- As part of our ongoing monitoring and in response to some stakeholders' concerns, we have completed due diligence with the exam regarding "American" content, testing for competencies and accuracy of the French translation. Our thorough reviews confirm that the exam is free of problems in these areas.
- Canadian nurses, including clinical educators, participated in reviewing all NCLEX-RN content in use. They continue to participate in the exam's review and development to ensure it meets the public's needs for safe nursing care and that it is testing for the current knowledge and skills needed by new nurses.
- The translation process and the steps taken to ensure equivalence of measurement between the anglophone and francophone populations is rigorous.
- Nursing applicants can attempt the entry-to-practice exam three times.
- People are passing the exam and becoming nurses. They are proving they're ready to be an integral part of the public's health care.
- The pass rates vary greatly across the province's nursing programs, but students from every nursing program are passing. We are trying to facilitate having schools share their best practices in exam preparation.
- CNO is closely monitoring the pass rates and other data related to the NCLEX-RN exam, and will continue to ensure any changes to the exam content are evidence-based and do not negatively impact public safety.

BACKGROUND

As the regulator of nursing practice in Ontario, the College of Nurses of Ontario (CNO) is responsible and accountable to the public for ensuring that nurses have the knowledge, skill and judgment to practise safely. It is the nurse regulator's role and authority to decide on and implement an entry exam that tests for specific competencies that Canadian nurses need to practice safely from their first day of practice. The regulator also must monitor the exam results to identify trends and areas for improvement or adjustment based on evidence and the impact on public safety.

CNO worked with other provincial and territorial regulators for over 10 years to find areas for improvement and ways to incorporate state-of-the-art best practices in an entry-to-practice exam. This review laid the foundation for a thorough business case and Request for Proposal (RFP) process that was reviewed by a third party. The process resulted in national nurse regulators choosing the NCLEX-RN as the exam that can best test RN applicants' readiness for entry to practice.

In late 2011, we announced to educators that we would be launching the NCLEX-RN on January 1, 2015, giving nursing programs three years to prepare students.

In Ontario and across the country, educators were given access to a number of resources with detailed information they needed to prepare students for the exam. These resources included: webinars, teleconferences, regularly updated FAQs, a quarterly NCLEX-RN newsletter, a series of face-to-face conferences organized by the National Council of State Boards of Nursing (NCSBN – the original developers of the exam) and CNO, and links to resources, such as test plans, information about computer-adaptive testing (CAT), exam preparation, and an online course — *Understanding the NCLEX*.

The translation process and the steps taken to ensure equivalence of measurement between the anglophone and francophone populations is rigorous. Translation of NCLEX-RN items is conducted by a Canadian company using federal translation standards. Translated items are reviewed by a translation panel consisting of three to six Canadian bilingual nurses. These nurses are required to be fluent in French and English, and practising in a bilingual facility or setting. Their participation is approved by the national nursing regulatory body (CCRN). Any items not approved by the translation panels are removed from the French version of the NCLEX-RN exam.

The process of administering the exam is handled by Pearson VUE, an international company headquartered in the U.S., which provides exams to millions around the world each year. In addition to administering the Graduate Management Admission Test (GMAT) and the Pharmacy College Admission Test (PCAT), used as part of the admission process of many Canadian education programs, Pearson also delivers exams for the Royal Colleges in the United Kingdom, the Health Authority Abu Dhabi and the European Board of Urologists, among others.

PURPOSE OF THE EXAM

The regulatory exam is part of a robust set of requirements applicants must meet to become a Registered Nurse. The NCLEX-RN accurately tests for the skills, knowledge and judgment needed by RNs starting their careers. Essential topics in the exam content include: pain management; medication

administration; basic care and comfort; safety and infection control; and, health promotion and maintenance —basic competencies that are the same regardless of where the nurse is located.

As the regulator, our requirement for this entry-to-practice exam is not to test all that educators have taught in their 4-year curriculum. The exam tests basic competencies taught in Canada’s nursing school programs.

The new exam has allowed regulators to establish more rigour and security in its testing to help ensure that the content of the exam is not compromised and that there is a comprehensive process to keep the content up to date with changing nursing practice.

VALIDITY OF THE EXAM

Exam questions are pulled from a large databank. Canadian nurses, including clinical educators, participated in reviewing the content for the NCLEX-RN currently in use. They continue to participate in its review and development to ensure it meets our needs as regulators.

Recently, we’ve heard claims from educators that writers were having to study “American” content, including such topics as the Food and Drug Administration and Obamacare.

To date, we have not received a concrete example of inappropriate “American” content in either the English or French exam. There is a process through which writers can bring such issues to our attention. If an example is brought to our attention, we will investigate.

We are aware of “American” content in prep courses being offered by third-parties and which are not associated with or endorsed by CNO or the exam provider.

The content of the exam is neither “Canadian” nor “American,” but about nursing competencies. It is not testing the writer’s knowledge of a particular health care system, history or legislation. Not only do such items vary by province and territory in Canada, but they vary across states in the U.S. While a nurse working in any specific jurisdiction would have to know about the health care system in which they are working, including about its legislation, testing for that is not the purpose of the NCLEX-RN.

Because it’s a test of the competencies deemed necessary for a Registered Nurse entering the profession to provide safe care, the same exam is used for Canadian and U.S. entry to nursing practice. Those basic competencies are the same regardless of where the nurse is located.

Due diligence: to ensure no “American content”

On Sept. 28, 2015, the exam’s administrator, Pearson VUE, completed a search of all NCLEX-RN items for any term that would bias the exam to American writers (e.g., USDA, Obamacare, Obama, FDA, Drug Administration, Affordable Care Act, and ACA). The findings indicated that none of these terms exist in the questions NCLEX-RN used for the exam this year.

A second, independent search of all item banks occurred on Oct. 1, 2015. The findings indicated no items include any overt or covert reference to the Food and Drug Administration and/or Obamacare.

Due diligence: French translation

Approach to item translation: All items that appear on an English version of the exam at any given period have been translated into French. We have not translated **all** of the NCLEX-RN items in the exam bank. This is because it would have required the immediate translation of thousands of items. The method we chose was to build an anglophone version of the NCLEX-RN and then translate the entirety of those items into French, thus ensuring identical items and measurement parameters.

Because the number of French writers remains small, we have not been able to conduct a thorough analysis of French writers' data. Data will be made available when we reach a sufficiently large enough number for the analysis to be valid and reliable. We have looked at French writers' response times to exam items and compared those times to the average response times of candidates taking the same items in English. We learned that the francophone examination candidate's response pattern is similar to most anglophone candidates who took the NCLEX-RN. The francophone examination candidate's response-time pattern is also similar to the average response-time pattern of first-time, anglophone candidates receiving the same items in English. In other words, no discernible relationship was found between the response times of francophone candidates writing the examination and the difficulty of items presented to them, suggesting that the translation is not impacting the measurement of the examination.

Due diligence on competencies tested

The Canadian Association of Schools of Nursing (CASN) recently released the following information resulting from a survey it conducted:

"One-third of the competencies expected of a Canadian nurse are not addressed at all by the NCLEX-RN and over a quarter are only partially tested. This represents more than half of the competencies," explains Dr. Cynthia Baker, Executive Director of CASN. "Examples of what is missing include nursing activities reflecting national guidelines related to patient safety, interprofessional collaboration, client-centred care, and cultural safety, each of which is an essential element of patient safety in the Canadian context. By the same token, many activities listed in the NCLEX-RN test plan aren't among the required entry-to-practice competencies."

The conclusion that the competencies are not addressed or only partially tested on the NCLEX-RN is inaccurate. For any process that grants approval for an RN to practice, it is essential to identify specific competencies that reflect the minimal knowledge, skills and abilities required of an RN to practice safely. To ensure the NCLEX-RN would be reflective of the Canadian national nurse competencies, in 2013 a comparative analysis was conducted of the RN Practice Analysis, the RN Knowledge, Skills, and Ability Survey (KSA), and the integrated processes outlined in the RN Test Plan.

The data indicates 93.10% of the Ontario RN competencies possessed a one-to-one relationship with an NCSBN activity statement, KSA statement or integrated process. Only two specific competency categories reflected the presence of less than 93% one-to-one relationships. Five competency categories were reported to have 100% one-to-one match across competencies. Those competency categories that reflected direct client care represented the largest overall percentage of one-to-one competency agreement between NCSBN and Canada nursing care.

The evidence from the analysis indicates that the NCLEX-RN is a suitable assessment of competencies taught in Canadian nursing educational programs.

PASS RATES

Nursing applicants can attempt the entry-to-practice exam three times.

People are passing the exam. Writers from every nursing program are passing, and many schools are showing high pass rates.

Preliminary pass rates were provided to educators in September, and reflected the first six months of data for the exam. This data cannot be accurately compared to former pass rates because:

- it measures different constructs;
- it includes a bias toward first-time writers;
- the computer adaptive testing (CAT) style is new to most Canadian students; and
- the number of writers at some schools was too small to provide significant analysis.

A lower-than-expected pass rate does not mean the exam is testing the wrong competencies.

DETAILED DATA AVAILABLE IN NOVEMBER 2015

In mid-November 2015, educators who have subscribed to them, will have access to in-depth reports about the pass rates of NCLEX-RN exam writers who are graduates of their programs. These reports describe how each program's graduates performed on several content dimensions compared against other programs both provincially and nationally.

The ***NCLEX-RN Test Plan Report*** presents information on the percentile ranks of the RN nursing program's typical graduate's performance compared to the performance of:

1. graduates from Ontario,
2. graduates from the same type of educational program, and
3. the national population of graduates.

The **Content Dimension Reports** are broken out as follows:

- Nursing Process
- Categories of Human Functioning
- Categories of Health Alterations
- Wellness/Illness Continuum
- Stages of Maturity
- Stress, Adaptation and Coping

The **Test Duration Report** includes the average number of questions taken by graduates in the program, graduates from Ontario, graduates from similar programs nationwide, and all graduates nationwide. The number of candidates includes all candidates except those testing under extended-timing conditions and/or completing less than the minimum number of items. This report also provides the average test time in minutes and the percentage of candidates taking the minimum and maximum number of questions.

The **Test Plan Performance Report** includes information on performance in each of the Client Needs subcategories for the program's graduates, graduates from the same jurisdiction, graduates from similar programs nationwide, and all graduates nationwide, as well as an indication of how a candidate precisely at the passing standard would have performed (passing performance). This differs from the Test Plan Report in that performance here is defined with respect to the content domain, rather than in comparison with performance of other graduates.

FIRST YEAR OF EXAM RESULTS RELEASED TO PUBLIC IN 2016

In the first quarter of 2016, CNO will be releasing to educators and posting on our website the pass rates for the first year of the exam (January to December 2015). This information will also include the pass rates of each nursing program.

NEXT STEPS

Although the data is preliminary, the reality is some programs will continue to have higher pass rates than others, as was the case with the previous exam. We don't know all the reasons for the variance between programs, but we are trying to facilitate having schools share their best practices in exam preparation.

We have reached out to stakeholders to continue to correct the misinformation that is circulating about the exam.

As regulators, we look for opportunities with government, educators, employers, nursing associations, students, and the public to share knowledge and collaborate to improve public safety as it relates to nursing care.

ITEM 6.9

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L'ORDRE DES PSYCHOLOGUES DE L'ONTARIO
THE COLLEGE OF PSYCHOLOGISTS OF ONTARIO

1011

APPOINTMENT OF DR. RICK MORRIS AS REGISTRAR AND EXECUTIVE DIRECTOR

The Council of College of Psychologists of Ontario is pleased to announce the appointment of Dr. Rick Morris, C.Psych. as Registrar and Executive Director of the College effective November 1, 2015.

Rick served as Deputy Registrar/Director, Professional Affairs with the College for many years and most recently had undertaken the role of Acting Registrar. He brings to the position his wealth of knowledge and experience in both the regulation of psychology in Ontario and the professional issues which arise for members in practicing the profession. His expertise in these areas is recognized not only in Ontario, but by regulators across Canada and in the United States. Rick is well known among the membership for his role as Practice Advisor and the many workshops and seminars he presents.

Please join us in welcoming Rick to his new role as Registrar and Executive Director.

Peter McKegney, President

The Council of the College of Psychologists of Ontario

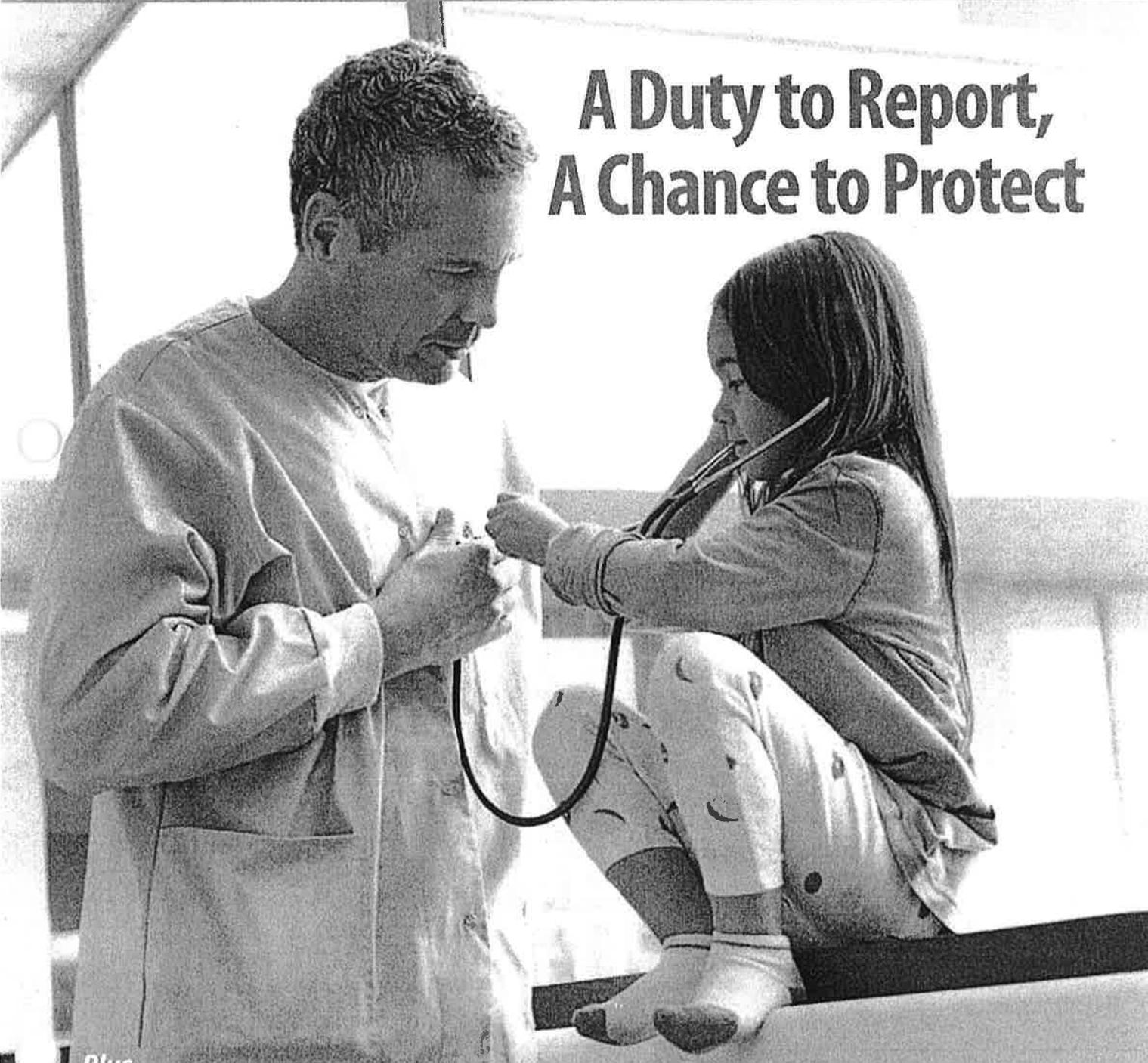
MD Dialogue 1012

ITEM 6.10

Volume 11, Issue 3, 2015

College of Physicians and Surgeons of Ontario

www.cpso.on.ca



A Duty to Report, A Chance to Protect

Plus

Top 10 Infection
Control Breaches

New End-of-Life
Care Policy

Why Hiring Patients
is Not Advised

Proposed enhancements for program that funds therapy

The College's Patient Relations Program is just one of the important ways in which the College supports survivors of sexual abuse, and advances its goal of preventing sexual abuse of patients. Providing patients who have been sexually abused with funding for therapy/counseling is one of the main components of this program.

This program, including the applications for funding, is administered by the College's Patient Relations Committee (PRC). Requirements for the funding program are set out in legislation.

In the last five years, the PRC has paid out an average of \$51,000 per year to therapists/counsellors of eligible applicants. The majority of the therapy/counseling is paid via the College's general revenue – approximately 93%. In cases where there is a Discipline Committee finding, the Committee can order a physician to post a letter of credit to make the physician responsible for paying for the therapy/counseling which is to be used by the eligible applicant. However, if the Committee does order a letter of credit, the physician may not always comply.

A person can be eligible for funding whether or not there is a Discipline Committee finding. In fact, the majority (57%) of applications for funding approved by the PRC were in the absence of or prior to a Discipline Committee finding, but fulfilled the eligibility criterion where sufficient evidence was presented to the PRC to support a reasonable belief that the person, while a patient, was sexually abused by a physician.

RHPA Provisions

Council has directed that the College seek amendments to the legislation, including expanding the eligibility criteria to allow persons other than patients to access the funding in certain circumstances and increasing the maximum amount of funding that can be granted to patients.

Currently, the legislation states that only patients who are sexually abused by their physicians are eligible for funding. Council has directed the College to seek an amendment which would expand the eligibility criteria for funding to include sexual abuse that occurs between physicians acting in a professional capacity and persons over whom physicians occupied positions of trust or power ("non-patients"). It is proposed that this includes: former patients, persons closely associated with patients (as defined in the College's **Maintaining Appropriate Boundaries and Preventing Sexual Abuse** policy), and persons in an employment relationship with the physician.

This proposed change is based on the notion that a power imbalance can exist not only between physicians and patients, but also between physicians and non-patients in certain circumstances where physicians are acting in a professional capacity and occupy a position of trust or power over the person. Should sexual abuse occur between physicians and non-patients in these circumstances, it may raise the same concerns as when patients are sexually abused, such as, breach of trust and risk of exploitation and harm. As such, non-patients would also benefit from funding for therapy/counseling to help address the harm that was caused by the physician sexual abuse.

1014


**RHPA
Provisions**

Council also directed the College to seek an amendment which would increase the maximum amount of funding that can be awarded.

The legislation currently states that the maximum amount of funding that may be awarded is the amount that OHIP would pay for 200 half-hour sessions of individual outpatient psychotherapy with a psychiatrist. As such, the current maximum is \$16,060.

The proposed amendment would allow eligible applicants to apply for more funding once they have exhausted the funding they have been awarded. The legislation could provide the PRC with the discretion to grant up to the current maximum amount of funding again after reviewing a second application for funding.

Council also directed the College to seek other legislative changes, including:

- Explicitly stating that eligibility for funding is not affected by an appeal from a criminal conviction.
- Ensuring the legislation reflects the College's current practices of not reducing the overall amount of funding granted where

the eligible applicant has private insurance coverage and allowing eligible applicants to use their funding past the five-year time limit in the current legislation.

- Creating exceptions to the requirement to keep confidential all information obtained through the application for funding process. The exceptions would allow the disclosure of limited funding information to: the therapist/counsellor, persons involved in facilitating access to the therapy/counselling, and others for the purpose of facilitating access to alternate sources of funding (e.g. Criminal Injuries Compensation Board).

In addition, Council supports expanding the program by providing the PRC with the discretion to permit patients to use a portion of their funding to cover costs related to accessing therapy/counselling. This would include funding for medication, childcare during therapy/counselling appointments, and reasonable travel/accommodation if the therapist/counsellor is not locally situated. 

College to scrutinize use of GBRs more closely

Gender-based restrictions found to be a useful tool in certain circumstances



Processes & Practices

Council has adopted a more rigorous approach to the use of gender-based restrictions on a physician's practice. This is intended to ensure a heightened scrutiny of the appropriateness of such restrictions in a particular matter.

Whenever a gender-based restriction is under consideration, Council has endorsed a set of factors to be uniformly applied to guide this analysis.

Gender-based restrictions (GBRs), both chaperones and absolute restrictions, have been used by the College as a means of protecting patients when a physician is either alleged to have engaged in sexual misconduct or has been found to have done so.

The presumption has been that where a physician is alleged to have engaged in sexual misconduct with a patient of one gender, either preventing future contact with patients of that gender or requiring that all future contact be supervised will help protect patients from harm.

These restrictions are often imposed by other bodies as well – such as other health regulatory colleges and the criminal courts.

After an analysis of the issue, Council directed that a set of factors be used to guide any decision to accept or order GBRs on a physician's certificate.

These factors would include careful consideration of the powers available to the College at that particular stage of the proceeding, the

Factors include careful consideration of the powers available at that particular stage of the proceeding, the facts of the matter, the history of the matter and the history of the physician.

facts of the matter, the history of the matter and the history of the physician.

GBRs have been the subject of particular scrutiny recently. Some have criticized the College for failing to remove a physician from practice when the physician is facing allegations of misconduct, even where there has been no finding. Others have criticized gender-based restrictions because of the perception that they are not sufficiently punitive – the physician maintains his or her privilege to be a member of the profession and can continue to earn a living through the publicly funded health-care system.

Others argue that GBRs do not sufficiently mitigate the risk of harm to patients for a variety of reasons, including that patients of the other gender will still be exposed to the physician or the physician cannot be trusted to abide by the restriction. There is also concern that chaperones may not always be in a position to carry out their role properly.

The College is responding to some of these concerns by evaluating and improving its processes with respect to choosing and monitoring chaperones, and also by enhanced monitoring of physicians who are subject to GBRs.

During its most recent meeting, Council heard of other alternatives to GBRs that address the risk of harm to patients – i.e., video-

Supporting patients: New protocol for initiating police contact

A recently approved internal policy sets out the circumstances in which the College may exercise its discretion to share information with the police about physicians who may have committed a criminal act.

Under the new policy, in certain circumstances, the College will proactively advise the police of suspected criminal behaviour even without the patient's consent.

Under the policy, College will:

- suggest to the individual who provided that information that he/she may wish to contact the police to file a report;
- offer to assist that individual with the filing of a report; and
- advise the individual that the College may initiate a report to the police if there are reasonable grounds to believe that a physician has committed a criminal act(s) and patients or the public may be harmed and reporting to the police could reduce the risk of future harm.

The report will include the physician's name and mailing address and a summary of the relevant allegations or documents redacted for confidentiality. Because of confidentiality restrictions imposed on the College by its governing legislation, unless the complainant consents to the inclusion of his/her name, the name of the complainant will be blacked out in a report to the police, along with any other information about a person other than a physician.

On public release of the College's Discipline Committee decisions, any matter that raises issues of physician criminal actions will be reported to the police by forwarding a copy of the public decision.

Have You Written A Book?

ITEM 6.11

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We'll Find A Publisher For You in 3 Easy Steps. Start Now!

1017

NATIONAL POST

October 25, 2015

Ontario newborn bleeds to death after family doctor persuades parents to get him circumcised

By Tom Blackwell

Ryan Heydari's parents say the regulators who handled their complaints have shed little light on what led to Ryan's death – or how to prevent...

TORONTO - An Ontario doctor has been cautioned after a 22-day-old baby bled to death from a circumcision gone horribly wrong, underscoring the heated debate over a simple yet contentious procedure.

Another physician involved in the case was urged by a medical governing body to be "mindful" of the operation's dangers.

But Ryan Heydari's parents say the regulators who handled their complaints have shed little light on what led to Ryan's death – or how to prevent similar tragedies in future.

They say they did not even want the newborn circumcised - a view in line with longstanding recommendations from the Canadian Pediatric Society - but were persuaded to do so by a family physician.

"We are so shocked that we will not have an answer to bring us some peace for our broken hearts, to prevent other cruel deaths like Ryan's and to ensure that doctors take proper care of their patients," mother Homa Ahmadi told the National Post.

In fact, the case only became public because the couple appealed the original Ontario College of Physician and Surgeons rulings, which were rendered in secret.

An appeal tribunal upheld this month a decision by the College to caution the doctor who saw Ryan in the emergency department hours after his circumcision, his diaper stained red with blood.

The Health Professions Appeal and Review Board also confirmed the college's separate advice to the pediatrician who conducted the procedure to be aware of its potential hazards, and document his efforts to get informed consent.

1018

We are so shocked that we will not have an answer to bring us some peace for our broken hearts, to prevent other cruel deaths

The pediatric society said in a recent report that death from bleeding caused by circumcision is "extremely rare," though it's not completely unheard of. A five-week-old B.C. baby bled to death after being circumcised in 2003.

Ahmadi gave birth on Jan. 3, 2013 to a boy who loved attention, cried relatively little and seemed to actually smile. "He gave us the most amazing moments of our life," says Ryan's mother.

She and husband John Heydari, who immigrated from Iran about 12 years ago, opposed having him circumcised, convinced that "mother nature created us the way she intended us to be."

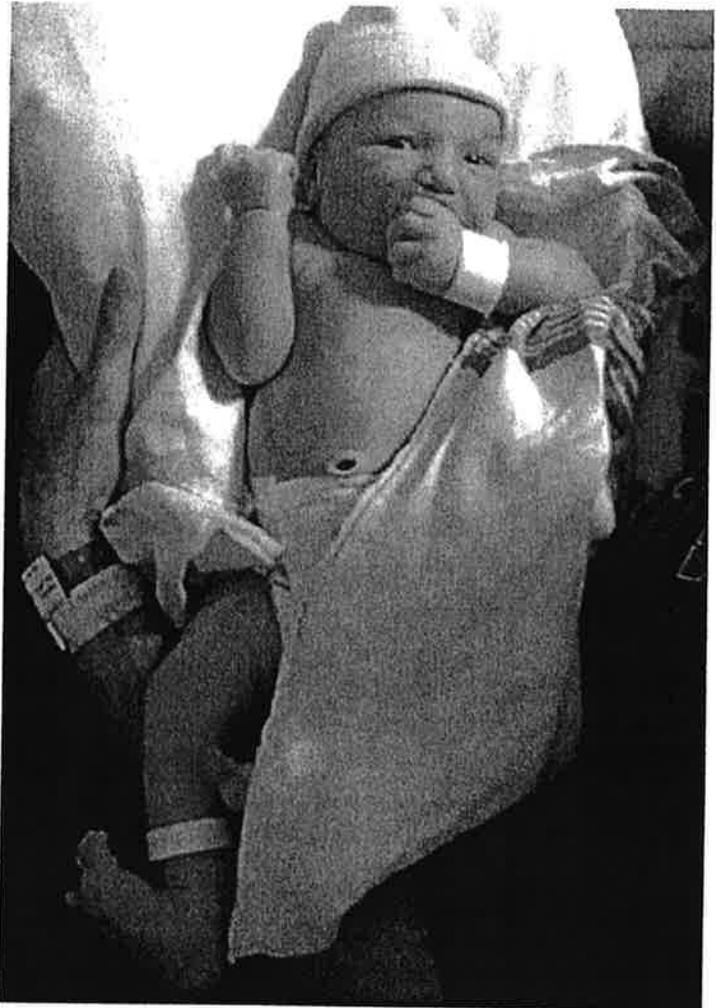
But their family physician persuaded them it was a good idea for medical reasons, despite contrary advice from pediatric specialists.

Once carried out on most Canadian boys and still common as a religious rite for Jews and Muslims, circumcision has generally fallen in popularity, rates hovering around 32 per cent.

The pediatric society has long held that its risks – including pain to a small baby, bleeding and the chance of disfigurement of the penis – outweigh its benefits.

The group revisited the issue with a report just last month that addressed growing evidence circumcision helps prevent sexually transmitted disease, acting almost like a vaccine in countries with high rates of HIV.

Circumcised boys are also less likely to suffer urinary-tract infections



Handout Newborn Ryan Heydari before a routine circumcision led to heavy bleeding and his death.

and to develop rare penile cancer later in life, the society says.

But its report still recommended against routine circumcision of every newborn male, saying that it may make sense in certain cases. For those who have the procedure, "close follow-up in the early post-circumcision time period is critical," the society warns.

One urologist says he has encountered a few cases where circumcised babies had to undergo transfusions because of dangerous bleeding, and sees less-serious complications routinely.

Handout Homa Ahmadi and John Heydari.



Dr. Jorge DeMaria of Hamilton's McMaster University believes regulators should require doctors to prove they have undergone proper training before doing circumcisions. He also questions circumcising newborns for preventive-health reasons, in a country with low levels of HIV and wide availability of condoms.

It was so obvious from the blood his tiny body had lost that he was in danger

"In our setting, in North America, really it's not necessary."

Ahmadi says she and her husband knew almost immediately after their son's procedure that something was seriously wrong.

The previously unfussy baby "was crying so much, so hard, and he wouldn't stop," she recalled in written answers to questions. "He was bleeding, and it only got worse over just hours ... It was so obvious from the blood his tiny body had lost that he was in danger."

The pediatrician who did the circumcision told the College he conducts many of them, that Ryan's was uneventful and there was no bleeding when he checked the dressing before the family left.

1020



Handout Homa Ahmadi gave birth on Jan. 3, 2013 to a boy who loved attention, cried relatively little and seemed to actually smile.

The parents called about bleeding later that day, though, and he advised them to take Ryan to Toronto's North York General Hospital, which they did.

"We ... waited for care that could have saved his life, but that level of care never came," says Ahmadi.

A sparse outline in the board's decision says Ryan was eventually transferred to Sick Kids hospital, but died there seven days later. Pathologists said he succumbed to "hypovolemic shock" caused by bleeding from the circumcision, which emptied his body of 35 to 40 per cent of its blood.

The doctor at North York General - whose name has been withheld according to College policy - was cautioned for failing to recognize the seriousness of the boy's condition or treating "compensated shock" - the first stage of the condition.

We hope that this never happens to any other baby

But the process left the family little further ahead in fathoming how Ryan could have died, said Brian Moher, their lawyer.

"My clients felt that there was a big gap in what the College had done with the investigations, essentially missing the point around the infant's death."

The devastated parents, meanwhile, have not had other children.

"The loss of Ryan, our only child, has made us realize that we can't possess anything, even our hopes and dreams," Ahmadi says. "We hope that this never happens to any other baby."

National Post

tblackwell@nationalpost.com¹



October 15, 2015

ITEM 6.12

The Registrars and Directors of Professional Practices of:

College of Chiropractors of Ontario

College of Chiropractors of Ontario

College of Massage Therapists of Ontario

College of Nurses of Ontario

College of Occupational Therapists of Ontario

College of Physiotherapists of Ontario

Royal College of Dental Surgeons of Ontario

College of Physicians and Surgeons of Ontario

College of Naturopaths of Ontario

College of Kinesiologists of Ontario

College of Dental Hygienists of Ontario

College of Medical Laboratory Technologists of Ontario

College of Medical Radiation Technologists of Ontario

College of Respiratory Therapists of Ontario

College of Opticians of Ontario

Derek Cheung, Policy Advisor - Regulatory Policy Unit Health System Labour Relations &
Regulatory Policy Branch, MOHLTC

Dr. Linda Rapson, MD, CAFCI

Danny Li, R.TCMP, R. Ac, PhD

Michael Arbutina, Blaney McMurtry

Joanne Pritchard-Sobhani, President, CTCMPAO

RE: Understanding the Scope of Practice of Traditional Chinese Medicine and Working Towards Integration with Western Medicine in Ontario

Dear Colleagues,

The College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario (CTCMPAO) cordially invites you to a Symposium. Our session will begin with a luncheon hosted by Registrar and CEO, Cristina De Caprio. We are pleased to announce the keynote address will be given by:

Speakers: Dr. Linda M. Rapson, MD, CAFCI
Danny Li, R. TCMP, R. Ac, PhD

Topic: The Integration of Traditional Chinese Medicine with Western Medicine:
Improving Patient Outcomes

The symposium will be held at the CTCMPAO office at 55 Commerce Valley Drive West, Unit 705, in Thornhill from 12 p.m. to 3 p.m. on **Monday, November 30, 2015.**

The luncheon will be followed by presentations and dialogue focused on the scope of practice and authorized controlled acts as defined in the *Traditional Chinese Medicine Act, 2006* for

1022

Traditional Chinese Medicine Practitioners and Acupuncturists. These discussions will also clarify, the exemption of select Health Regulatory Colleges for the purpose of performing acupuncture within the scope of practice of these Colleges. Our College Legal Counsel, Michael Arbutina of Blaney McMurtry, will be attending in order to answer questions regarding the application of governing legislation.

CTCMPAO has over 900 dual registrants from other Health Regulatory Colleges and we wish to share information about our scope of practice and invite your input on the development of a Standard of Practice for our Dual Registrants.

In an effort to foster inter-collaboration, and carry on the process of dialogue and information sharing, the CTCMPAO is pleased to provide this opportunity. Hopefully, the process of information sharing can extend far beyond the day's symposium.

Please RSVP to Michelle Yiu at michelle.yiu@ctcmpao.on.ca by November 23, 2015.

I look forward to hearing from you and I welcome any suggestions from you about how we can ensure a fulsome discussion.

Best regards,



Cristina De Caprio, LL.B.
Registrar & CEO
College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario



**COLLEGE OF TRADITIONAL CHINESE MEDICINE PRACTITIONERS AND
ACUPUNCTURISTS OF ONTARIO**

AGENDA

FOR the Symposium, to be held on November 30, 2015 from 12:00 a.m. to 3:00 p.m.
705- 55 Commerce Valley Drive West, Thornhill, ON L3T 7V9

Item	Time	Speaker
1. Registration, Meet and Greet and Lunch	12:00 p.m.	
2. Introduction	12:20 p.m.	Cristina De Caprio <i>Registrar and CEO</i>
3. TCM Scope of Practice, Controlled Acts, TCM Techniques, TCM Therapies and Protected Titles	12:30 p.m.	Cristina De Caprio <i>Registrar and CEO</i>
4. WHO Strategic Plan for Traditional Medicine	12:45 p.m.	Cristina De Caprio <i>Registrar and CEO</i>
5. The Integration of Traditional Chinese Medicine with Western Medicine: Improving Patient Outcomes	1:00 p.m.	Dr. Linda M. Rapson, MD, CAFCI <i>Assistant Professor, DFCM, University of Toronto</i> <i>Affiliate Scientist, Toronto Rehabilitation Institute</i> <i>Medical Director, Rapson Pain and Acupuncture Clinic</i> Danny Li, R. TCMP, R. Ac, PHD <i>Lead TCM instructor, University of Toronto</i> <i>Former TCM program manager, Ryerson University</i>
6. Questions and Answer/Open discussion	1:45 p.m.	Dr. Linda M. Rapson, MD, CAFCI <i>Assistant Professor, DFCM, University of Toronto</i> <i>Affiliate Scientist, Toronto Rehabilitation Institute</i> <i>Medical Director, Rapson Pain and Acupuncture Clinic</i> Danny Li, R. TCMP, R. Ac, PHD <i>Lead TCM instructor, University of Toronto</i> <i>Former TCM program manager, Ryerson University</i>
7. Developing Standards for Health Professionals Who are Dual Registrants	2:00 pm	Cristina De Caprio <i>Registrar and CEO</i>
8. Unauthorized Practice and Enforcement	2:20 p.m.	Michael Arbutina, <i>Legal Counsel, Blaney McMurtry</i>
9. Question and Answer/Open Discussion	2:45 pm	Cristina De Caprio <i>Registrar and CEO</i>

Rethinking Regulation in the UK

by Richard Steinecke
September 2015 - No. 199

Last month, a United Kingdom agency released a major report entitled “Rethinking Regulation”. The Professional Standards Authority (PSA) oversees statutory bodies that regulate health and social care professionals in the UK. The PSA developed the widely respected concept of “right touch regulation” in 2010. The report should be mandatory reading for regulators of all professions everywhere.

In the words of Harry Cayton, CEO of the PSA:

Regulation is asked to do too much - and to do things it should not do. We need to understand that we cannot regulate risk out of healthcare and to use regulation only where we have evidence that it actually works. Ironically, the regulations that are meant to protect patients and service users are distracting professionals from this very task.

The opening words of the report give a good indication of what the reader should expect:

The regulatory framework for health and care is rapidly becoming unfit for purpose.

Without reading the sources cited in its many footnotes, the report comes across as an opinion piece or guest editorial. Only a few examples are given to illustrate the assertions made, but many of the assertions will resonate with those involved in the regulation of professions.

For example, many readers will be able to relate to the report’s description of the evolution of professional regulation:

Each new organisation, and each new regulatory intervention, has been created in response to specific stimuli without the benefit of an overarching design, a controlling intelligence, or a coherent set of principles. Regulation, which under the current system is an instrument of law, is dependent on detailed primary legislation and therefore parliamentary timetables and legislative resources. It is slow and generally behind the trend, neither keeping pace with current changes nor anticipating future needs. It has led to a vastly complicated and incoherent regulatory system where the costs and benefits are unquantified and unclear.

Role of Regulators

The report’s first major discussion related to identifying the role of regulators, as well as the risks regulators are addressing. It discussed the evolution of professionalism shifting from the concept of autonomous, self-managing experts to the concept of a set of values, behaviours and relationships that underpin the trust the public has in the profession. As such, the regulator needs to clarify its focus and role and avoid “regulatory mission creep”. Regulators need to:

...redefine the outcomes that they are seeking to achieve, and rethink how they will do so, based on evidence of what works, and drawing on a wide range of research and data.

FOR MORE INFORMATION

This newsletter is published by Steinecke Maciura LeBlanc, a law firm practising in the field of professional regulation. If you are not receiving a copy and would like one, please contact: Richard Steinecke, Steinecke Maciura LeBlanc, 401 Bay Street, Suite 2308, P.O. Box 23, Toronto, ON M5H 2Y4, Telephone: 416-626-6897
Facsimile: 416-593-7867, E-Mail: rsteinecke@sml-law.com

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The report also states:

We should also be careful not to perpetuate the idea that the business of regulation is the elimination of risk as opposed to the reduction of harms. ... To eliminate all risk would probably also eliminate the possibility of any benefit for the patient ... [and] prevent beneficial innovation...

The report paraphrases Professor Malcolm Sparrow as saying “that the focus of regulation should move away from the efficient completion of process to a focus on the prevention of specific types of harm.”

Relationship between Professional and System Regulation

The next portion of the report contains an intriguing discussion of how the practice context and environment often influence the behaviour and competence of practitioners more so than professional standards promulgated and enforced by regulators. The report states: “It seems strange to us therefore that people are regulated separately from the systems and places in which they work.”

The report discusses some of the challenges of regulating both professions and systems and how such regulation works together. Controversially, the PSA suggested that while regulators should develop and promote compliance with professional standards, it was a mistake for regulators to take over the responsibility from practitioners and the workplace to achieve those standards or to become involved in pursuing continuous quality improvement:

Once a regulator becomes too intimately involved in putting improvement into effect it loses its objective and impartial advantage, ends up marking its own homework and being blamed more deeply for continuing problems. It also obscures achievement by pursuing continuous improvement rather than consistently measuring against a benchmark. It loses sight of the progress that has been made and becomes demoralised by the rediscovery of failure.

Supporting Professional Conduct

Another interesting section of the report addresses how regulators could creatively achieve their identified goals by such means as:

- Exploring preventative approaches to fulfilling professional standards;
- Using engagement techniques to help practitioners fulfill standards;
- Targeted regulation where feasible given human rights concerns (e.g., older workers);
- Transparent publication of data by or from practitioners (e.g., surgical outcomes); and
- Mobilizing others (e.g., other practitioners) to help achieve the regulator’s purposes.

Governance

The report also contains a brief description of governance strategies that the PSA found helpful including:

- Smaller sized Councils / Boards;
- Equal numbers of professional and public members on Councils / Boards; and

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A COMMENTARY ON LEGAL ISSUES AFFECTING PROFESSIONAL REGULATION

- Transparency of the appointment process (which assumes that they are not elected by members of the profession).

The Rethinking Regulation report can be found at: www.professionalstandards.org.uk.

Conclusion

The report ends with a summary of principles and a list of recommendations. The summary of principles includes:

Some important principles are becoming well established: these are the antiseptic power of transparency, a commitment to both personal and shared responsibility and a renewed engagement with patients and the public.

The recommendations include the following:

- A shared 'theory of regulation' based on right-touch thinking
- Shared objectives for system and professional regulators, and greater clarity on respective roles and duties
- Transparent benchmarking to set standards
- A rebuilding of trust between professionals, the public and regulators
- A reduced scope of regulation so it focuses on what works (evidence based regulation) ...
- A drive for efficiency and reduced cost which may lead to mergers and deregulation
- To place real responsibility where it lies with the people who manage and deliver care

Whether one agrees or disagrees, the report provides a fascinating discussion of the direction of professional regulation. In addition, it is full of pithy statements that will be quoted liberally by regulators for years to come.

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A COMMENTARY ON LEGAL ISSUES AFFECTING PROFESSIONAL REGULATION

Cozy Counsel

by Richard Steinecke
October 2015 - No. 200

Regulators tend to develop good working relationships with their legal counsel. Staff in particular who work regularly with counsel usually develop a friendly comradery. Where the regulator employs in-house counsel, the day to day contact can become even closer.

A problem can arise, however, where the board or members of adjudicative committees also develop close relationships that appear to go beyond the professional. In *DeMaria v Law Society of Saskatchewan*, 2015 SKCA 106 the Law Society used in-house counsel. As such, the counsel would regularly advise the Benchers (i.e., the Law Society's board of directors) and appear before Benchers when committees would sit in an adjudicative capacity.

Mr. DeMaria's application for membership was refused because of concerns about his suitability to be a member of the profession. There was a hearing in which evidence was heard. There was then an internal appeal to different Benchers. Mr. DeMaria was found to have failed to have demonstrated his suitability. He sought a further review by the courts.

The main issue before the Court of Appeal was whether Mr. DeMaria had established a reasonable appearance of bias. There were three main areas of concern. The first was that the chair of the hearing committee sent in-house counsel a copy of the hearing committee's final decision before it was sent to Mr. DeMaria and, at the same time, invited counsel to play golf. The Court concluded that, while it was

noteworthy that the decision was sent to one party before the other, it was not significant since the decision was final. In terms of the invitation to play golf, the Court said:

In my assessment, the relevant evidence is insubstantial and does not support a *reasonable* apprehension of bias, except—perhaps—to the 'very sensitive or scrupulous conscience'. Put another way, in the light of a *strong* presumption of impartiality and the institutional context at play here, the impugned conduct—a single flippant display of familiarity between a Bencher and the in-house counsel for the Law Society—simply would not demonstrate to a *reasonable* and *informed* person that the chairman had not been open to persuasion on the evidence and arguments presented in Mr. DeMaria's case.

A second concern was that the internal review panel had breakfast on the day of the review with in-house counsel and then in-house counsel stayed in the hearing room with the review panel for at least ten minutes after the review was finished. While concerned about the appearance that this created, the Court concluded:

In my assessment, the evidence, when considered *realistically* and *practically* in the institutional context of the matter, does not give rise to a *reasonable* apprehension of bias on the part of the Benchers.

The third concern was that one of the Benchers was a Facebook friend of in-house counsel. The Court was unconcerned with this circumstance:

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Lastly, in today's world, a reasonable and informed person would place little or no weight on the fact a Bencher is 'friends' on Facebook with the Law Society's in-house counsel. Without more, that unadorned fact is indicative of nothing more than the two individuals know each other, which would be presumed in any event from their respective offices within the corporate structure of the Law Society. This fact does not add anything to the balance.

The Court accepted that legal counsel could act as both counsel to the Benchers and as the regulator's counsel in adjudicative hearings before its committees. However, in those circumstances, board and committee members "should have been *particularly* keen to abstain at all times when acting as adjudicators from public displays of too-cosy familiarity with the Law Society's counsel, whether in-house or a retained private lawyer, in all administrative and disciplinary matters."

The appeal dealt with another allegation by Mr. DeMaria that the hearing committee's decision had been "doctored". This was based on suspicious aspects about the appearance of the decision and reasons. For example, there were multiple footers to various pages of the document. However, the Court accepted the explanatory evidence from the Law Society that there were formatting errors brought on by the use of different versions of word processing software. The only role of Law Society personnel in the document was administrative and clerical.

Yet the Court was critical of the Law Society, on this point, however, stating:

That said, I would strongly echo the Chambers judge's statement that the irregularities and concerns that underpin this ground of appeal "all raise legitimate concerns about the integrity of the process itself." The A&E Panel and the Law Society handled the A&E Panel's final decision in a sloppy manner. The evidence bears out an absence of impropriety, but the Law Society can take no pride in that result because it should not have had to prove an absence of impropriety at all.

While the Court did not find there was an appearance of bias, it indicated that the circumstances were suspicious enough that Mr. DeMaria was warranted in "fearlessly" raising them. Even though the Law Society succeeded in the appeal, it was not awarded costs.

The *DeMaria* case can be found at: www.canlii.org.

Council Member Terms as at October 14, 2015 ¹

ITEM 6.14

1029

Name	District	Date First Elected/Appointed	Date Re-elected/Reappointed	Date of Expiry of Current Term
<u>Elected Members</u>				
Dr. Liz Anderson-Peacock	3 (Central East)	April 2013	N/A	April 2016
Dr. Reginald Gates	5 (Central West)	April 2015	N/A	April 2018
Dr. Brian Gleberzon	4 (Central)	April 2007	April 2010 April 2013	April 2016
Dr. Cliff Hardick	6 (Western)	May 2011	April 2014	April 2017
Dr. Bruce Lambert	5 (Central West)	April 2014	NA	April 2017
Dr. Gauri Shankar	2 (Eastern)	April 2010	April 2013	April 2016
Dr. David Starmer	4 (Central)	April 2014	NA	April 2017
Dr. Pat Tavares	4 (Central)	April 2012	April 2015	April 2018
Dr. Bryan Wolfe	1 (Northern)	December 2008 (by-election)	April 2009 April 2012 April 2015	December 2017
<u>Appointed Members ²</u>				
Mr. Shakil Akhter	Toronto	May 7, 2008	May 7, 2011 May 7, 2014	May 6, 2017
Ms Georgia Allan	Smiths Falls	September 8, 2014	N/A	September 7, 2017
Ms Patrice Burke	Brantford	April 21, 2015	N/A	April 20, 2018
Ms Wendy Lawrence	Toronto	September 8, 2015	N/A	September 7, 2018
Ms Judith McCutcheon	Unionville	August 12, 2009	August 12, 2012 August 12, 2015	August 11, 2018
Mr. Scott Sawler	Ottawa	November 14, 2012	November 14, 2013	November 13, 2016
Vacant				

¹ Please advise Ms Rose Bustria a.s.a.p. if you are aware of any discrepancies.
² CCO requires at least 6 public members to be properly constituted.