COLLEGE OF CHIROPRACTORS OF ONTARIO

ELECTRONIC PUBLIC INFORMATION PACKAGE FOR COUNCIL MEETING

WEDNESDAY, FEBRUARY 26, 2020 – 8:30 A.M.

RHPA

Duties and Objects of Colleges

Duty of College

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

Objects of College

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

1. To regulate the practice of the profession and to govern the members in accordance with the health profession Act, this Code and the *Regulated Health Professions Act, 1991* and the regulations and by-laws.
2. To develop, establish and maintain standards of qualification for persons to be issued certificates of registration.
3. To develop, establish and maintain programs and standards of practice to assure the quality of the practice of the profession.
4. To develop, establish and maintain standards of knowledge and skill and programs to promote continuing evaluation, competence and improvement among the members.

4.1 To develop, in collaboration and consultation with other Colleges, standards of knowledge, skill and judgment relating to the performance of controlled acts common among health professions to enhance interprofessional collaboration, while respecting the unique character of individual health professions and their members.

5. To develop, establish and maintain standards of professional ethics for the members.
6. To develop, establish and maintain programs to assist individuals to exercise their rights under this Code and the *Regulated Health Professions Act, 1991*.
7. To administer the health profession Act, this Code and the *Regulated Health Professions Act, 1991* as it relates to the profession and to perform the other duties and exercise the other powers that are imposed or conferred on the College.
8. To promote and enhance relations between the College and its members, other health profession colleges, key stakeholders, and the public.
9. To promote inter-professional collaboration with other health profession colleges.
10. To develop, establish, and maintain standards and programs to promote the ability of members to respond to changes in practice environments, advances in technology and other emerging issues.
11. Any other objects relating to human health care that the Council considers desirable. 1991, c. 18, Sched. 2, s. 3 (1); 2007, c. 10, Sched. M, s. 18; 2009, c. 26, s. 24 (11).

Duty

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

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

MISSION

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

VISION

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

VALUES

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

STRATEGIC OBJECTIVES

1. Build public trust and confidence and promote understanding of the role of CCO amongst all stakeholders.

2. Ensure the practice of members is safe, ethical, and patient-centered.

3. Ensure standards and core competencies promote excellence of care while responding to emerging developments.

4. Optimize the use of technology to facilitate regulatory functions and communications.

5. Continue to meet CCO's statutory mandate and resource priorities in a fiscally responsible manner.

Developed at the strategic planning session: September 2017

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

Executive Committee
Approved by Council: September 28, 2012
Amended: February 23, 2016, April 19, 2016, September 15, 2016
Re-Affirmed by Council: November 29, 2018

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

1. be familiar and comply with the provisions of the *Regulated Health Professions Act, 1991 (RHPA)*, its regulations and the *Health Professions Procedural Code*, the *Chiropractic Act 1991*, its regulations, and the by-laws and policies of the College;

2. diligently take part in committee work and actively serve on committees as elected and appointed by the Council;

3. regularly attend meetings on time and participate constructively in discussions;

4. offer opinions and express views on matters before the College, Council and committee, when appropriate;

5. participate in all deliberations and communications in a respectful, courteous and professional manner, recognizing the diverse background, skills and experience of members on Council and committees;

6. uphold the decisions made by Council and committees, regardless of the level of prior individual disagreement;

7. place the interests of the College, Council and committee above self-interests;

8. avoid and, where that is not possible, declare any appearance of or actual conflicts of interests[1];

9. refrain from including or referencing Council or committee positions held at the College in any personal or business promotional materials, advertisements and business cards;[2]

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

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

10. preserve confidentiality of all information before Council or committee unless disclosure has been authorized by Council or otherwise exempted under s. 36(1) of the *RHPA*;

11. refrain from communicating to members, including other Council or committee members, on statutory committees regarding registration, complaints, reports, investigations, disciplinary or fitness to practise proceedings which could be perceived as an attempt to influence a statutory committee or a breach of confidentiality, unless he or she is a member of the panel or, where there is no panel, of the statutory committee dealing with the matter;

12. refrain from communicating to members and stakeholder[3] on behalf of CCO, including on social media, unless authorized by Council[4];

13. respect the boundaries of staff whose role is not to report to or work for individual Council or committee members; and

14. be respectful of others and not engage in behaviour that might reasonably be perceived as verbal, physical or sexual abuse or harassment.

Potential Breaches of the Code of Conduct

15. An elected or appointed member of Council or non-Council committee member who becomes aware of any potential breach of this code of conduct should immediately advise the President and Registrar, or if the potential breach involves the President, advise the Vice President and Registrar; and

16. Potential breaches will be addressed first through informal discussion with the Council member(s) or non-Council committee member(s), and subsequently by written communication expressing concerns and potential consequences.

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

Signature: ____________________ Witness: ____________________

Date: ____________________

[3] Stakeholders include professional associations, societies, and other organizations related to the regulation, education and practice of chiropractic.
[4] This does not preclude Council members from communicating about CCO, provided they are not communicating on behalf of CCO.

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

1. In this Schedule, "member" means a council member.

2. Each agenda topic will be introduced briefly by the person or committee representative raising it. Members may ask questions of clarification, then the person introducing the matter shall make a motion and another member must second the motion before it can be debated.

3. When any member wishes to speak, he or she shall so indicate by raising his or her hand and shall address the chair and confine himself or herself to the matter under discussion.

4. Staff persons and consultants with expertise in a matter may be permitted by the chair to answer specific questions about the matter.

5. Observers at a council meeting are not allowed to speak to a matter that is under debate.

6. A member may not speak again on the debate of a matter until every council member who wishes to speak to it has been given an opportunity to do so. The only exception is that the person introducing the matter or a staff person may answer questions about the matter. Members will not speak to a matter more than twice without the permission of the chair.

7. A member may not speak longer than five minutes upon any motion except with the permission of Council.

8. When a motion is under debate, no other motion can be made except to amend it, to postpone it, to put the motion to a vote, to adjourn the debate of the council meeting or to refer the motion to a committee.

9. A motion to amend the motion then under debate shall be disposed of first. Only one motion to amend the motion under debate can be made at a time.

10. When a motion is on the floor, a member shall make every effort to be present and to remain in the room.

11. When it appears to the chair that the debate in a matter has concluded, when Council has passed a motion to vote on the motion or when the time allocated to the debate of the matter has concluded, the chair shall put the motion to a vote and no further debate is permitted.

12. A member is not entitled to vote upon any motion in which he or she has a conflict of interest, and the vote of any member so interested will be disallowed.

13. Any motion decided by the Council shall not be re-introduced during the same session except by a two-thirds vote of the Council then present.

14. Whenever the chair is of the opinion that a motion offered to the Council is contrary to these rules or the by-laws, he or she shall rule the motion out of order and give his or her reasons for doing so.

15. The chair shall preserve order, etiquette and decorum, and shall decide questions of order, which include addressing any distractions that interfere with the business of the meeting, subject to an appeal to the Council without debate.

16. The above rules may be relaxed by the chair if it appears that greater informality is beneficial in the particular circumstances unless the Council requires strict adherence.

17. Members are not permitted to discuss a matter with observers while it is being debated.

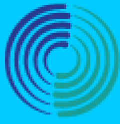
18. Members are to be respectful, courteous and professional while others are speaking.

19. In all cases not provided for in these rules or by other rules of Council, the current edition of Robert's Rules of Order shall be followed so far as they may be applicable.

List of Commonly Used Acronyms at CCO

as at September 2017

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



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

AGENDA

(Public) [1]

Wednesday, February 26, 2020 *(8:30 a.m. – 4:30 p.m.)* [2]

59 Hayden Street, Suite 800,
Toronto, M4Y 0E7
Council Room

Breakfast – 7:45 a.m. – 8:30 a.m. (Members' Lounge)

Photo Day [3]

Invited Guests

Beaconsfield, Government Relations Consultants, Presenting at 1:00 a.m.
Karen Jones, Paliare Roland (available at 1:45 p.m.)
Odette Soriano, Paliare Roland (available at 2:15 p.m.)

Attendees

Council members
Ms Jo-Ann Willson, Registrar and General Counsel
Mr. Joel Friedman, Director of Policy and Research
Ms Andrea Szametz, Recording Secretary

SECTIONS OF THE *CODE* FOR IN-CAMERA SESSIONS *IF* DIRECTED BY COUNCIL	Page No.	ITEM	Action Required	Action By	Priority Level [4]	Time [5]
		CALL TO ORDER		Mizel	***High***	***8:30 a.m.***

[1] If you would like the complete background documentation relating to any item on the agenda, please speak to Ms Willson (subject to confidentiality provisions).
[2] Subject to Council's direction.
[3] Photographer will be at CCO to take photos of Council and committees for 2019 Annual Report.
[4] Subject to Council's direction.
[5] Approximate (subject to Council's direction).

SECTIONS OF THE *CODE* FOR IN-CAMERA SESSIONS *IF* DIRECTED BY COUNCIL	Page No.	ITEM	Action Required	Action By	Priority Level [4]	Time [5]
		Parliamentarian [6]		All members	***Medium***	
		1. Consent Agenda	Approve	Council	***High***	
	9	1.1 Discipline Committee Report				
	10	1.1.1 CCO v Dr. Amalraj Sivapathasuntharam (Released, December 19, 2020)				
	16	1.2 Fitness to Practise Committee Report				
	17	1.3 Inquiries, Complaints and Reports Committee Report (ICRC)				
	18	1.3.1 Terri Fass and Dr. Chris Kraemer, (HPARB decision received December 16, 2019)				
	39	1.3.2 Ryan Armstrong and Dr. Kresimir Jug, (HPARB decision received, December 17, 2019)				
	47	1.3.3 Ryan Armstrong and Dr. Brian Nantais, (HPARB decision received December 18, 2019)				

[6] Council members to act as their own parliamentarian i.e. being familiar with and complying with the rules of order rather than formal appointment of Parliamentarian.

SECTIONS OF THE *CODE* FOR IN-CAMERA SESSIONS *IF* DIRECTED BY COUNCIL	Page No.	ITEM	Action Required	Action By	Priority Level [4]	Time [5]
	57	1.3.4 Jordan Himel and Dr. William Edwards, (HPARB decision, January 10, 2020)				
	72	1.4 Registration Committee Report				
		2. Adoption of Agenda	Adopt	Council	***High***	
		2.1 Conflict of Interest	Review/ Declare any real or perceived conflicts of interest as agenda item reached	Council	***High***	
		3. Adoption of Minutes [7]				
	74	3.1 November 28 - 29, 2019	Approve	Council	***High***	
		4. Committee Reports				
	100	4.1 Executive Committee Report	Report/ Approve Recom-menda-tions	Mizel/ Council	***High***	***9:00 a.m.***

[7] Only members present at the meeting should approve the minutes.

SECTIONS OF THE *CODE* FOR IN-CAMERA SESSIONS *IF* DIRECTED BY COUNCIL	Page No.	ITEM	Action Required	Action By	Priority Level [4]	Time [5]
		Old/Ongoing Business				
		Ministry of Health				
	136	4.1.4 CCO Link to Ministry bulletins re: Coronavirus				
	143	4.1.5 Bulletin dated February 19, 2020 re: Premier's Council on Improving Healthcare and Ending Hallway Medicine	FYI			
		Communications/Strategic Planning				
	151	4.1.7 President's Message – December 6, 2019	Review			
	161	4.1.8 Various Feedback re: President's Message	Review			
	171	4.1.9 President's Message – January 27, 2020	Review			
	174	4.1.10 Various Feedback re; President's Message	Review			
	182	4.1.11 CPSO Discipline decision suspending member for inappropriate social media	FYI			
	194	4.1.12 Newspaper reports re: suspensions for inappropriate social media				
		Elections	Verbal Report	Willson	Medium	
	202	4.1.13 Election Notice (distributed January 21, 2020)				
	214	4.1.14 Memo dated February 14, 2020 re: Close of Nominations				
	224	4.1.16 CV from Dan Faulkner	Verbal Report Election Review Committee	Friedman	Medium	

Sections of the *Code* for In-Camera Sessions *if* directed by Council	Page No.	ITEM	Action Required	Action By	Priority Level [4]	Time [5]
	233	4.1.19 G-009: Code of Ethics (current)	FYI			
	237	4.1.20 CV from Hanno Weinberger	FYI			
		Governance/Training Opportunities	Consider other opportune-ities	Council	Medium	
	359	4.1.29 CTV News dated January 21, 2020 entitled "*Animal chiropractic becoming more common place with Canadian pet owners*"				
		Chiropractic/Health Related Stakeholders	Primarily FYI (subject to questions)			
		Federation of Canadian Chiropractic (FCC)				
	390	4.1.32 Communication from Dr. Halowski dated January 13, 2020 re: Labour Mobility Guide for Canadian Regulators				
	396	4.1.34 Communication dated February 12, 2020 re: elimination of Billing Arrangements in British Columbia [8]	FYI			
		Canadian Chiropractic Examining Board (CCEB)				
	398	4.1.35 Communication dated February 11, 2020 re: speaking at CCO AGM	Invite?			
	399	4.1.36 Notification dated January 6, 2020 re: Survey prize winners	FYI			
		Federation of Chiropractic Licensing Boards (FCLB)				

[8] Full information to be included with Quality Assurance Committee agenda for review.

SECTIONS OF THE *CODE* FOR IN-CAMERA SESSIONS *IF* DIRECTED BY COUNCIL	Page No.	ITEM	Action Required	Action By	Priority Level [4]	Time [5]
	403	4.1.37 Information re: meeting April 21 – 24, 2020 [9]	FYI			
		Health Profession Regulators of Ontario (HPRO, formerly FHRCO)				
	412	4.1.38 Notification dated January 23, 2020 re: Novel Coronavirus	FYI			
	418	4.1.39 Notification re: Irwin Glasberg, Fairness Commissioner	FYI			
	420	4.1.40 Legislative Update (November, 2019, December 2019, January 2020)	FYI			
		Ontario Chiropractic Association	Verbal Report re: Dinner Meeting January 24, 2020	Mizel/ MacKay / Willson	Medium	
	444	4.1.43 Miscellaneous Bulletins	FYI			
		Canadian Chiropractic Association				
	521	4.1.45 Various bulletins/communiques [10]	FYI			
		Alliance for Chiropractic (AFC)	Verbal Report re: teleconference call January 29, 2020 and Dinner meeting February 25, 2020	Mizel/ MacKay / Willson	Medium	
	528	4.1.46 Various bulletins/communiques	FYI			

SECTIONS OF THE *CODE* FOR IN-CAMERA SESSIONS *IF* DIRECTED BY COUNCIL	Page No.	ITEM	Action Required	Action By	Priority Level [4]	Time [5]
		Canadian Chiropractic Protective Association (CCPA)				
	532	4.1.47 Communique dated January 20, 2020	FYI			

[9] Ms Willson will be attending as CCO delegate.
[10] New direction includes reference to NMSK.

		Break (Members' Lounge)				***10:00 a.m.***
	535	4.2 Advertising Committee Report	Report	Budgell	Medium	***10:15 a.m.***
	537	4.2.1 Advertising Committee Handbook (draft – February 26, 2020)	FYI			
	560	4.3 Patient Relations Committee Report [11]	Report/ Approve Recom-mendations	Bourdeau	High	***10:30 a.m.***
	562	4.3.1 Exchange with Rolph Schwartz	FYI			
		Quality Assurance Committee Report in separate yellow binder				
	1	4.4 Quality Assurance Committee Report	Report/ Approve Recom-mendations	Peterson	High	***10:45 a.m.***
		Re: Recommendation 1 (approve amendments to G-008: Business Practices)				
	6	4.4.1 G-008: Business Practices (draft with changes underlined/crossed out)	Approve			
	16	4.4.2 G-008: Business Practices (draft – clean copy)	Approve			
	26	4.4.3 G-008: Business Practices (current)	FYI			
	33	4.4.4 Memo re: amendments to G-008: Business Practices - draft (if approved by Council)	Approve			

[11] Time permitting, sample video will be shown.

	35	4.4.5	Memo dated June 2019 and G-008: Business Practices (revisions circulated to stakeholders including members)	FYI			
	45	4.4.6	Summary of feedback to on line survey re: proposed revisions to G-008: Business Practices	Review			
	140	4.4.7	Miscellaneous feedback re: proposed revisions to G-008: Business Practices [12]	Review			
	284	4.4.8	Petitions from public/patients re: proposed revisions to G-008: Business Practices	Review			
	697	4.4.9	Various feedback from chiropractic organizations	Review			
	725	4.4.10	Miscellaneous feedback from members re: Block Fees	Review			
	733	4.4.11	Information from other Canadian chiropractic regulators re: Block Fees/Payment Plans	FYI			
	740	4.4.12	Information from other Ontario health regulatory colleges	FYI			
	758	4.4.13	Extracts from CCO Annual Reports re: ICRC statistics	FYI			
	761	4.4.14	Sample ICRC decisions re: Block Fees/Payment Plans	FYI			
	828	4.4.15	Memos dated August 6, 2019 and September 19, 2019 from ICRC re: G-008: Business Practices	FYI			

[12] E-mail addresses have been redacted.

		Re: Recommendation 2: approve draft standard and guideline re: Health Care Claims etc.				
	830	4.4.16 S- ??? Health Care Claims in Advertising, Websites and Social Media (draft)	Approve for circulation and feedback			
	834	4.4.17 G-??? Health Care Claims in Advertising, Websites and Social Media (draft)	Approve for circulation and feedback			
	837	4.4.18 Memo re: draft Standard and Guideline re: Health Care Claims in Advertising, Websites and Social Media – draft (if approved by Council) with draft survey	Approve			
	842	4.4.19 Information from other Canadian chiropractic regulators re: advertising, websites and social media	FYI			
	919	4.4.20 RFP re: website and social media compliance (March 27, 2019)	FYI			
	922	4.4.21 Proposal from Guaranteed SEO dated May 3, 2019	FYI			
	936	4.4.22 Feedback re: tool	FYI			
	943	4.4.23 Feedback re: Peer Assessor Workshop (January 25, 2020)	Review	Council		
		Lunch (Members' Lounge)				***12:00 Noon***
		Potential in camera items in separate red binder				

Ss. 7 (2)(a) (b)(c) (d)(e)		**5. Potential In Camera Items [13]**				***1:00 p.m.***
		Move out of Camera and Ratify Decisions				
		Break If Required (Members' Lounge)				***2:30 p.m.***
		6. New Business				
	566	6.1 Information re: FSRA – FHRCO Collaboration Discussion January 31, 2020	Verbal Report	Friedman	Medium	***2:45 p.m.***
		7. For Your Information [14]	FYI (subject to questions)			
	581	7.1 Bergquist, Life Chiropractic College West, *Perspective on chiropractic Research in Canada* (2019)				
	585	7.2 Communication from Dr. Simon re: Chiropractic Report (2011), Dr. Brown				
		College of Medial Radiation and Imaging Technologists of Ontario				
	596	7.3 Announcement dated January 3, 2020 re: changes				
		Ontario College of Pharmacists				
	606	7.4 Briefing Note dated September 2019 re: competence-based elections				
		Ontario College of Teachers (OCT)				

[13] Subject to direction from Council. Council may go in camera to discuss items identified in Ss. 7 (2) of the Code, such as financial matters, property acquisitions, litigation and legal advice (including government relations).

[14] The FYI section has been pared down considerably. On a go forward, if members/individuals want information included for Council, they should include the public interest rationale i.e. how is the article/information relevant to CCO's public interest mandate?

	610	7.5 *OCT v Ahmed Bouragba* (2019) (Ont. Court of Appeal) [15]				
	625	7.6 Extract from 2019 Auditor General's Report re: Ministry of Health/CNO etc.[16]				
	683	7.7 Grey Areas – January 2020 The Trouble with Awards				
	685	7.8 *Canada (Minister of Citizenship and Immigration) v Vavilov* (2019) (SCC) [17]				
	692	7.9 BMC, J. Keith Simpson, *At-risk advertising by Australian chiropractors and physiotherapists* (2019)				
	709	7.10 Council Member Terms				
		DATE AND TIME OF MEETINGS [18]				

[15] The OCT sued a member and a former member of Council for defamation. The defendants' motion to dismiss the statement of claim was dismissed (matter going to trial).
[16] Reflects government's commitment to evaluating organizations to ensure performance is consistent with mandate.
[17] The standard of review is relevant to Discipline Committee decisions.
[18] Please mark your Calendar and Advise Rose Bustria ASAP if you are unable to attend any meetings.

Executive Committee Meeting Dates to December 2020

All Executive Committee meetings are at CCO and are scheduled from ***8:30 a.m. – 4:00 p.m.*** unless otherwise noted.

Year	Date	Time	Event	Location
2020	Thursday, March 12	8:00 a.m. – 3 p.m.	Meeting	CCO
	Tuesday, May 12	8:30 a.m. – 4 p.m.	Meeting	CCO
	Friday, August 14	8:30 a.m. – 4 p.m.	Meeting	CCO
	Tuesday, October 20	8:30 a.m. – 4 p.m.	Meeting	CCO

		ADJOURNMENT				***4:30 p.m.***

Council Meeting Dates to December 2020

All Council meetings are at CCO and are scheduled from ***8:30 a.m. – 4:30 p.m.*** unless otherwise noted.

Year	Date	Time	Event	Location
2020	Wednesday, April 15	8:30 a.m. – 4:30 p.m.	Council Meeting	CCO
	Thursday, April 16 (Council Orientation/Elections)	8:30 a.m. – 2:00 p.m.	Council Meeting	CCO
	Tuesday, June 16	6 p.m. – 9:30 p.m.	Annual General Meeting	CCO
	Wednesday, June 17	8:30 a.m. – 4:30 p.m.	Council Meeting	CCO
	Friday, September 11	1:00 p.m. – 4:30 p.m.	Strategic Planning/Topic Specific Focused Meeting (in camera items)	White Oaks Resort & Spa 253 Taylor Road SS$ Niagara-on-the-Lake, Ontario L0S 1J0 www.whiteoaksresort.com
	Saturday, September 12	8:30 a.m. – 4:30 p.m.	Council Meeting	White Oaks
	Sunday, September 13	8:30 a.m. – 12 noon	Strategic Planning/Topic Specific Meeting (as required)	White Oaks
	Thursday, November 26	8:30 a.m. – 4:30 p.m.	Council Meeting	CCO
	Friday, November 27	8:30 a.m. - noon	Council Training	CCO
	Friday, November 27	Evening	Holiday Party	TBD

Generated Internally

College of Chiropractors of Ontario
Discipline Committee Report to Council
February 26, 2020

Core Members: Ms Karoline Bourdeau, *Chair*
Dr. Paul Groulx
Dr. Steven Lester
Mr. Rob MacKay
Dr. Daniela Arciero, *non-Council member*
Dr. Liz Gabison, *non-Council member*
Dr. Colin Goudreau, *non-Council member*
Dr. Colleen Pattrick, *non-Council member*
Dr. Brian Schut, *non-Council member*
Dr. G. Murray Townsend, *non-Council member*
Dr. Matt Tribe, *non-Council member*

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

Since the last council meeting there have been no committee meetings or hearings.

The panel's decisions and reasons for the following hearing was released to the parties:

- Dr. Amalraj Sivapathasuntharam – received December 19, 2019

The work of the Discipline Committee is vital to protecting the public interest and I would like to thank the members of the Discipline Committee for their time and dedication. In addition, I would also like to extend my thanks to all members of council who are willing to serve on panels.

Respectfully submitted,
Karoline Bourdeau, Chair

Rose Bustria

From:	Jo-Ann Willson
Sent:	Thursday, December 19, 2019 11:21 AM
To:	Rose Bustria
Cc:	Joel Friedman; Madeline Cheng
Subject:	FW: In the matter of the College of Chiropractors of Ontario and Dr. Amalraj Sivapathasuntharam
Attachments:	Decision Dr. Amalraj Sivapathasuntharam 2019 12 19 (01208593xC34D3).pdf

Exec and Council etc.

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Registrar & General Counsel
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From: Carolyn Raber <CRaber@swlawyers.ca>
Sent: Thursday, December 19, 2019 11:19 AM
To: Chris Paliare (Chris.Paliare@paliareroland.com) <Chris.Paliare@paliareroland.com>; Karen Jones (Karen.Jones@paliareroland.com) <Karen.Jones@paliareroland.com>; 'Rebecca Young' <ryoung@damienfrost.ca>
Cc: Jo-Ann Willson <jpwillson@cco.on.ca>; Colin Stevenson <CStevenson@swlawyers.ca>
Subject: In the matter of the College of Chiropractors of Ontario and Dr. Amalraj Sivapathasuntharam

Good morning,

Herewith the decision of the Discipline Committee, released this morning.

Thank you.

Carolyn Raber Legal Assistant | Contact
Assistant to Colin P. Stevenson and Daniel McConville
416.599.7900 x841

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11

DISCIPLINE COMMITTEE
OF THE COLLEGE OF CHIROPRACTORS OF ONTARIO

PANEL:	Ms. Karoline Bourdeau, Chair	Public Member
	Dr. Paul Groulx	Professional Member
	Ms. Robyn Gravelle	Public Member
	Dr. Colleen Pattrick	Professional Member
	Dr. Matt Tribe	Professional Member

BETWEEN:

COLLEGE OF CHIROPRACTORS OF ONTARIO	)	Mr. Chris Paliare and Ms. Karen Jones for the College of Chiropractors of Ontario
- and -	)	
	)	
Dr. Amalraj Sivapathasuntharam	)	Ms. Rebecca Young
	)	
	)	Heard: October 9, 2019

Also present at the hearing were:

Mr. Colin Stevenson—Independent Legal Counsel to the Panel
Ms. Jo-Ann Willson—Registrar and General Counsel, CCO
Ms. Lydia Pak- Court Reporter

DECISION AND REASONS

INTRODUCTION

A hearing into allegations of professional misconduct against Dr. Amalraj Sivapathasuntharam ("Dr. Sivapathasuntharam", or the "Member") took place before a panel of the Discipline Committee (the "Panel") of the College of Chiropractors of Ontario (the "College" or "CCO") on October 9, 2019. The College has a mandate to regulate the practice of the chiropractic profession and to govern its members and, in so doing, serve and protect the public interest.

THE ALLEGATIONS

The allegations against the Member are set out in the Notice of Hearing, dated May 29, 2019 filed as Exhibit 1. The hearing proceeded only in relation to the following allegations (allegations 2, 3 and 4 were withdrawn).

1. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the Health Professions Procedural Code of the *Chiropractic Act, 1991*, S.O. 1991, c. 21, as amended, and paragraph 1(2) of Ontario Regulation 852/93, in that during the period March 2014 to November 2016, on one or more occasions, 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 claims made to Manulife and accepting payment for services that were not provided.

5. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the Health Professions Procedural Code of the *Chiropractic Act*, 1991, S.O. 1991, c. 21, as amended, and paragraph 1(33) of Ontario Regulation 852/93, in that during the period March 2014 to November 2016, on one or more occasions, you engaged in conduct or performed an act, that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional with respect to your making claims to Manulife for treatments that were not provided and accepting payment for the claims.

For the reasons that follow the Panel found that the Member engaged in professional misconduct. The Panel accepted a joint submission on penalty and costs and ordered that its terms be implemented.

AGREED FACTS

Dr. Amalraj Sivapathasuntharam ("Member") became a member of the College of Chiropractors of Ontario ("CCO") in 2011. The Member has not been the subject of a previous Discipline Committee hearing.

The Member is currently enrolled in an educational program and is not practising chiropractic.

During the period February 2014 to June 2017, the Member co-owned and practised chiropractic at Gore Road Physiotherapy and Foot Clinic in Brampton, Ontario (the "Clinic"). The co-owner of the Clinic, known as "S.I.," was not a regulated health professional and was a silent business partner. The Member was the "face" of the Clinic so it appeared that he was its owner operator. As such, all accounts for the Clinic were set up in his name, including email and a contract with Telus which permitted him, through the Telus provider submit portal, to send claims and other information electronically to insurers.

S.I. primarily focused on the day-to-day operations of the Clinic and of the Kennedy Road Physiotherapy and Foot Clinic, which she also co-owned with the Member.

The Member employed a number of regulated health professionals, including registered massage therapists and registered physiotherapists, to provide treatment at the Clinic, including chiropractic, physiotherapy, acupuncture, massage, orthotics and braces. Each regulated health professional documented the services provided to each patient, and the documentation was added to the patient's file. Patient files were maintained at the Clinic. Individual regulated health professionals did not retain custody of patient files.

THE COMPLAINT

On September 19, 2017, Manulife reported to the CCO that it had reviewed electronic claims submitted by the Member from the Clinic during the period March 19, 2014 to November 19, 2016. Manulife then asked three of the health care professionals who had worked at the Clinic during the period to confirm whether they had provided the treatments that were claimed by the Clinic via the Member's Telus portal. The health care providers indicated that, in the 32 month audit period, 26 claims made by the Clinic on behalf of 13 patients over a period of 16 days were for services that had not been provided (the "False Claims"), for a total of $2,380.00. Manulife had paid out $1,955.60 for the False Claims, with $1,790.60 of that amount being paid to the Clinic and $165.00 to patients.

THE CCO INVESTIGATION

When the CCO investigated the complaint, it requested the Member provide the patient files for the 13 patients for whom the Clinic had made False Claims. The Member advised that he had closed the Clinic in June 2017. He said that he left the Clinic patient files with S.I., and he did not know how to contact her or where the patient files were.

ADMISSIONS RE FALSE CLAIMS MADE TO MANULIFE

Had the Member testified, he would have said that he personally had not made the False Claims and did not know that the Clinic had made them. However, he admits that they were made and, further, admits that, as the regulated health professional in charge of the Clinic, he was ultimately responsible for ensuring that claims made to the insurer were accurate. As such, he accepts responsibility for the False Claims.

In particular, the Member admits that he:

(a) contravened a standard of practice of the profession or failed to maintain the standard expected of members of the profession with respect to claims made to Manulife and accepting payment for services that were not provided, as described in Allegation 1 of the Notice of Hearing dated May 29, 2019 ("NOH"); and

(b) engaged in conduct or performed an act that, having regard to all of the circumstances, would reasonably be regarded by members as disgraceful, dishonourable and unprofessional with respect to the claims made to Manulife for treatments not provided and accepting payment for the claims, as described in Allegation 5 of the NOH.

Based on these facts and the Member's admissions the CCO and the Member asked the Panel to make findings of professional misconduct as set out in Allegations 1 and 5 of the NOH.

INDEPENDENT LEGAL ADVICE

The Member acknowledged that he had received advice from his counsel, Rebecca Young, prior to entering into this Resolution Agreement. The Member agreed that he was entering into the Resolution Agreement and signing the Agreed Statement of Facts freely and voluntarily.

DECISION AND ORDER

After hearing submissions the Panel met and accepted these facts. We agreed that these facts and admissions provided a sufficient basis for making the findings of professional misconduct that the parties invited the Panel to make. Consequently, we found that the Member had engaged in the professional misconduct set out in allegations 1 and 5.

SUBMISSIONS ON PENALTY AND COSTS

After hearing submissions on penalty and costs from the parties and reviewing the joint written submission (filed on consent as Exhibit 3) in which the Member again acknowledged having received advice from his counsel, Ms. Young, and that he had signed the joint submission on penalty and costs freely and voluntarily, the Panel made the following order:

1. requiring the Member to appear before the panel to be reprimanded;

2. directing the Registrar and General Counsel ("Registrar") to suspend the Member's certificate of registration for a period of six months ("Suspension") with the Suspension to take effect on October 9, 2019;

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

   (a) by February 9, 2020, the Member must,

      (i) review and undertake in writing to comply with all CCO regulations, standards of practice, policies and guidelines, including but not limited to the business practices portion of the Misconduct Regulation, CCO Guideline G-008, Business Practices, CCO Standard of Practice S-002: Record Keeping, CCO Standard of Practice S-022 Ownership, Storage, Security and Destruction of Records of Personal Health Information, and

      (ii) provide evidence that he has successfully completed, at his own expense, the Legislation and Ethics Examination and the Record Keeping Workshop;

(b) requiring the Member to immediately notify the Registrar in writing if he practises chiropractic, including providing the name and address of his place of practice;

(c) requiring the Member to be peer assessed at his own expense, within six months of returning to the practice of chiropractic.

4. directing the Registrar to suspend two months of the Suspension if the Member completes the Conditions set out in paragraph 3(a), by February 9, 2020; and

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

The panel also made the following order regarding costs:

> requiring the Member to pay $10,000.00 to the CCO to partially reimburse it for its costs of the investigation and the costs and expenses of the hearing and of legal counsel, to be paid by December 31, 2019 with post dated cheques for the amount to be provided to the Registrar at the hearing.

The Panel believes that this order serves the public interest by sending a strong message of deterrence while also imposing specific remedial measures on the Member.

REPRIMAND ADMINISTERED

Dr. Sivapathasuntharam undertook not to appeal or seek judicial review if we accepted, as we did, the Joint Submission on penalty and costs. Consequently at the conclusion of the hearing the Panel administered the reprimand required by paragraph 1 of the order.

I, Karoline Bourdeau, sign this decision and reasons for the decision for the decision as chair of this Discipline Panel and on behalf of the members of the Discipline Panel listed above.

December 19, 2019

MS. KAROLINE BOURDEAU

ITEM 1.2

Generated Internally

College of Chiropractors of Ontario
Fitness to Practise Committee Report to Council
February 26, 2019

Members: Dr. Steven Lester, *Chair*
Dr. Dennis Mizel
Ms Robyn Gravelle Michelutti

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

Committee Mandate

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

I. Introduction and Recommendations

The Fitness to Practise Committee has no recommendations at this time.

Since the last council meeting the committee has not held a meeting or hearing.

There are no acknowledgements at this time.

Respectfully submitted,

Dr. Steven Lester, Chair
Fitness to Practise Committee

Submitted to CCO on February 10, 2020

College of Chiropractors of Ontario
Inquiries, Complaints and Reports Committee Report to Council
February 26, 2020

Members: Dr. David Starmer, *Chair*
Ms Georgia Allan, *Public Member*
Dr. Peter Amlinger, *Council Member*
Dr. Steve Gillis, *non-Council Member*
Mr. John Papadakis, *Public Member, Alternate*

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

Since the last Council meeting, the Inquiries, Complaints and Reports Committee (ICRC) met on three occasions and reviewed 47 complaints and two reports. ICRC made decisions on 29 complaints. One section 75(a) and five section 75(c) investigator appointments were requested by the ICRC. The Health Professions Appeal and Review Board (HPARB) upheld four Committee decisions (attached).

As Chair, I would like to express my gratitude for the hard work of all the committee members and staff support.

Respectfully submitted,

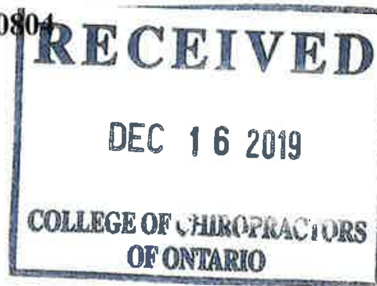
Dr. David Starmer, Chair
Inquiries, Complaints & Reports Committee

Health Professions Appeal and Review Board

La Commission d'appel et de révision des professions de la santé

ITEM 1.3.1

In reply please quote: File # 18-CRV-0804



CONFIDENTIAL

18

December 16, 2019

Terri Fass — Applicant

Chris Kraemer, D.C. — Respondent

Dear Ms. Fass and Dr. Kraemer

RE: COMPLAINT REVIEW - CHIROPRACTIC
TERRI FASS AND CHRIS KRAEMER, D.C.

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

Alpha Aberra
Case Officer

Encl: Decision dated December 16, 2019

cc: College of Chiropractors of Ontario (CCOPRA File # KRAEMER-18-MR-01)

File # 18-CRV-0804

HEALTH PROFESSIONS APPEAL AND REVIEW BOARD

PRESENT:

Katherine Ball, Designated Vice-Chair, Presiding
James Dault, Board Member
Timothy P. D. Bates, Board Member

Review held on June 13, 2019 in Ontario (by teleconference)

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

B E T W E E N:

TERRI FASS

Applicant

and

CHRIS KRAEMER, DC

Respondent

Appearances:

The Applicant:	Terri Fass (by teleconference)
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 Terri Fass (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 Chris Kraemer, DC (the Respondent). The Committee investigated the complaint and decided to take no further action.

II. BACKGROUND

3. The Applicant has a history of chronic plantar fasciitis. She initially received physiotherapy for the pain in her feet from 2010 to 2012 but this did not provide any relief.

4. In 2012, the Applicant's pedorthist referred her to Dearborn Health and Wellness Centre (the "Clinic") for treatment for her persistent plantar foot pain.

5. On October 22, 2012, the Applicant attended at the Clinic and was examined and assessed by the Respondent, a chiropractor. The Respondent recommended a treatment plan that included shockwave therapy and Active Release Technique (ART) for a period of 18-24 months, which the Respondent advised the Applicant was the length of time healing often took.

6. The Applicant attended at the Clinic for weekly treatment with the Respondent from October 22, 2012 to February 24, 2014.

7. After a break in treatment, the Applicant returned to the Clinic for weekly appointments from April 7 to June 6, 2014. During this second period of treatment, the Respondent also treated the Applicant's vertigo and dizziness.

8. The Applicant received treatment from other health care professionals, including other practitioners at the Clinic (another chiropractor, a massage therapist and a physiotherapist) and also at other clinics (her family doctor, a naturopathic doctor, a sports medicine specialist, a urologist, a physiotherapist and a rheumatologist).

9. At a treatment session with the Respondent on June 6, 2014, the Applicant felt unwell. The Respondent called an ambulance and the Applicant was taken to Grand River Hospital (GRH).

10. The June 6, 2014 appointment with the Respondent was the Applicant's last session at the Clinic. The Respondent discharged the Applicant from the Clinic shortly thereafter.

11. The Applicant continued to suffer with problems with her health and in 2015 was unable to work and starting receiving disability benefits. In December 2016, the Applicant's employment was terminated.

The Complaint and the Response

12. In a letter dated February 6, 2018, the Applicant complained to the College about the conduct and actions of the Respondent. In the letter of complaint, the Applicant set out the detailed background to her interactions and appointments with the Respondent and provided extensive information regarding her health issues and treatment she has received from other health care providers.

13. Within her complaint, the Applicant stated how she had asked the Respondent to write a letter to her family doctor about the treatment she was receiving from him. The Applicant complained that she had to follow-up with the Respondent to provide the letter and recommended that:

a) all recognized healthcare providers should be required to provide regular written updates, including treatment to date, effectiveness, prognosis/expectations; and

b) patients/clients should be required to sign-off on these reports so that errors can be "caught and corrected."

14. In the letter of complaint, the Applicant set out why she felt the Respondent was neither qualified nor adequately experienced to do his job and that the way he "treated" patients disqualified him as a professional. Within her letter, the Applicant identified a number of concerns including, but not limited to, the following:

- the Respondent's "professional misconduct" in managing her care, especially on/after June 6, 2014, his abruptly cancelling the Applicant's appointments at the Clinic and inappropriately advising her regarding her serious health concerns;
- the Respondent's willful negligence by knowingly inappropriately treating the Applicant and knowingly and wrongfully attributing her symptoms to anxiety in an attempt to "distract from his incompetence";
- the Respondent's overall competency, as the Applicant questioned the Respondent's suitability and fitness in being able to execute the responsibilities of a doctor of chiropractic and his competency specific to the Applicant's health situation given his failure to acknowledge the seriousness of her overall health;

- the Respondent's poor communication style, lack of a communication policy and his use of his personal social media account for business purposes;
- the Respondent's "atrocious" medical record keeping and lack of "valuable progress tracking" and consistent reporting;
- the Respondent's lack of professionalism and breaches of privacy and confidentiality, especially regarding communications with the Applicant's family doctor and also the Respondent's sharing of information with family members and friends and the posting of remarks on social media;
- the Respondent's nepotism regarding referrals and the quality of care provided by other individuals within the Clinic and the lack of diagnosis or resolution of her health concerns; and
- anything else that the College might feel is appropriate and warranting discipline after reading the letter of complaint.

15. After the last appointment with the Respondent on June 6, 2014, the Applicant wrote to the Respondent recounting troubles she was having with her family doctor's office. The Applicant complained that the Respondent wrote back to her telling her to see the physiotherapist at the Clinic but then subsequently cancelled that appointment and wrote that he did not have the "skills and facilities" to have the Applicant back at the Clinic.

16. In subsequent correspondence, the Respondent gave the Applicant the name of a counsellor whom he recommended.

17. In her letter of complaint, the Applicant set out the difficulties she had encountered in her work and the demanding and stressful nature of her job. The Applicant stated that things in her life have "gotten worse" and she blames the Respondent for a large part of the unfortunate situation in which she finds herself. The Applicant stated of the Respondent:

> I was not looking for anything but help with my health issues, and I find him completely ignorant and self-centered for his erroneous assumptions, whatever they were as he, obviously, didn't have my health and wellness in mind when treating me.

18. The Applicant described in her letter of complaint that she has been exposed to harassment and she "can connect [the Respondent] and his family to the people who have been involved." The Applicant stated that the Respondent had harassed her on social media and posted confidential material about her, following conversations with her family doctor. The Applicant provided copies of the screenshots from the Respondent's social media accounts and the posts that she alleged relate to her situation and were inappropriate and full of "intimidation, innuendo and criticism."

19. At the end of her letter of complaint, the Applicant requested the following:

- an acknowledgement of her correspondence;
- an acknowledgement of the legitimacy and gravity of the health concerns that fell within the boundaries of the Respondent's "expected responsibilities as a Doctor of Chiropractic";
- a formal reprimand levied against the Respondent and publicly documented;
- information regarding any "corrective action" that is taken;
- for the Respondent to address his "incorrect diagnosis" of the Applicant's health situation addressed to the Applicant in writing; and
- an acknowledgement from the College with regard to the Respondent's lack of communications policy and conflicting use of social media.

20. The Committee summarized the Applicant's complaint as having raised the following issues with regard to the care provided by the Respondent:

- dismissing (not listening) / poor communication / atrocious records
- misdiagnosis / lack of skill / failure to refer
- dismissing (abandonment);
- breach of confidentiality/privacy/cell phone use/social media; and
- repercussions / sabotage

21. In a letter of response, dated May 8, 2018, the Respondent set out the treatment that he provided to the Applicant from the first appointment on October 22, 2012 to June 6, 2014 when an ambulance was called and the Applicant was taken to hospital for assessment. The Respondent included a copy of the Applicant's patient file with his letter and addressed the concerns raised by the Applicant in her complaint. The Respondent stated that:

- he disagreed with the Applicant's characterization of his management of her care and said that he managed her condition responsibly, reasonably and professionally and that the patient records supported his clinical methodology;
- he did not cancel the Applicant's appointments with him or any other healthcare provider nor abandon his responsibilities or act in a reckless, irresponsible or negligent manner;
- he managed his communications in a responsible and professional manner having regard to the circumstances and applicable standards;
- the Applicant's challenge to his qualifications was misplaced. The Respondent set out his qualifications and chiropractic experience since he became licensed in Ontario in 2001;
- the Applicant's care was primarily focused on musculo-skeletal treatment. Complementary recommendations and adjunctive therapies are both recognized as conventional extensions of traditional treatment and fall within the overall ambit of chiropractic care. The call for an ambulance on June 6, 2014, was in "an abundance of prudence" to rule out the uncertainty of a more serious cardiac or neurological event;
- he denied the Applicant's mischaracterization of his communication exchanges and stated that in his office he maintained a professional decorum and tone in discussions. In the context of social media, the Respondent stated that it was a more relaxed environment and form of exchange but his communications did not blur professional lines;

- his record keeping met or exceeded the applicable standards of the profession and his notes were neither atrocious nor mistaken as the Applicant suggested. While the Applicant may disagree with the content of the notes, his determinations were based on testing and investigation and are a matter of clinical opinion and judgment;
- he disagreed that there had been any breach of the Applicant's privacy or confidentiality;
- he denied having unauthorized contact with any doctors or therapists or having communicated anything to anyone regarding the Applicant without her authorization and at no time did he post restricted information regarding the Applicant on social media.
- no one, including family and friends, had unauthorized access to the Applicant's information for use on social media;
- the Clinic is comprised of five chiropractors, three physiotherapists, five massage therapists, a kinesiologist and a pedorthist, all of whom are well qualified and have a demonstrated track record of providing service of the utmost caliber. When referrals are indicated, the collaborative environment benefits patients by enhancing accessibility and delivery of patient care; and
- any familial relationship with referred specialists is coincidental and not a factor in determining the merit of a referral. Patients are not compelled to use service providers at the Clinic and are always at liberty to seek care from outside providers of their own choosing. There is nothing unprofessional in this model of health care service.

22. In an email dated June 4, 2018 and a letter dated June 31, 2018, the Applicant commented upon the Respondent's letter of response to the complaint. In her comments, the Applicant reiterated her concerns regarding the Respondent's care.

The Committee's Decision

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

III. REQUEST FOR REVIEW

24. In a letter dated December 4, 2018, the Applicant requested that the Board review the Committee's decision.

IV. POWERS OF THE BOARD

25. 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.

26. 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

27. 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.

28. The Respondent did not attend the Review. There is no legal obligation upon a party to participate in a Review and the Board draws no inference from the Respondent's decision not to attend.

29. In her request for review, the Applicant stated that the Respondent had lied in his response to her complaint and that she was deeply concerned that the Committee was not able to find the Respondent at fault. The Applicant stated that she "quite emphatically believed that [the Respondent] should be disciplined for his actions towards [her]."

30. In her letter of December 4, 2018 requesting the review, the Applicant set out the concerns that she had raised in her "very lengthy and very detailed" letter of complaint and asked the Board to review the matter giving her an opportunity to highlight several serious issues that she believed the Committee had overlooked or chosen to disregard.

31. In her letter, the Applicant told the Board that the Respondent put her at great risk when he dismissed her as a patient in June 2014. The Applicant stated that the medical notes state that he did cancel the appointment made for her after June 6, 2014 and he lied to the Committee in his letter of response. The Applicant told the Board that the Respondent abandoned his care of her and the Committee had been reckless in dismissing her concerns.

32. The Applicant told the Board that she was seeking an appeal of the Committee's decision because this was a case where there was "a great deal of dishonesty, breach of trust right from the outset (e.g. abuse of client) or deliberate breach of a significant professional value." The Applicant queried how the Committee measured "significant professional value" and wrote that the statement by the Committee had led her to believe that the Respondent's interests were being protected.

33. The Applicant wrote that the Respondent had lied and that the Committee should be able to assess credibility despite its assertion that it was not their job to do so. In the Applicant's view, a complaint of any kind always comes down to credibility.

34. The Applicant stated that the screen shots of the social media posts that she had sent to the investigator were printed out in colour and were clear, not unclear as the Committee had found in its decision.

35. In her oral submissions to the Board, the Applicant stated that she had nothing new to add but that she wanted to reinforce her complaint and she repeated her assertion that the treatment she received from the Respondent minimised her very serious health concerns.

36. Central to her submissions was the Applicant's concern that the Respondent had discharged her without any referral to another health care provider. The Applicant told the Board that, contrary to what the Committee said in its decision, she did not have a network of people trying to help her. The Applicant reiterated that the Respondent had deliberately abandoned his care of her and she felt alone and that there was no-one who was trying to help her.

37. The Applicant told the Board that in its decision the Committee's summary of her complaint was "pleasing" but the decision itself had minimised the nature of her complaint. The Applicant stated that her concerns were not serious like sexual assault or other misconduct but they were serious to her and the Respondent's behaviour had impacted her profoundly. The Applicant submitted that she had lost her job because of the Respondent.

38. The Board has considered the Applicant's submissions, examined the Record of Investigation (the Record), and reviewed the Committee's decision.

Adequacy of the Investigation

39. 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.

40. In the course of its investigation, the Committee obtained the following documents:

- the Applicant's letter of complaint together with the enclosures that included the letter referring the Applicant to the Clinic, a list of appointments at the Clinic and at the Vestibular & Orthopaedic Rehabilitation Clinic (VOR), sample copies of the Applicant's symptom logs (spreadsheets) provided to the Respondent, email correspondence between the parties during the periods of treatment, screen shots from the Respondent's social media account and invoicing from the Clinic;
- the Applicant's patient chart from the Respondent (provided by the Applicant);

- the Respondent's letter of response to the complaint together with enclosures, including the Applicant's patient chart (provided by the Respondent);
- the Applicant's comments on the Respondent's letter of response to the complaint;
- subsequent correspondence to/from the parties during the course of the investigation;
- the College's Standard of Practice S-019-*Conflict of Interest in Commercial Ventures*; and
- the College's Guideline G-012-*Use of Social Media*;

41. The Board notes that the Applicant's complaint encompasses the care provided by the Respondent during the course of her treatment, his conduct outside the Clinic, including his use of social media, and the Applicant's concerns regarding the impact of the Respondent's care on the termination of her employment.

42. The Board has reviewed the Record and notes that it includes the letter referring the Applicant to the Clinic and her history of foot pain, the records relating to the assessment and treatment provided by the Respondent, the communications between the parties during and after the periods of treatment and correspondence from other health care providers who assessed the Applicant. The Record also includes screen shots from the Respondent's social media account, which were sent to the College by the Applicant and formed part of her concerns.

43. The Applicant's records from the Clinic include the Respondent's notes from the treatment undergone by the Applicant and records of phone calls and covered the period in June 2014 when the treatment ended and the context for the termination of the Respondent's discharge from the Clinic.

44. The Board notes the Applicant's submission that the Respondent had not been truthful and the view she expressed that "a complaint of any kind always comes down to credibility". When considering the Applicant's complaint, the Committee is charged with performing a screening function to determine whether the Applicant's specified allegations of professional misconduct warrant referral to the Discipline Committee. In the course of investigating the complaint, the Committee's review is primarily paper-based and the Committee is limited in its ability to make determinations of credibility or to decide which version of events is to be preferred, in cases where parties have differing recollections.

45. The Board therefore finds that the Committee's role when investigating the Applicant's concerns in this case did not include making a determination of either party's credibility when they gave differing versions of events. The Board finds that the Committee gathered the essential information for it to make an informed decision regarding the Applicant's concerns raised in her complaint and to decide whether the complaint warranted referral to the Discipline Committee.

46. There is no indication of additional information that, had it been before the Committee, might reasonably be expected to have affected its decision.

47. Accordingly, the Board finds the Committee's investigation was adequate.

Reasonableness of the Decision

48. 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.

49. As set out above, the concerns raised by the Applicant in her letter of complaint encompassed many broad areas of the Respondent's practice. The Applicant reiterated her concerns in her letter to the Board requesting a review of the Committee's decision and in her oral submissions. In its decision, the Committee summarized the Applicant's concerns into the categories as set out above.

50. The Board has considered the extensive material submitted by the Applicant in her letter of complaint to the College and her submissions at the Review and finds that the Committee's summary of her concerns is reasonable. The Board finds that the summary of concerns includes all the issues raised by the Applicant regarding the Respondent's care when she was receiving treatment and her concerns regarding feeling abandoned when she was discharged from the Clinic.

Dismissing (not listening) / poor communication / atrocious records

51. In its decision, the Committee found that the Respondent's records were thorough and though many of the progress notes in the Applicant's chart were brief summaries of her subjective condition on a particular day, they were sufficient. The Committee noted that chiropractors are expected to exercise professional judgment about which information was relevant.

52. The Board acknowledges the Applicant's concerns regarding the Respondent's poor communications, that she felt he was dismissive, that he did not listen to her and that he kept atrocious records. The Board has reviewed the Applicant's narrative around these concerns and notes that on many occasions the Applicant provided information both orally and in writing that she felt was relevant to her health and her ongoing care. In addition, the Board notes that the Applicant was methodical in preparing a spreadsheet of her symptoms and recording how her pain was affecting her daily activities.

53. As the Committee noted in its decision, the Applicant kept a daily log of her ongoing health concerns that she provided to the Respondent. The log included notes regarding her neck pain and the effect it had upon her head movements, her vertigo, the problem identified by her optometrist relating to a "bundle of nerves" at the back of her neck, the effect on her driving and her fear of losing her driver's licence, her worry that she was not seeing lasting improvement in her feet, her fatigue and difficulty concentrating, the pain in her right ankle, the concern regarding the Respondent's use of ART on her calves, which was painful, areas of her body that were not healing after surgery and injury, trouble the Applicant had swallowing, pneumonia, vision and hearing problems and other matters that the Applicant felt were contributing to her problems.

54. The Board has reviewed the information in the Record, including extracts from the Applicant's log, and notes that it is detailed and that the level of detail is not reflected in the Applicant's patient chart and the progress notes made by the Respondent.

55. The Board finds that the Committee's conclusion that the progress notes are brief summaries of the Applicant's condition on a particular day is supported by the information in the Record. In the Board's view, it was reasonable for the Committee to find that the Respondent had exercised his professional judgment to decide what information was relevant when making his notes.

56. In addition, the Board finds that the progress notes made during a consultation are, as the Committee noted, a summary of how a patient presents on a particular day. The Applicant's daily log of her symptoms, while helpful in informing the Respondent of the impact of her health concerns on her activities, could not form part of the Respondent's observation and assessment of the Applicant during visits to the Clinic.

57. The Board notes that the Committee included in its decision a response to the Applicant's question about "oversight of patient files" for chiropractors. The Committee stated that as part of the College's ongoing Quality Assurance program all members of the College are peer reviewed and this peer review included record keeping.

58. In addition, the Board finds that it was reasonable for the Committee to conclude that some of the information recorded by the Applicant in the log was not related directly to her chiropractic care but contributed to the Respondent's referrals and suggestions regarding other health care providers. In its decision, the Committee found that these referrals suggested that the Respondent was listening to the Applicant and trying to find help for her.

59. The Board has reviewed the Applicant's patient chart and notes that it includes reports from other health care providers at the Clinic and reports from investigations ordered by the Respondent. The Board finds that the Committee's conclusions regarding the Respondent trying to find help for the Applicant are therefore supported by the information in the Record and are reasonable.

60. From the Board's review of the patient chart and the letter of complaint, it appears that the physician-patient relationship deteriorated following email correspondence between the parties from May 2014. Around this time, the Applicant states that she expressed her own frustration with her family life in an email to the Respondent and intended to convey to him that she "had a challenging life" and that she wanted to have her health problems sorted. The Applicant appears to have been displeased with the response that she received from the Respondent and his lack of appreciation for the challenges she was facing. Thereafter, it appears to the Board that there were difficulties in the parties' communications.

61. In its decision, the Committee noted that communication affects many areas of practice and are subjective, such that it would be difficult for the Committee to assess. The Board finds that this is a reasonable conclusion for the Committee to reach regarding this aspect of the Applicant's complaint.

62. The Board notes that the Applicant entered into extensive email correspondence with the Respondent and included information about health concerns that were within the practice of chiropractic care and information that was unrelated, sometimes relating to her private life. Many of the Applicant's complaints about the Respondent's communication were her interpretation of his responses to her emails, which are subjective. The Board therefore finds it was reasonable for the Committee to consider the Respondent's communication as a professional and the records he kept and information the Applicant shared as the basis for his referrals to other health care providers.

63. The Board finds that the Committee's decision to take no further action on the Applicant's complaint that the Respondent did not listen, communicated poorly and kept atrocious records is therefore reasonable and based upon the information in the Record.

Misdiagnosis / Lack of Skill / Failure to Refer

64. In her complaint, the Applicant raised concerns regarding the Respondent's misdiagnosis, lack of skill and his failure to refer her for treatment. In her submissions to the Board, the Applicant stated that she could not understand how the Committee had overlooked the issues she had raised regarding the Respondent's incompetence and deliberate negligence.

65. In its decision, the Committee noted that the Applicant was concerned that at a visit to the physiotherapist at VOR, her neck was jerked and this was a significant event in her medical history that the Respondent failed to recognize or respond to appropriately. The Committee found that the Respondent did recognize something was wrong and he responded.

66. The Board notes that in his response to the complaint, the Respondent states that in April 2014 when the Applicant relayed concerns related to dizziness or vertigo, for which she had consulted others, he investigated the matter and decided on a cervicogenic contribution which ART might alleviate. The Respondent then gave the Applicant a number of ART treatments, which he noted had mixed results.

67. The Board notes that the Applicant also referred in her complaint to the Respondent adjusting the crystals in her ears to treat her vertigo and the Record includes a report from a neurologist from February 2017 diagnosing the Applicant's cervical radiculopathy, which the Applicant included with her complaint.

68. In its decision, the Committee opined that the neurologist's opinion was consistent with the treatment that the Respondent provided when the Applicant expressed concern regarding vertigo and dizziness. The Committee concluded that the Respondent's professional opinion regarding the Applicant's inner ear problem was reasonable based upon the information before it.

69. Regarding the complaint that the Respondent failed to refer the Applicant, the Board has noted above that the information provided to the Respondent in the Applicant's daily logs of her symptoms led the Respondent to make referrals. The Applicant has expressed concern that the Respondent had a conflict of interest where the referrals were to other health care professionals at the Clinic. The Committee noted that the Applicant stated that she received good care from other providers and opined that her health is complex and it was in her best interest to have input from other professionals.

70. The Board has not found any information to support the suggestion that the Respondent acted out of any interest other than assisting the Applicant with her health problems. The Board notes that the Committee had before it the College Standard S-019: *Conflict of Interest in Commercial Ventures* when considering the Applicant's concern.

71. The Board finds that the Committee's decision to take no further action on this aspect of the Applicant's complaint is reasonable. The information in the Record supports the Committee's finding that the Respondent acknowledged the Applicant's concern and responded to it.

Dismissing (abandonment)

72. In its decision, the Committee noted that the parties' doctor-patient relationship ended in June 2014, following the Applicant's last appointment on June 6, 2014, when she reported feeling unwell and the Respondent called an ambulance. Shortly thereafter, the Respondent emailed the Applicant and advised her that he did not have the skills and facilities to have the Applicant back at the Clinic.

73. The Applicant stated in her complaint that the Respondent's manner, tone and words were "reckless and irresponsible" and it was negligent on his part and "humiliating and degrading." In her submissions to the Board, the Applicant said that contrary to the Committee's finding, she did not have a network of people trying to help her and she felt that the Respondent had deliberately abandoned his care of her leaving her feeling alone and without any help.

74. In its decision, the Committee stated that chiropractors are not required to seek the permission from the College or from a patient's family physician before terminating the doctor-patient relationship, nor are they required to inform the College that this has happened. The Committee recognized the Applicant's statement in her complaint that she felt that the "rug had been pulled from under her" when the Respondent decided he could no longer have her as a patient.

75. The Committee found that the treatment the Respondent had provided the Applicant, while it had been reasonable and somewhat beneficial, was not yielding the desired results and that the Applicant, objectively, had a network of people who were trying to help her.

76. The Board has reviewed the Record and notes that following the termination of her care at the Clinic, the Applicant continued to receive care from her family physician and other health care professionals. For example, the Board notes the report from the neurologist in 2017 and the diagnosis of cervical radiculopathy.

77. The Board finds the Committee's conclusion that the Applicant had a network of people trying to help her is based upon the information in the Record and that it led the Committee to conclude that the Respondent's termination of the doctor-patient relationship, as he was entitled to do, was reasonable.

78. The Committee noted that the relationship between the parties was deteriorating and, while the Applicant felt that she had been abandoned, the Committee found that, objectively, this was not the case. The Board notes that in the Applicant's recount of emails exchanged during May and June 2014, she describes her frustrations in her personal life and her dissatisfaction at the Respondent's response leading her to book an appointment with another chiropractor. In the Board's view, the Committee's findings are supported by the information in the Record.

Breach of Confidentiality / Privacy / Cellphone Use / Social Media

79. The Committee decided to take no further action in regard to this aspect of the Applicant's complaint. The concerns regarding a patient "across the hall' listening to the Applicant talking to the Respondent during appointments are noted by the Committee, which stated that chiropractors should be cognizant of patient confidentiality and privacy and having a private space available is reassuring for patients. The Board finds that in its decision the Committee acknowledged the Applicant's concern and set out the standard that is expected of the profession to maintain confidentiality and privacy, at the same time recognizing that offices can be busy spaces.

80. The Board finds this aspect of the decision is reasonable and supported by the information in the Record.

81. Regarding the Respondent's use of the Applicant's personal information and posting of remarks on social media, the Committee decided to take no further action on the concerns raised by the Applicant but set out in its decision the relevant standard of practice from the College Guideline G-012: *Use of Social Media.*

82. The Applicant provided screen shots from the Respondent's social media account and referred to postings on his Twitter feed and said:

> On its own, you would wonder what he was talking about; you would think this post is benign. In context with my involvement with him and his family and friend - - or rather their involvement with me because I do not know these people at all, yet they have mucked-up my life something horrible - - it is anything but benign.

83. The Board finds that the information in the Record does not support the concern expressed by the Applicant that the Respondent has shared her personal information on social media.

84. The Board has reviewed the screen shots of social media posts and notes that most of them post-date the Applicant's last appointment with the Respondent by nearly two years and many of the posts are by individuals other than the Respondent. The Board can find no reference to the Applicant in the posts and, as the Applicant stated, they are open to interpretation.

85. The Board finds that the Committee's decision to take no further action on this aspect of the Applicant's complaint is reasonable and based upon the information in the Record.

Repercussions / Sabotage

86. In her complaint, the Applicant expresses concern that by expressing his opinion that the Applicant was experiencing "anxiety" when she went to hospital on June 6, 2014, the Respondent sabotaged her relationships with a number of health care professions "to distract from his incompetence." The Applicant expressed concern that the Respondent was directly responsible for her benefits being cancelled and her job being terminated in December 2016.

87. As set out above, the Committee found that there was no basis for the suggestion by the Applicant that the Respondent lacked skill or competency in his provision of chiropractic care. In light of its finding that the Respondent provided adequate care and treatment to the Applicant, the Committee went on to state that there was no information that the Respondent actively intervened to ruin any of the Applicant's other doctor-patient relationships.

88. The Board has reviewed the information in the Record and notes that while the Respondent called an ambulance for the Applicant, with her consent, on June 6, 2014, there is no information to support the concern that the Respondent provided an opinion to the hospital regarding the Applicant's health. There is no information in the Record regarding the management of the Applicant's care following her discharge from the Clinic.

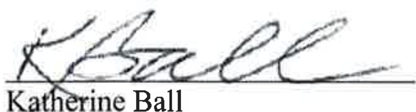
89. The Board finds that the information in the Record supports the Committee's decision to take no further action on the Applicant's concern that the Respondent sabotaged her ongoing health care.

90. Accordingly, the Board finds that the Committee's investigation was adequate and its decision to take no further action is reasonable and supported by the information in the Record.

VI. DECISION

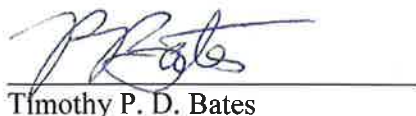
91. Pursuant to section 35(1) of the *Code*, the Board confirms the decision of the Committee to take no further action.

ISSUED December 16, 2019



Katherine Ball

James Dault



Timothy P. D. Bates

ITEM 1.3.2

File # 18-CRV-0783

HEALTH PROFESSIONS APPEAL AND REVIEW BOARD

PRESENT:

James Beamish, Designated Vice-Chair, Presiding
Maria Capulong, Board Member
Brenda Petryna, Board Member

Review held on June 12, 2019 in Ontario (by teleconference)

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

B E T W E E N:

RYAN ARMSTRONG

Applicant

and

KRESIMIR JUG, DC

Respondent

Appearances:

The Applicant:	Ryan Armstrong
The Respondent:	Kresimir Jug, DC
For the Respondent:	Henry Ngan, Counsel
For the College of Chiropractors of Ontario:	Tina Perryman

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 Ryan Armstrong (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 Kresimir Jug, DC (the Respondent). The Committee investigated the complaint and decided to take no further action.

II. BACKGROUND

3. The Respondent, a chiropractor who practices in London, Ontario, maintains a clinical website in which he provides information regarding his practice and the benefits of chiropractic.

The Complaint and the Response

4. The Applicant complained that:

- the Respondent makes claims on his clinical website regarding conditions that are outside the purview of chiropractic, including allergies, digestive issues and the treatment of autoimmune;
- the Respondent performs diagnostic techniques that are invalid and not supported by credible evidence including the use of an ear thermometer to diagnose a condition (vertebral subluxation) that does not exist;
- the Respondent cites studies in his video description that are not relevant to the practice employed and that are misleading to the public; and
- the Respondent disseminates misleading information regarding vaccinations; he does not understand basic immunology and misleads his audience on important matters of public health.

5. The Respondent responded to the complaint as follows:

- He has revised his website so that it no longer lists 17 conditions that are outside the purview of chiropractic and changed the wording of his disclaimer.
- In his video, he was attempting to explain thermography, a procedure within the scope his practice; he made no claims about the diagnosis or treatment of subluxation; he acknowledged that he inadvertently mis-cited one of the studies referenced in his video.
- Regarding vaccination, he stated that he was speaking from a personal perspective and was not offering clinical advice or commenting on the effectiveness of vaccines.

The Committee's Decision

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

7. In reaching its decision, the Committee made the following findings:

- Regarding the complaint that the Respondent made claims that are outside the purview of the practice of chiropractic, the Committee noted that the Respondent did not guarantee the results advertised but merely noted that these are benefits that were reported by patients. The Committee further noted that the Respondent had revised his website to remove any reference to specific treatment benefits and added a more specific disclaimer that the Committee found to be reasonable.
- Regarding the complaint that the Respondent performed invalid diagnostic techniques, the Committee noted that thermography is a test commonly used by chiropractors.
- Regarding the complaint that the Respondent purports to diagnose and treat a condition that does not exist (subluxation), the professional

members of the Committee opined that the concept that subluxations may contribute to visceral disorders is "biologically plausible but as yet unconfirmed."

- Regarding the complaint that the Respondent disseminated misleading information about vaccinations, the Committee noted that the Respondent stated that he advises patients that he did not comment on the effectiveness of vaccines and that immunology is outside the scope of his chiropractic practice. The Committee further noted that the Respondent had deleted the videos in question and found that the Respondent's approach was generally consistent with the College policy regarding general health-related questions.

III. REQUEST FOR REVIEW

8. In an email dated November 30, 2018, the Applicant requested that the Board review the Committee's decision.

IV. POWERS OF THE BOARD

9. 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.

10. 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

11. 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.

12. The Board has considered the submissions of the parties, examined the Record of Investigation (the Record), and reviewed the Committee's decision.

Adequacy of the Investigation

13. 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.

14. The Committee obtained the following information and documents:

- the Applicant's letter of complaint;
- the Respondent's letter of response; and
- the College Standards of Practice regarding Chiropractic Scope of Practice and Record Keeping and the College Guideline regarding the Use of Social Media.

15. Neither party took issue with the adequacy of the investigation.

16. The Board finds that the information and documents listed in paragraph 14 above contain the essential information relevant to making an informed decision regarding the issues raised in the complaint. There is no indication of any further relevant information that the Committee could have obtained and that might reasonably be expected to have affected its decision.

17. Accordingly, the Board finds the Committee's investigation to be adequate.

Reasonableness of the Decision

18. 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.

19. The Applicant made the following submissions regarding the reasonableness of the decision to take no further action:

- There is no clinical evidence to support the claims that chiropractic can assist any of the conditions listed on the Respondent's website nor is there any evidence to establish that any of the reported benefits were due to chiropractic treatment;
- There is no clinical evidence to support the use of thermography as a diagnostic tool or therapy; and
- The Respondent's disclaimer and changes to his website were not sufficient to overcome the misstatements on his website.

20. Counsel for the Respondent submitted that the Committee reached a reasonable decision regarding all aspects of the Applicant's complaint. He noted that the Respondent took the complaint seriously and took the time to provide a detailed response and to change his website. He submitted that it was inappropriate for the Board to deal with the issue of the science behind chiropractic.

21. The Board finds that the Committee's decision to take no further action falls within a range of possible, acceptable outcomes and is reasonable.

22. The Board notes that where the Committee finds that a referral to the Discipline Committee is not warranted, as was the case in these circumstances, the Committee's role is educational and remedial to assist the Respondent to improve his practice and to protect the public.

23. Regarding the Applicant's concerns about the conditions listed on the Respondent's website, the Board notes that the Respondent described the listed conditions as "secondary problems" that can only be helped by chiropractic if they are caused by a core problem with the patient's spine. The Board further notes that the Respondent changed his website to delete the information in question after receiving the complaint. The Board finds that it was reasonable for the Committee to take no further action on this aspect of the complaint.

24. Regarding the concerns that the Respondent was performing a diagnostic test (thermography) that has no proven clinical value for a condition (subluxation) that does not exist, it is not the role of the Board to assess the science (or lack thereof). From the information available to the Board it appears that thermography is listed in the tests commonly used by chiropractors and that subluxations are an unconfirmed but plausible condition that is commonly used for treatment by chiropractors.

25. These concerns go to the very essence of the practice of chiropractic which is a regulated health profession recognized under the *Chiropractic Act, 1991.* Sections 3 and 4 of that statute describe the scope of practice of chiropractic and the authorized acts that may be performed by members. It is beyond the role of the Board to determine whether any particular test or condition that appears to be generally accepted by the profession is invalid or non-existent.

26. The Board therefore finds that the Committee's decision to take no further action regarding these aspects of the complaint is reasonable.

27. Regarding the concern that the Respondent was providing misleading information about vaccinations, the Committee found that the Respondent's approach was consistent with the College policy regarding controlled acts outside the scope of practice of chiropractors. The Board finds this to be reasonable along with the Committee's decision to take no further action.

VI. DECISION

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

ISSUED December 17, 2019

James Beamish

Maria Capulong

Brenda Petryna

Health Professions Appeal and Review Board

La Commission d'appel et de révision des professions de la santé

Ontario

ITEM 1.3.3

In reply please quote: File # 18-CRV-0784

CONFIDENTIAL

47

December 18, 2019

Dr. Ryan Armstrong — Applicant Complainant

Dr. Brian Nantais, D.C. — Respondent

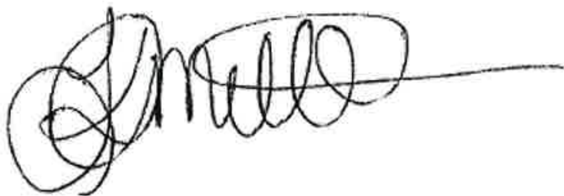
Dear Dr. Armstrong and Dr. Nantais

RE: COMPLAINT REVIEW - CHIROPRACTIC
RYAN ARMSTRONG AND BRIAN NANTAIS, D.C.

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



Kemar Miller for Maureen Baker
Case Officer

Encl: Decision dated December 18, 2019

cc: College of Chiropractors of Ontario (CCOPRA File # NANTAIS-18-MY-01)

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Toronto, Ontario M5S 1S4

File # 18-CRV-0784

HEALTH PROFESSIONS APPEAL AND REVIEW BOARD

PRESENT:

James Beamish, Designated Vice-Chair, Presiding
Maria Capulong, Board Member
Brenda Petryna, Board Member

Review held on June 14, 2019 in Ontario (by teleconference)

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

B E T W E E N:

RYAN ARMSTRONG

Applicant

and

BRIAN NANTAIS, DC

Respondent

Appearances:

The Applicant:	Ryan Armstrong
The Respondent:	Brian Nantais, DC
For the College of Chiropractors of Ontario:	Tina Perryman

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 advise Dr. Nantais to adhere to the following:

   - Standard of Practice S-001: Scope of Practice
   - Standard of Practice S-016: Advertising

- Guideline G-012: Use of Social Media
- Guideline G-016: Advertising

2. This decision arises from a request made to the Health Professions Appeal and Review Board (the Board) by Ryan Armstrong (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 Brian Nantais, DC (the Respondent) The Committee investigated the complaint and decided provide advice to the Respondent as noted above.

II. BACKGROUND

3. The Respondent is a chiropractor practicing in Windsor, Ontario. The Respondent maintains a practice website on which various claims and representations were made including advertisements for workshops on cancer prevention and other health related issues.

The Complaint and the Response

4. The Applicant complained that the Respondent was practicing outside the scope of the practice of chiropractic and/or misleading the public on matters of health in that:

    - The Respondent stated on his website "we employ a highly specialized chiropractic technique as a means to address not just pain, but disease and organ disfunction", that could be interpreted to mean that he gives advice concerning medication.
    - The Respondent advertised for a "Cancer and Detox Workshop" in which claims were made that interference or blockage of the nervous system flow weakens the body and the immune system and that his chiropractic technique can strengthen the immune system and help to fight cancer.

5. The Respondent responded to the complaint as follows:

- He explained that his workshops are focused on teaching lifestyle modifications, including modifications that can, along with chiropractic, promote health.
- He agreed to change the reference to "highly specialized chiropractic technique" to either "has a special interest in" or "uses a special corrective chiropractic technique called Chiropractic Biophysics".
- Regarding the statement that chiropractic can strengthen the immune system, the Respondent cited a study that indicated that patients who were under chiropractic care had a 200% greater immune competence than those who had not received chiropractic care; the Respondent also agreed to change his website to indicate that interference or blockage of the nervous system *may* weaken the immune system.
- He stated that he does not give advice regarding pharmaceuticals but allows patients to make their own decisions after consultation with their physician or pharmacist.
- He did not agree that organ disfunction is not within the scope of chiropractic and cited two studies on the issue.

6. The Applicant responded to the Respondent's response as follows:

- The studies cited by the Respondent in support of the proposition that chiropractic can help organ disfunction are of dubious provenance and value.
- Two recent studies by chiropractic researchers concluded that there is no evidence that chiropractic prevents human disease.
- There is no benefit to immunocompetence greater than the normal level.
- There is no valid scientific evidence that chiropractic can boost the levels of antioxidants as claimed by the Respondent.

The Committee's Decision

7. The Committee investigated the complaint and decided to provide advice to the Respondent as noted above.

8. In reaching it decision, the Committee made the following findings:

- Regarding the Respondent's advertising of a "highly specialized chiropractic technique", the Committee noted that the Respondent was not a specialist but also noted his willingness to change his advertising to read "uses a spinal corrective technique called Chiropractic Biophysics".
- Regarding the Respondent's claims that chiropractic is a means to address disease, the Committee noted that many conditions have multiple contributing causes, not all of which are understood and found that it would be appropriate for the Respondent to change his website to indicate that subluxations *may* weaken the body and the immune system.
- Regarding the Respondent's claims about cancer prevention, the Committee noted that much of the information in question could relate to matters in the public domain however careful phrasing is important so as not to raise the hopes of vulnerable readers.
- Regarding the concerns about the Respondent's scope of practice, the Committee had reference to the applicable College Standard which provides that chiropractors should advise patients that for matters that are outside the scope of chiropractic practice, patients should consult an appropriate health professional; the Committee stated that chiropractors who advertise or participate in workshops should include a disclaimer about the limits of their advice.
- The Committee reviewed the Respondent's prior history and took all prior decisions into account in deciding to provide advice to the Respondent.

III. REQUEST FOR REVIEW

9. In a letter dated November 29, 2018, the Applicant requested that the Board review the Committee's decision.

IV. POWERS OF THE BOARD

10. 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.

11. 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

12. 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.

13. The Board has considered the written and oral submissions of the Applicant, examined the Record of Investigation (the Record), and reviewed the Committee's decision.

14. The Respondent attended the Review but did not provide submissions or otherwise participate in the Review. There is no statutory obligation on parties to participate in a review and the Board draws no inference from the Respondent's non-participation.

Adequacy of the Investigation

15. 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.

16. The Committee obtained the following information and documents:

- the Applicant's letter of complaint and further communications with the Committee;
- the Respondent's letters of response and further communications with the Committee;
- the College Standards of Practice S-001 and S-016, College Guidelines G-012 and G-016 and College Policy P-029; and
- the Respondent's complaint history with the College.

17. The Applicant did not take issue with the adequacy of the investigation.

18. The Board finds the information and documents listed in paragraph 16 above include the essential information relevant to making an informed decision regarding the issues raised in the complaint. There is no indication of any further relevant information or documents that the Committee could have obtained and that might reasonably be expected to have affected its decision.

19. Accordingly, the Board finds the Committee's investigation to be adequate.

Reasonableness of the Decision

20. 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.

21. The Applicant made the following submissions regarding the reasonableness of the Committee's decision:

- There is no scientific or medical support for the notion that "subluxations" are a legitimate condition or that they have any effect on bodily health;
- In fact, a chiropractic study done in 2009 found no support for the theory of subluxations;
- In finding that the hypothesis regarding subluxations is "possible albeit unconfirmed" the College and the Committee are not objective and are supporting an unsupported therapy;
- The Committee, by its decision, has given the Respondent a licence to lead patients to believe that spinal massage can prevent cancer.

22. For the reasons that follow, the Board finds that the Committee's decision to provide advice to the Respondent falls within a range of possible, acceptable outcomes and is reasonable.

23. The Appellant's primary concern is with respect to the validity of the notion that "subluxations" are a legitimate condition or that they have any effect on bodily health. The Appellant has referred the Committee and the Board to two recent studies in the chiropractic literature that have concluded that there is no scientific support for the theory of subluxations or that such a condition, if it exists, has any effect on bodily health.

24. This concern goes to the very essence of the practice of chiropractic which is a regulated health profession recognized under the *Chiropractic Act, 1991.* Sections 3 and 4 of that statute describe the scope of practice of chiropractic and the authorized acts that may be performed by members. It is beyond the role of the Board to determine whether any particular condition that appears to be generally accepted by the profession is invalid or non-existent. It is the College rather than the Board that is responsible to establish standards of practice for its members. Although the Appellant has provided information that casts considerable doubt on the theory of subluxations, the role of the Board is to consider whether the Committee's findings as to whether the Respondent met the applicable standards of practice was reasonable not whether the standards themselves are reasonable.

25. The Board concludes that the Committee's findings regarding the Respondent's advertising, including his website and his participation in workshops were reasonable and its decision to offer him advice regarding his advertising, scope of practice and social media was reasonable in light of the changes that the Respondent agreed to make to his website.

VI. DECISION

26. Pursuant to section 35(1) of the *Code*, the Board confirms the Committee's decision to advise the Respondent to adhere to the following:

    - Standard of Practice S-001: Scope of Practice
    - Standard of Practice S-016: Advertising
    - Guideline G-012: Use of Social Media
    - Guideline G-016: Advertising

ISSUED December 18, 2019

James Beamish

Maria Capulong

Brenda Petryna

Health Professions Appeal and Review Board

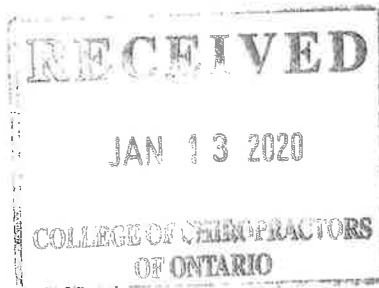
La Commission d'appel et de révision des professions de la santé

ITEM 1.3.4

CONFIDENTIAL

In reply please quote: File # 18-CRV-0871

January 10, 2020



Mr. Jordan Himel — Applicant Complainant

Dr. William Edwards, D.C. — Respondent

Dear Mr. Himel, Dr. Edwards

RE: COMPLAINT REVIEW - CHIROPRACTIC
JORDAN HIMEL AND WILLIAM EDWARDS, D.C.

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

Maureen Baker
Case Officer

Encl: Decision dated January 10, 2020

cc: College of Chiropractors of Ontario (CCOPRA File # 18-AP-18(HIMEL))

151 Bloor Street West, 9th Floor
Toronto, Ontario M5S 1S4

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151, rue Bloor ouest, 9e étage
Toronto, Ontario M5S 1S4

File # 18-CRV-0871

HEALTH PROFESSIONS APPEAL AND REVIEW BOARD

PRESENT:

David Scrimshaw, Designated Vice-Chair, Presiding
Christine Moss, Chair
Yasmeen Siddiqui, Board Member

Review held on November 12, 2019 in Ontario (by teleconference)

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

B E T W E E N:

JORDAN HIMEL

Applicant

and

WILLIAM EDWARDS, DC

Respondent

Appearances:

The Applicant:	Jordan Himel
For the College of Chiropractors of Ontario:	Tina Perryman

DECISION AND REASONS

I. DECISION

1. The Health Professions Appeal and Review Board confirms the decision of the Inquiries, Complaints and Reports Committee of the College of Chiropractors of Ontario to remind Dr. Edwards to adhere to Guideline G-001: *Communication with Patients* and to maintain professionalism at all times.

2. This decision arises from a request made to the Health Professions Appeal and Review Board (the Board) by Jordan Himel (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 William Edwards, DC (the Respondent). The Committee investigated the complaint and decided to remind the Respondent as described above.

II. BACKGROUND

3. The Applicant attended three appointments for treatment from the Respondent, a chiropractor, in August 2017. The first appointment took place on August 21, 2017. On his patient intake form, the Applicant indicated that he suffers bipolar disorder and depression. He sought treatment for lower back pain.

4. At the second appointment on August 23, 2017, the Applicant questioned the Respondent about the clinical evidence to support the treatment.

5. The third and final appointment took place on August 25, 2017.

The Complaint and the Response

6. The Applicant complained about the Respondent in a detailed letter. The Committee provided a five-page summary of the complaint to the Applicant and the Applicant submitted revisions to the summary, which was included in the Committee's decision. The Applicant complained that the Respondent committed acts of professional misconduct at his third appointment on August 25, 2017, which have had a physical and psychological impact on him. Regarding the final appointment, the Applicant's complaint included the following concerns:

   - The Respondent entered the treatment room and was distinctly unfriendly to the Applicant.

- The Respondent was aggressive to the point of causing pain with the activator device.
- The Respondent pressed the activator twice deep into the right side of the Applicant's spine and twice applied hard pressure on the back of the Applicant's right hipbone.
- At the end of the treatment, the Respondent approached the Applicant with a raised voice and said, "about our discussion the other day, if you have any doubts about being here, don't come back." He then pointed his finger close to the Applicant's face and said in anger, "you remember what I said."
- After the appointment, the Applicant arrived at his mother's house and noticed significant pain in both his lower back and his left leg. He consulted another chiropractor and confirmed that the activator should never be used aggressively, nor should it cause bruising as it had done in this case.
- The Applicant's mother called the clinic to request urgent care, the receptionist advised the Applicant to rest his back and informed him that the Respondent would no longer treat him as a patient following negative reaction to treatment. The receptionist provided no referral to an alternative healthcare provider.
- Later, the Applicant spoke to the receptionist who reiterated that chiropractic care was not appropriate for the Applicant. The Applicant was reimbursed for all payments made to the Respondent.

7. The Respondent responded to the complaint, describing his treatment of the Applicant and responded to the Applicant's concerns that:

- At the second appointment on August 23, 2017, the Applicant began asking questions about chiropractic in general and the Respondent attempted to reasonably answer to the best of his ability. Not long after, the Applicant's questions took on a different character and became

cynical, judgmental and disrespectful. The Respondent offered the Applicant the option of discontinuing care or limiting his overt criticism, as the Respondent felt it was serving to undermine the doctor-patient relationship.

- There was no material change in the volume or intensity of care at the third appointment from the previous appointments.
- The Respondent denied causing bruising or other injury.
- His manner was courteous and professional throughout the August 25, 2017, appointment.
- He denied shouting or pointing.
- The Applicant was initially pleasant and cooperative. However, his mood altered as the session progressed. When the Applicant resumed the disrespectful discourse from the previous appointment, the Respondent interjected and informed the Applicant that, in the circumstances, he could no longer continue to provide care.
- When the Applicant's mother contacted the office seeking a refund, the office staff confirmed that they were discontinuing their involvement in his care and a full refund was made as a gesture of goodwill.

8. Following a letter from the Committee asking for a copy of a discharge letter provided to the Applicant, the Respondent replied: "No formal letter of discharge was issued as it was [the Applicant] who elected to end his attendances."

The Committee's Decision

9. The Committee investigated the complaint and decided to remind the Respondent to adhere to Guideline G-001: *Communication with Patients* and to maintain professionalism at all times.

10. The Committee reviewed the Applicant's records of health information and communications from the Applicant's mother and found no documentation that the

Respondent purported to treat the Applicant's bipolar disorder or depression. The professional members of the Committee observed that the traditional chiropractic perspective is that the removal of vertebral subluxations allows the nervous system to work without interference, which in turn allows the body to function as efficiently as possible. The Committee stated that such care does not purport to treat bipolar disorder itself, but rather, aims to maximize the patient's inherent potential for health. The professional members opined that it would be appropriate for a chiropractor to provide care as part of a multi-disciplinary approach, but not as a substitute for the patient's primary care physician.

11. The Committee stated that it appeared that an impression had been allowed to form in the minds of the Applicant and his mother that the Respondent would treat bipolar disorder in the Applicant, and/or attention deficit disorder for the Applicant's son and anxiety for his mother.

12. The Committee opined that the Applicant asking at his second appointment about the placebo effect would not have been inherently disrespectful, but since the term "placebo" can refer to a sham intervention, the question could be perceived as insulting the practitioner. The Committee found that regardless, the chiropractor must answer politely and accurately. The Committee noted the differing accounts the Applicant and Respondent gave of their interaction at the third appointment and stated it was impossible to know with certainty what happened, but regardless, it is the professional's responsibility to maintain a professional demeanor. In this context, the Committee issued its reminder about communication and professionalism.

13. The Committee reviewed photographs of the Applicant that he provided and noted that slight bruises were visible that corresponded to the areas the Respondent adjusted with the activator. The Committee found that the images could be consistent with the Applicant's version of events, but that was not the only possible explanation for these bruises and because the photographs were not date stamped, they were of limited probative value.

14. The Committee noted that the Applicant and his mother reported that the Respondent's staff relayed that the Respondent was dismissing the Applicant from his practice, and that the Respondent reported in his first response to the complaint that he informed the Applicant that he could no longer continue to provide care. However, when the Committee wrote to the Respondent asking for his discharge letter, the Respondent replied that no names were provided because the Applicant did not wish to continue chiropractic care.

15. The Committee noted that the Applicant said he continued to experience sequelae. The Committee further noted that the record of personal health information indicated that the Applicant was an appropriate candidate for activator treatment in the areas recorded and that the signed consent form mentioned that exacerbation of symptoms is possible. The Committee opined that the symptom flare-up appears to reflect the natural progression of the Applicant's condition and even if the Respondent's treatments were a factor in the Applicant's symptoms, it would not necessarily mean that the Respondent's treatments were inappropriate.

16. The Committee noted that the Respondent had no history of previous complaints with the College.

III. REQUEST FOR REVIEW

17. In a letter dated December 28, 2018, the Applicant requested that the Board review the Committee's decision.

IV. POWERS OF THE BOARD

18. 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.

19. 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

20. 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.

21. The Respondent did not attend the Review, however he provided written submissions to the Board. The Board notes there is no legislative requirement for parties to attend a review and draws no inference from the Respondent's non-attendance.

22. The Board has considered the submissions of the parties, examined the Record of Investigation (the Record), and reviewed the Committee's decision.

Adequacy of the Investigation

23. 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.

24. The Committee's mandate is that of a screening committee with regard to complaints about its members. The Committee considers the information it obtains to determine whether, in all of the circumstances, a referral of specified allegations of professional misconduct to the College's Discipline Committee is warranted or if some other remedial

action should be taken. Actions available to the Committee upon considering a complaint include taking no action with regard to a member's practice, directing remedial measures intended to improve an aspect of a member's practice or referring specified allegations of professional misconduct to the Discipline Committee.

25. The Committee obtained the following documents:

- the Applicant's initial complaint and subsequent correspondence including written statements from the Applicant's mother, sister and wife; and photographs of the Applicant;
- the Respondent's response and subsequent correspondence;
- the Applicant's patient records; and
- the College's Guideline G-001: *Communication with Patients*.

26. The Respondent submitted the Committee adequately investigated the matter and obtained information sufficient to enable it to reasonably assess the complaint.

27. The Applicant submitted that the investigation was inadequate because the Committee did not follow up on his complaint by interviewing him or any witnesses.

28. The Board finds that the Committee did not need to interview the Applicant and his suggested witnesses to obtain the essential information to assess the complaint. The Applicant provided ample written information to support his complaint including written statements from his wife, sister and mother. The investigator provided him with a summary of his complaint and he sent in revisions that were reflected in the Committee's decision.

29. The Committee obtained the Applicant's records from the Respondent. Both parties submitted information to the Committee and the Applicant provided additional clarifications of his concerns.

30. The Board finds the Committee's investigation covered the events in question, and that it obtained relevant information to make an informed decision regarding the issues raised in the complaint. There is no indication of additional information that, if obtained, might reasonably be expected to have affected the Committee's decision.

31. Accordingly, the Board finds that the Committee's investigation was adequate.

Reasonableness of the Decision

32. 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.

33. The Applicant submitted that the Committee's decision was not reasonable because the Committee paid insufficient attention to the information he provided and the Committee showed a lack of diligence and bias against him.

Diligence and bias

34. The Applicant submitted that the Committee's actions regarding his summary of concerns and Authorization and Consent to Investigate form left him with "less than high confidence" and that the Committee's decision was cursory, leaving him the impression of a "biased exercise."

35. The Board does not share these concerns. The Committee prepared a five-page summary of the Applicant's complaint. The Applicant identified revisions he wished to have made in the summary. These included inserting missing words like "a" and "the" and in one case reversing the order of two bulleted points in order to clarify the context. In preparing

any document, it is common for there to be minor mistakes and omissions. Even if there were substantial errors in the first draft of the summary, by following a process in which the Applicant was provided the summary and asked to make revisions shows diligence on the part of the Committee.

36. The Committee provided the Applicant with its standard Authorization and Consent to Investigate form. The Applicant identified provisions on the form that he was not comfortable with and asked that they be removed from the version of the form that he signed. The Committee agreed to this request and the Applicant signed the revised form.

37. The Board notes that in its 14-page decision, the Committee included the entire summary of the Applicant's concerns and further described the written reports from the Applicant's wife, sister and mother as well as the Respondent's reply. The Committee addressed each of the Applicant's areas of concerns and explained the reasons for its conclusions. The Board finds that the information in the Record does not support a finding of bias against the Applicant.

Clinical treatment

38. The Committee examined the Applicant's records of health information and found no concerns with the Respondent's diagnosis and treatment choices. These conclusions were supported by the information in the Record and by the Committee's expertise in the standards of the profession.

39. The Applicant had provided photographs that showed bruising. The Committee found that the photographs are of limited probative value because the Applicant's explanation for the bruises was not the only possible explanation and because the photographs are not date stamped. The Board finds this to be a reasonable decision that falls within a range of possible, acceptable outcomes. Similarly, the Committee's findings regarding the sequelae the Applicant continues to experience fall within the Committee's expertise in

the standards of the profession. There is no indication that the Committee's expertise was inappropriately applied.

Communication

40. In assessing the concerns involving communications between the parties, the Committee identified a number of instances in which the Applicant and the Respondent provided different accounts of their interactions.

41. When the Committee has conflicting accounts of events it cannot prefer one person's account to another's unless there is independent information to support one or the other.

42. Although the Committee could not determine with certainty what happened, the Committee found it to be the professional's responsibility to maintain a professional demeanor and reminded the Respondent to adhere to Guideline G-001: *Communication with Patients* and to maintain professionalism at all times.

43. The Board notes that Guideline G-001: *Communication with Patients* contains provisions that are relevant to the concerns raised by the Applicant, for example under the heading "Verbal Communication" the Guideline states:

> A member can help enhance the trust and care in the doctor/patient relationship by using appropriate communication practices in all verbal interactions with the patient at all times. A member shall ensure that the way he/she verbally conveys information to the patient is understandable and comfortable for the patient, by:
>
> - using language associated with chiropractic care that is clear and comprehensible to the patient;
> - using charts and diagrams to help explain elements of chiropractic care and overcome any conceptual difficulties;
>
> ...
>
> - encouraging the patient to ask any questions to clarify any misunderstandings and providing clear and concise answers;

- being honest, straightforward and tactful;
- demonstrating respect and empathy for the patient;
- acknowledging and legitimizing any fears, embarrassment or discomfort of the patient;
- demonstrating respect and empathy for the patient; and
- avoiding any misunderstandings by asking the patient to verify the intended message, and if appropriate, asking the patient to repeat it in his/her own words.

44. The Board finds the Committee's finding regarding communications to be reasonable because the information in the Record supports that there were differing accounts from the parties and the Committee's decision to remind the Respondent of the Guideline was within the range of possible, acceptable outcomes.

Discontinuation of care

45. Regarding the ending of the chiropractor-patient relationship between the parties, the Committee was again faced with different accounts. The Applicant and his mother stated that the Respondent's office staff stated that the Respondent was dismissing the Applicant from the practice. In his first response to the Committee, the Respondent wrote that during the August 25, 2017, appointment, he "interjected and informed [the Applicant] that in the circumstances [the Respondent] could no longer continue to provide care." The Respondent also wrote that on the telephone, his staff "confirmed that we were discontinuing involvement in his care." However, in a subsequent letter to the Committee, the Respondent wrote: "No formal letter of discharge was issued as it was [the Applicant] who elected to end his attendances."

46. The Committee identified no concerns with the ending of the parties' chiropractor-patient relationship and took no action on this aspect of the Applicant's complaint.

47. Following a question from the Board at the Review, the College's representative identified that a chiropractor who chooses to discontinue treating a patient can do so with a written letter or can do it verbally, and that the discontinued patient should be provided with the name of another practitioner.

48. The Board finds it reasonable that the Committee took no action on this aspect of the complaint.

Conclusion on reasonableness of the decision

49. The Board acknowledges that the Applicant remains dissatisfied with the care he received. Nonetheless, the information in the Record provides support for the Committee's conclusions, which fall within a range of possible, acceptable outcomes that are defensible in respect of the facts and the law. Accordingly, the Board finds the Committee's decision to be reasonable. The Board notes that the Committee, composed of three chiropractors and one public member, applied its knowledge of the standards of the profession. The Board finds that the Committee's conclusions were within the Committee's expertise and based on the information in the Record.

VI. DECISION

50. Pursuant to section 35(1) of the *Code*, the Board confirms the Committee's decisions to remind the Respondent to adhere to Guideline G-001: *Communication with Patients* and to maintain professionalism at all times.

ISSUED January 10, 2020

David Scrimshaw

Christine Moss

Yasmeen Siddiqui

College of Chiropractors of Ontario
Registration Committee Report to Council
February 26, 2020

Members: Dr. Cliff Hardick, *Chair*
Dr. Paul Groulx
Ms Georgia Allan
Ms Sheryn Posen

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

I. Report

The Registration Committee has not met since the last meeting of Council. CCO held a legislation and ethics examination and record keeping workshop on February 4, 2020, attended by 26 individuals.

Current Member Status

Chart 1: Membership Statistics as at February 12, 2020

Status	**Total**
Active	4688
Inactive – Resident	220
Retired	141
All categories	**5069**

Chart 2: Change in Registration statistics for November 19, 2019 – February 12, 2020

Description	**Total**
New registrants	27
Female	12
Male	15

Chart 3: Colleges of Graduation for New Registrants

CMCC	7
Life	1
Logan	1
MacQuarie	1
NHSU	1
NYCC	12
NZCC	1
Palmer FL	1
Palmer IOWA	2

I would like to thank the members of the Registration committee and the support staff for their time and commitment.

Respectfully submitted,

Dr. Cliff Hardick,
Chair, Registration Committee

ITEM 4.1

Generated Internally

College of Chiropractors of Ontario
Executive Committee Report to Council
February 26, 2020

Members: Dr. Dennis Mizel, *President*
Mr. Rob MacKay, *Vice-President*
Dr. Cliff Hardick, *Treasurer*
Dr. Peter Amlinger
Ms Georgia Allan
Ms Karoline Bourdeau

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

I Introduction

- Since the last meeting of Council, the Executive Committee ("Committee") has met in person on one occasion, namely, January 29, 2020 (in addition to one in person meeting on January 15, 2020 to address Code of Conduct matters). The draft, confidential minutes are included in the Council information package, and are subject to review and approval on March 12, 2020.

- In addition to the various ongoing matters before the Committee, a great deal of time, money and energy has been expended addressing a number of Code of conduct allegations made against Council members

- The dispositions of these matters are included at this time in the in-camera section of the council information package. It will be up to Council to determine what aspects of these dispositions should be public. It may be that some of the individuals against whom complaints have been made will consent to the information being publicly available in the interests of openness and transparency.

- By the time of the Council meeting, some council members will have attended a governance training workshop on February 25, 2020 consistent with recommendations from the Committee which has had the responsibility to address the various matters.

- It is my fervent hope and expectation that all of us can more forward in a manner which is respectful and professional and consistent with CCO's statutory responsibility to regulate chiropractic in the public interest. I am mindful of the various presentations we have had from leading experts, including Ms Deanna Williams at the November 29, 2020 training session where she reflected on a general rule of thumb that approximately 80 % of a regulator's efforts should be expended on matters which relate specifically to its core mandate, specifically public interest protection. I am acutely aware of the toll managing the various allegations has had on everyone concerned.

- Ms Willson and I are trying various formats relating to the structure of the agenda and council information packages to ensure the packages are as helpful as possible, and we would appreciate any feedback from Council members relating to the changes being made.

II Ministry of Health

- Since the last report to Council, we have had various communications with the Ministry of Health and have taken the step of linking the Ministry's bulletins relating to the recent health challenges on the CCO website for stakeholders including members' information. As reported at the November 29, 2020 training session, the Ministry is continuing its work on a framework for evaluating regulatory performance. My understanding is that in preparing the 2019 Annual Report, Ms Willson and her team will be trying to structure the reporting of CCO's activities to be consistent with the draft framework, and in particular, to demonstrate how the various committee and Council activities relate to public protection and furtherance of CCO's strategic objectives.

III Elections

- Council members will recall concerns were raised about the elections in 2019, and accordingly, several efforts have been made to facilitate and enhance respectful, professional communications and a fair election process. I am very pleased that Mr. Dan Faulkner has agreed to participate on the Election review Committee as a resource and representative from someone outside of chiropractic. Mr. Faulkner has previously served at the CPSO and assisted in making modifications to their election processes. He is also currently co-chair of the Ministry task force developing the College Performance Measurement Framework (CPMF).

- As previously reported, a number of revisions were made to the various election documents, including the candidate undertaking. All the election material is included in the council information package. Congratulations to Dr Starmer for being CCO's first academic representative. Elections in the other three districts are currently underway with the various safeguards in place to ensure a fair election.

- Council members are reminded that CCO has supported the submissions of the College of Nurses and the College of Teachers to move towards a competency-based selection criteria and balance of elected and public members, but unless and until any legislative amendments are made, the current system will continue.

IV Communications/Strategic Planning

- Mr. MacKay, Ms Willson and I had an opportunity to meet on January 28, 2020 with Ms Caroline Brereton, Dr. Ken Brough and Dr. Brian Gleberzon of the OCA to discuss several matters of mutual interest, including the need for all leadership to enhance respectful communications. The OCA was very receptive to this communication. We will also be communicating further with the Alliance for Chiropractic (AFC) and others to repeat the same message.

- Included in the Council information package are various President's Messages that have been circulated over the past few months. I am trying to have shorter, more timely communications on an ongoing basis, rather than waiting for a comprehensive newsletter addressing several matters.

V Matters in Progress

- Given the various other pressing matters being addressed by the Committee, some matters have been deferred to the March 12, 2020 Committee agenda, including:

    - best practices relating to minutes and the publication of a summary of minutes; how best to solicit useful feedback on survey documents while maintaining transparency;
    - communication to stakeholders that information cannot be considered "confidential" if it is intended to influence/guide CCO decision making;
    - compilation of information about government relations initiatives by other regulators;
    - refinement of existing conflict of interest provisions;
    - development of key messages relating to the chiropractic treatment of children;
    - further consideration of the Cayton Report from British Columbia; and
    - proposed amendments to various internal policies.

- Council members should be aware that Ms Deanna Williams and Mr. Joel Friedman are working on a review of CCO's internal policies from the perspective of any learnings for Council arising from the various governance matters, and the Committee hopes to have recommendations for Council's consideration at the April 15, 2020 Council meeting.

- One matter that is ready for Council's consideration is the following recommendation:

Recommendation 1

That Council approve the amendment to G-009: Code of Ethics to reference a requirement that members engage in professional, respectful communications with other members and health professionals and not engage in any in-person or online bullying, intimidation or harassment.

VI Strategic Planning/Training Opportunities

- The Committee continues to make efforts to focus on key priorities, and to facilitate learning and training opportunities. It will be useful to hear from Council members about any suggestions or feedback for the September 2020 Strategic Planning Session and Council Specific Topic meeting which will be held at the White Oaks in Niagara. Please forward your suggestions as soon as possible as a great deal of time and preparation is required to make the sessions a success.

- At the January 29, 2020 meeting, the Committee heard from Mr. Hanno Weinberger, who has served as an elected member on the College of Teachers and as a public member (including as President) on the College of Denturists. It was interesting to hear about some of his perspectives on effective regulation and governance from the perspective of two very different regulators, in both size, resources, and types of members/practice settings. We will continue to investigate other best practices for the purpose of ensuring an efficient, effective Council.

VII Chiropractic/Other Stakeholders

- We continue to participate in various initiatives with stakeholders. For example:

  - Ms Willson was asked to attend the upcoming FCLB meeting, which includes an educational training day for regulators; the FCLB is the national group of chiropractic regulators in the United States which has a register identifying chiropractors who have been found guilty of professional misconduct or incompetence. CCO has recently re-joined the FCLB and Ms Willson will report back on the possible learnings and benefits of membership and dialogue with North American colleagues;

  - CCO was invited to the CCA's summit in Halifax in April 2020. To date, we have declined the invitation, being cognizant of Council's previous discussions concerning the need to ensure a focus on regulatory matters;

  - Arising from the joint meeting of regulators and the CCO in November 2019, the FCC has established various working groups to try to harmonize standards nationally. Ms Willson and Dr. Walton have been participating in the working group dealing first with the CCPA's Road Map to Care document; Time permitting, I will ask them for a verbal report; and

- Ms Willson continues to serve on the Executive of the Health Profession Regulators of Ontario (formerly the Federation of Health Regulatory Colleges). CCO will be hosting the HPRO board meeting on March 3, 2020.

VIII Conclusion

- I look forward to working with all of you over the months to come. I am cognizant of the transition anticipated on Council with four pubic members also having terms expiring in 2020, as well as the pending elections. I have confidence that we can harness the skills and abilities and reaffirm our commitment to focusing on public interest protection. Thank you for your ongoing support and commitment to CCO.

Respectfully submitted by,

Dr. Dennis Mizel,
President

Ministry of Health Announcement – Wuhan Novel Coronavirus

ITEM 4.1.4

136

Please **click here** for important information from the Ontario Ministry of Health concerning the Wuhan Novel Coronavirus.

Ontario

137

The 2019 Novel Coronavirus (COVID-19)

Learn about how the Ministry of Health is preparing for the 2019 novel coronavirus in Ontario. Find out how to protect yourself, what to do if you're sick after you travel and how to recognize possible symptoms.

Get information in other languages

Status of cases in Ontario

Every weekday at 10:30 a.m. ET, this web page will be updated with the most up-to-date information on the status of cases in Ontario.

The symptoms of the 2019 novel coronavirus, which can include fever and cough, are similar to other respiratory infections, including influenza. As a result, individuals who may simply have the flu are being tested out of an abundance of caution and in line with Ontario's robust detection protocols. This means that most individuals who are tested are unlikely to be infected with the 2019 novel coronavirus.

Negative[1]	462
Currently under investigation[2]	14
Presumptive positive[3]	0
Confirmed positive[4]	1
Resolved[5]	2
Total number of patients approved for COVID-19 testing to date	**479**

[1]Patient negative based on testing performed at Public Health Ontario (PHO) Laboratory (Note: Testing at National Microbiology Lab (NML) no longer required due to enhanced national testing protocols.)
[2]Test results are pending
[3]Patient who has tested positive at PHO Laboratory but not yet tested at NML
[4]Patient who is currently positive based on tests performed at both PHO Laboratory and NML
[5]Patient is no longer infectious based on two consecutive negative tests performed at PHO Laboratory at least 24 hours apart

Last updated: February 20, 2020 at 10:30 a.m. ET

Coronaviruses

Coronaviruses are a large family of viruses that can cause illnesses ranging from the common cold to more serious respiratory infections like bronchitis, pneumonia or severe acute respiratory syndrome (SARS).

Coronaviruses are spread mainly from person to person through close contact, for example, in a household, workplace or health care centre.

Some human coronaviruses spread easily between people, while others do not.

Your risk of severe disease may be higher if you have a weakened immune system. This may be the case for:

- older people
- people with chronic disease (for example, diabetes, cancer, heart, renal or chronic lung disease)

The 2019 novel coronavirus (COVID-19)

The 2019 novel coronavirus (COVID-19) causes a respiratory infection that originated in Wuhan, China.

The first presumptive case of this infection in Ontario was identified on January 25, 2020.

Current affected areas

The following geographic areas are identified as affected areas:

- mainland China

Travellers returning from affected areas

Travellers who have returned from Hubei province, including Wuhan City, should:

- contact their local public health unit (http://www.health.gov.on.ca/en/common/system/services/phu/locations.aspx) within 24 hours of arriving in Canada
- **stay at home and avoid close contact with others, including those in their home,** for a total of 14 days from the date they left Hubei province
- contact Telehealth Ontario at 1-866-797-0000 or their local public health unit (http://www.health.gov.on.ca/en/common/system/services/phu/locations.aspx) if they experience symptoms of the 2019 novel coronavirus

Travellers who have returned from mainland China should:

- monitor themselves for symptoms of the 2019 novel coronavirus for 14 days after leaving China
- contact Telehealth Ontario at 1-866-797-0000 or their local public health unit (http://www.health.gov.on.ca/en/common/system/services/phu/locations.aspx) if they experience symptoms of the 2019 novel coronavirus

Learn about travel advisories (http://travel.gc.ca/travelling/advisories/pneumonia-china) related to the 2019 novel coronavirus.

Laboratory testing

Testing is being conducted at the Public Health Ontario Laboratory, which is working collaboratively with the National Microbiology Laboratory in Winnipeg.

How Ontario is preparing

Ontario is working with its partners in the health care system implementing a robust plan to monitor for, detect and, if needed, isolate any cases of the 2019 novel coronavirus. The Ministry of Health is taking several steps to ensure the health and safety of Ontarians. This includes:

- monitoring hospitals for potential cases of the virus in individuals with travel history to current affected areas
- adding the 2019 novel coronavirus as a designated disease reportable under Ontario's public health legislation, enabling local public health units to quickly and effectively take all necessary measures to investigate, complete lab tests and do case and contact management to prevent and control further spread of the infection
- ongoing planning with federal and provincial/territorial partners and readiness to coordinate with other provinces/territories
- meeting with hospitals, paramedics and local public health units near Pearson International Airport to provide further information on the federal border screening measures

Symptoms and treatment

Symptoms range from mild – like the flu and other common respiratory infections – to severe, and can include:

- fever
- cough
- difficulty breathing

Complications from the 2019 novel coronavirus can include serious conditions, like pneumonia or kidney failure, and in some cases, death.

There are no specific treatments for coronaviruses, and there is no vaccine that protects against coronaviruses. Most people with common human coronavirus illnesses will recover on their own.

You should:

- drink plenty of fluids
- get rest and sleep as much as possible
- try a humidifier or a hot shower to help with a sore throat or cough

If you need immediate medical attention you should call 911 and mention your travel history and symptoms.

How to protect yourself

Coronaviruses are spread mainly from person to person through close contact, for example, in a household, workplace or health care centre. The 2019 novel coronavirus has evidence of limited human-to-human transmission.

There is no vaccine available to protect against the 2019 novel coronavirus.

There are everyday actions that can help prevent the spread of germs that cause respiratory illnesses. Take these everyday steps to reduce exposure to the virus and protect your health:

- wash your hands often with soap and water or alcohol-based hand sanitizer
- sneeze and cough into your sleeve
- avoid touching your eyes, nose or mouth
- avoid contact with people who are sick
- stay home if you are sick

If you are travelling to an area known to have cases of coronavirus, be sure to avoid:

- high-risk areas such as farms, live animal markets and areas where animals may be slaughtered
- contact with animals (alive or dead), including pigs, chickens, ducks and wild birds
- surfaces with animal droppings or secretions on them

140

Information on the 2019 novel coronavirus for health care professionals

If you are a health care professional, learn how to protect yourself and your patients by reading our guidance documents (http://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/2019_guidance.aspx) and learning about:

- screening
- laboratory testing
- treatment recommendations
- occupational health & safety and infection prevention & control measures

Ontario news about the 2019 novel coronavirus

News Release: Ontario Confirms Resolved Case of the 2019 Novel Coronavirus (February 12, 2020) (https://news.ontario.ca/mohltc/en/2020/02/ontario-confirms-resolved-case-of-the-2019-novel-coronavirus.html)

News Release: Ontario's Public Health System Keeping the Public Safe (January 31, 2020) (https://news.ontario.ca/mohltc/en/2020/01/ontarios-public-health-system-keeping-the-public-safe.html)

News Release: Ontario Confirms Third Case of 2019 Novel Coronavirus (January 31, 2020) (https://news.ontario.ca/mohltc/en/2020/01/ontario-confirms-third-case-of-2019-novel-coronavirus.html)

News Release: Ontario Government Protecting Students from Emerging Issue of the 2019 Novel Coronavirus (January 28, 2020) (https://news.ontario.ca/mohltc/en/2020/01/ontario-government-protecting-students-from-emerging-issue-of-the-2019-novel-coronavirus.html)

News Release: Ontario Confirms Second Presumptive Case of Wuhan Novel Coronavirus (January 27, 2020) (https://news.ontario.ca/mohltc/en/2020/01/ontario-confirms-second-presumptive-case-of-wuhan-novel-coronavirus.html)

News Release: Ontario Protecting Students from Emerging Issue of the Wuhan Novel Coronavirus (January 26, 2020) (https://news.ontario.ca/mohltc/en/2020/01/ontario-protecting-students-from-emerging-issue-of-the-wuhan-novel-coronavirus.html)

News Release: Ontario Confirms First Case of Wuhan Novel Coronavirus (January 25, 2020) (https://news.ontario.ca/mohltc/en/2020/01/ontario-confirms-first-case-of-wuhan-novel-coronavirus.html)

News release: Federal Government Increasing Measures to Monitor Wuhan Novel Coronavirus Risks at Canadian Airports, Including Pearson (January 24, 2020) (https://news.ontario.ca/mohltc/en/2020/01/federal-government-increasing-measures-to-monitor-wuhan-novel-coronavirus-risks-at-canadian-airports.html)

News release: Ontario Takes Steps to Safeguard the Health of the Public Against the Coronavirus (January 22, 2020) (https://news.ontario.ca/mohltc/en/2020/01/statement-by-deputy-premier-and-minister-of-health-christine-elliott.html)

Information sheet (available in multiple languages)

The Ministry of Health has developed an information sheet about the 2019 novel coronavirus (COVID-19) to inform Ontarians about the virus, how they can protect themselves and what to do if they think they have contracted the 2019 novel coronavirus. The information sheet is available in multiple languages.

141

- العربية (Arabic) (https://files.ontario.ca/moh-coronavirus-info-sheet-arabic-2020-02-18.pdf)
- বাংলা (Bengali) (https://files.ontario.ca/moh-coronavirus-info-sheet-bengali-2020-02-18.pdf)
- 中文 (简体) (Simplified Chinese) (https://files.ontario.ca/moh-coronavirus-info-sheet-simplified-chinese-2020-02-18.pdf)
- 中文 (繁體) (Traditional Chinese) (https://files.ontario.ca/moh-coronavirus-info-sheet-traditional-chinese-2020-02-18.pdf)
- English (https://files.ontario.ca/moh-coronavirus-info-sheet-english-2020-02-18.pdf)
- فارسی (Farsi) (https://files.ontario.ca/moh-coronavirus-info-sheet-farsi-2020-02-18.pdf)
- Français (French) (https://files.ontario.ca/moh-coronavirus-info-sheet-french-2020-02-18.pdf)
- Deutsch (German) (https://files.ontario.ca/moh-coronavirus-info-sheet-german-2020-02-18.pdf)
- Ελληνικά (Greek) (https://files.ontario.ca/moh-coronavirus-info-sheet-greek-2020-02-18.pdf)
- ગુજરાતી (Gujarati) (https://files.ontario.ca/moh-coronavirus-info-sheet-gujarati-2020-02-18.pdf)
- हिंदी (Hindi) (https://files.ontario.ca/moh-coronavirus-info-sheet-hindi-2020-02-18.pdf)
- Italiano (Italian) (https://files.ontario.ca/moh-coronavirus-info-sheet-italian-2020-02-18.pdf)
- 한국어 (Korean) (https://files.ontario.ca/moh-coronavirus-info-sheet-korean-2020-02-18.pdf)
- Polski (Polish) (https://files.ontario.ca/moh-coronavirus-info-sheet-polish-2020-02-18.pdf)
- Português (Portuguese) (https://files.ontario.ca/moh-coronavirus-info-sheet-portuguese-2020-02-18.pdf)
- ਪੰਜਾਬੀ (Punjabi) (https://files.ontario.ca/moh-coronavirus-info-sheet-punjabi-2020-02-18.pdf)
- Русский (Russian) (https://files.ontario.ca/moh-coronavirus-info-sheet-russian-2020-02-18.pdf)
- Română (Romanian) (https://files.ontario.ca/moh-coronavirus-info-sheet-romanian-2020-02-18.pdf)
- Soomaali (Somali) (https://files.ontario.ca/moh-coronavirus-info-sheet-somali-2020-02-18.pdf)
- Español (Spanish) (https://files.ontario.ca/moh-coronavirus-info-sheet-spanish-2020-02-18.pdf)
- Tagalog (https://files.ontario.ca/moh-coronavirus-info-sheet-tagalog-2020-02-18.pdf)
- தமிழ் (Tamil) (https://files.ontario.ca/moh-coronavirus-info-sheet-tamil-2020-02-18.pdf)
- اردو (Urdu) (https://files.ontario.ca/moh-coronavirus-info-sheet-urdu-2020-02-18.pdf)
- Tiếng Việt (Vietnamese) (https://files.ontario.ca/moh-coronavirus-info-sheet-vietnamese-2020-02-18.pdf)

Updated: February 20, 2020
Published: January 25, 2020

Related

Government of Canada Travel Advisories (https://travel.gc.ca/travelling/advisories)

Public Health Ontario (https://www.publichealthontario.ca/)

Public Health Agency of Canada (https://www.canada.ca/en/public-health.html)

World Health Organization (https://www.who.int/emergencies/diseases/novel-coronavirus-2019)

Ontario Protecting Students from Emerging Issue of the Wuhan Novel Coronavirus

January 26, 2020 5:00 P.M.

TORONTO — Today, Christine Elliott, Deputy Premier and Minister of Health, and Stephen Lecce, Minister of Education, issued the following statement in response to the first presumptive case of the Wuhan novel coronavirus in Ontario and following a briefing of the province's directors of education:

"The health and well-being of Ontarians, including and especially our students and school staff, is our number one priority. To that end, earlier today Dr. David Williams, Chief Medical Officer of Health, and Dr. Barbara Yaffe, Associate Chief Medical Officer of Health, briefed Ontario's directors of education on the province's extensive protocols to monitor, detect and contain any cases of the Wuhan novel coronavirus.

Ontario continues to work directly alongside our partners at the Public Health Agency of Canada and local public health units to monitor the situation closely. Newly strengthened protocols for identification and control are working to keep the public safe.

We want to assure students, parents and school communities that officials at the Ministry of Health and the Ministry of Education are working together in close cooperation with our partners in both the education and health care sectors to ensure the continued safety and well-being of students and staff."

To help educate Ontarians about Wuhan novel coronavirus, how they can protect themselves and what to do if they suspect they may be at risk, the province has launched a dedicated webpage.

Travis Kann Director, Communications
travis.kann@ontario.ca
647-388-5845
David Jensen Communications Branch
media.moh@ontario.ca
416-314-6197

Available Online
Disponible en Français

From: Jo-Ann Willson
Sent: Wednesday, February 19, 2020 12:58 PM
To: Rose Bustria
Subject: FW: Premier's Council on Improving Healthcare and Ending Hallway Medicine - Newsletter
Attachments: PremiersCouncilNewsletter-February 2020.pdf; PremiersCouncilNewsletter- February 2020-French.pdf

Council.

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From: Orofino, Mirella (MOH) <Mirella.Orofino@ontario.ca> **On Behalf Of** Scarth, Fredrika (MOH)
Sent: Wednesday, February 19, 2020 12:37 PM
Subject: Premier's Council on Improving Healthcare and Ending Hallway Medicine - Newsletter

Please see attached Premier's Council on Improving Healthcare and Ending Hallway Medicine newsletter on behalf of the Secretariat.

Regards,

Fredrika Scarth
Director, Secretariat
Premier's Council on Improving Healthcare & Ending Hallway Medicine
fredrika.scarth@ontario.ca
hallwayhealthcare@ontario.ca

February, 2020

Premier's Council on Improving Healthcare and Ending Hallway Medicine--Update, Email Newsletter

The Premier's Council on Improving Healthcare and Ending Hallway Medicine is looking forward to another transformative year in health care and wanted to take this opportunity to provide you, our partners in health care, with an update on our work and a glimpse into the year ahead.

Our first year as a Council saw the release of two reports containing our assessment of the health care system and recommendations for ending hallway health care. The first report, *Hallway Health Care: A System Under Strain*, identified challenges facing Ontario's health care system. The second report, *A Healthy Ontario: Building a Sustainable Health Care System*, made 10 strategic policy recommendations focused around four common areas for improvement that emerged from our work: integration, innovation, efficiency and alignment, and capacity.

In our second year, the Council will help guide implementation of our recommendations, shifting from what to do, to providing advice on how best to do it.

Providing Our Best Advice.

To inform our first two reports, the Council heard from over 1,500 patients, caregivers, families, health care professionals and organizations on the future of health care in the province, conducting 10 regional engagement sessions in communities across the province, and a virtual engagement session with more than 250 Francophone stakeholders and participants. Council members also heard from a range of system leaders through six sub-committees, representing various themes related to hallway health care, began initial dialogue with Indigenous communities and partners and received more than 500 written survey responses, emails and formal submissions from individuals across the province. The collective advice from this engagement helped shape our recommendations and will contribute to meaningful change across the health care system.

Our second-year focus on implementation will be informed by working groups of clinicians and health system leaders from across the province, focused on the four common areas for improvement, including:

- **Integration.**
  Chair: Dr. Jack Kitts, President and Chief Executive Officer of The Ottawa Hospital;
  Supporting Council Member: Dr. Suzanne Filion, Vice President, Hawkesbury & District General

  This working group is exploring ways to better support patients and providers at every step of their health care journey in order to create an integrated and patient-centred health care system that is easy for patients to navigate. It will be focused on supporting implementation of Ontario Health Teams.

- **Innovation.**
  Chair: Dr. Rueben Devlin, Special Advisor and Chair of the Premier's Council on Improving Healthcare and Ending Hallway Medicine;
  Supporting Council Member: Dr. Richard Reznick, Dean, Faculty of Health Sciences Queens University

  This working group is exploring opportunities for innovative technology and digital solutions on health care delivery by nurturing innovative ideas and designing new solutions to solve long-standing problems. It will also suggest foundational work required to ready the system for ever changing technology.

- **Capacity.**
  Chair: Dr. Gillian Kernaghan, President and Chief Executive Officer of St. Joseph's Health Care London;
  Supporting Council Member: Kimberley Moran, Chief Executive Officer, Children's Mental Health Ontario

  This working group is focusing on health care capacity planning to address both the immediate and longer-term needs of the health care system. The committee will focus not just on the bricks and mortar of bed and service capacity, but also on health human resources planning and cross-sectoral leadership capacity.

- **Efficiency and Alignment.**
  Chair: Barb Collins, President and Chief Executive Officer of Humber River Hospital;
  Supporting Council Member: Shirlee Sharkey, Chief Executive Officer, SE Health

  This working group is taking a deeper look at how to overcome barriers and ensure alignment among community services and supports to achieve an efficient and sustainable health care system. The committee will focus on the use of tools to improve efficiency and health care quality together.

The outcomes of these four sub-committees will be a key stream of information influencing the Council's future work .

The Council is always exploring opportunities to learn from partners across the health care system and will keep you updated on future opportunities. Your input remains vital to our success. Please connect with us to share your insights and feedback by email at hallwayhealthcare@ontario.ca.

Thank you for the invaluable insights and advice that you've shared to date. The Council looks forward to continuing to engage with as many of you as possible to help achieve our common goal of a more connected and sustainable health care system in Ontario.

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

President's Message - December 6, 2019

In my ongoing commitment to communicate with stakeholders, including members, I am updating you on some recent initiatives at CCO. I am interested in ensuring CCO is open and responsive, and receptive to modernizing and strengthening its efforts to serve and protect the public interest.

National Meeting - November 16, 2019, Calgary, Alberta

On November 16, 2019, CCO co-hosted, with the Canadian Chiropractic Protective Association (CCPA), a meeting of all chiropractic regulators from across Canada, to discuss best practices and challenges around such common issues as scope of practice, advertising claims and social media. A working group has been established with national representation and will be spearheaded by the Federation of Canadian Chiropractic. All regulators have an interest in ensuring patients across the country receive chiropractic care that is consistent, ethical, competent, and compliant with standards of practice which are harmonized nationally to the extent possible (provincial legislation differs somewhat across the country). It is a big task, but I have confidence we can work collaboratively at a national level, and with a focus on enhanced public protection.

National Meeting of Canadian Chiropractic Regulators and CCPA - November 16, 2019

Every chiropractic regulator in Canada has examples of best practices from which we can all learn and consider adopting and adapting in our own provinces. I look forward to the ongoing dialogue and action plan developed in conjunction with other regulators, many of whom have taken important steps to enhance public protection

There are many provisions already in place in Ontario, that are specifically designed to ensure safe, ethical and competent chiropractic care to patients, including S-001: Chiropractic Scope of Practice, S-016: Advertising, G-016: Advertising and G-012: Use of Social Media. These provisions and others are regularly reviewed by the relevant committee. CCO standards of practice, guidelines and policies are reviewed and enforced through the complaints and discipline process as well as through comprehensive peer assessments as part of our quality assurance program.

Future of Health Regulation

On November 29, 2019, CCO Council and staff were pleased to welcome Ms Deanna Williams, who has extensive local and international experience in health regulation, to speak to us on the "*Use of Learnings to Maximize Regulatory Performance*." Ms Williams' presentation was followed by a presentation from Ms Rebecca Durcan, Steinecke Maciura LeBlanc, who stimulated continued conversation around effective regulation and also addressed Council on the recently released report from the government of British Columbia dated November 2019 and entitled "Modernizing the provincial health profession regulatory framework: A paper for consultation". CCO will be looking for opportunities to work collaboratively with government and with other regulators in Ontario (particularly those with common controlled acts such as communicating a diagnosis), as well as continue to work with chiropractic regulators across Canada to modernize health regulation legislation and our accountability to the public.

Ms Williams addressing Council, November 29, 2019

Ms Durcan addressing Council, November 29, 2019

Recent Media

A *National Post* article dated December 6, 2019 by longtime critics of chiropractic Wayne MacPhail and Paul Benedetti, unfortunately mischaracterized the decision of CCO Council regarding changes to CCO's by-laws. Linked here is CCO's response dated October 10, 2019 to the free-lance reporters' enquiries, prior to publication.

It is important to remember that CCO Council is comprised not just of chiropractors who are elected by their peers in different districts across Ontario, but by six or seven public members, appointed by the provincial government, with a mandate to participate on CCO Council and committees and to facilitate CCO's responsibilities under the *Regulated Health Professions Act, 1991*. Every member of Council, elected and appointed, has a vote with respect to matters before Council, and CCO is pleased that public members are in leadership positions on Council and as Chairs of statutory committees. I am reminded of the significant input and guidance from CCO's public members in decision making over the past several months, including changes to S-001: Scope of practice, the position statement on vaccination, as well as the by-law amendments to the composition of Council that creates a fair representative balance to Council while reducing the risks associated with real or perceived conflicts of interest.

CCO has a mandate that is different from many other organizations, but I trust and expect that within our respective mandates, we can have a respectful, professional dialogue about matters of mutual interest, especially where there is disagreement about the action CCO should be taking on any policy matter. All feedback, from all stakeholders, is considered before Council approves any amendments to its provisions and typically is made public in its entirety, as was the case with respect to these changes.

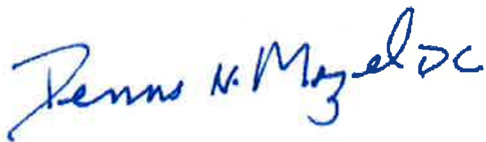
I remain confident that many members of CCO can appropriately participate in the self-regulation of chiropractic in various capacities at CCO, including serving on Council, and that broad representation and a diversity of viewpoints should be encouraged, with an understanding that once elected or appointed, the mandate of all Council members is the same - protection of the public interest.

Modernizing CCO's Office Space

After many years of careful planning, CCO is finally moved into its permanent home at 59 Hayden Street, Suite 800, Toronto, Ontario, M4Y 0E7. This major undertaking was accomplished through the vision and

commitment of many, and, as promised, was completed without any increase in members' dues and with a focus on CCO's strategic objective to ensure fiscal responsibility. CCO now has a suitable home to carry out its obligations which I hope many of you will have an opportunity to visit by attending Council meetings or training sessions. I am justifiably proud of this milestone and evolution in CCO's history.

Finally, I wish each of you a wonderful holiday, and a renewed energy and commitment in 2020. I appreciate your ongoing feedback and engagement in the CCO's important work and responsibility to guide the profession and protect the public interest.



Dr. Dennis Mizel, President

College of Chiropractors of Ontario, 77 Bloor Street West, Suite 600,
Suite 600, Toronto, Ontario M5S1M2 Canada

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October 10, 2019

Re: Your Inquiry Received October 7, 2019 re: CCO By-law 6: Elections

Dear Mr. MacPhail and Mr. Benedetti:

As you know, CCO received a great deal of feedback and many submissions concerning the proposed amendments to By-law 6: Elections. CCO believes it is in the public interest to have a healthy and respectful discussion concerning important matters before Council.

Moreover, Council determined that there should be full transparency with respect to the nature of the feedback, even if some of the comments received from college members might be inaccurate, unflattering or otherwise inappropriate. Council has been very consistent in making public the feedback received from members during the course of its deliberations, and this information has often been used by you to inform your articles.

The Executive Committee carefully considered all of the feedback regarding By-law 6 before making its recommendations to Council. The amendments include 6.9 which now reads as follows:

(k) for District 7 only, the member is a member of the faculty of the CMCC; and

(l) for any district other than District 7, the member is not eligible for election in District 7.

Council, comprised of elected and public members, approved the recommended amendments, bearing in mind the possibility or existence of any real or perceived conflicts of interest. We should point out that this type of restriction of candidate eligibility is not by any means unique to the CCO, and is the case with at least two other Ontario health regulatory colleges.

In making its decision, Council considered a variety of current, actual and perceived conflicts of interest and scenarios (including but not limited to) public positions taken that are indicative of a potential appearance of bias and do not reflect the diversity of the styles of chiropractic practice provided for in the scope of practice, participation in discussions of credentialing other academic institutions, or in continuing education requirements where such courses may be offered by member institutions, and other instances where the organization may be involved in matters before the regulator.

However, as noted above, Council also determined that of the three Toronto district seats available, one should be filled by an existing CMCC *faculty* member, to be elected by *the full CCO membership*. This ensures that the voice of the profession's academic institution is heard at the Council table while avoiding situations in which a large number of elected Council members are prevented from participating in important decisions where there is a real or perceived conflict of interest.

In closing, please understand that it is not the role nor intention of the CCO to respond to requests for comment on individual feedback or commentary submitted to the CCO as part of Council deliberations. Rather, the entirety of such feedback is made available on the CCO website in the interests of transparency and in serving the public.

We would remind you also, as we have shared previously, that members of CCO Council, Executive, and committees are precluded by the CCO code of conduct from speaking or responding to enquiries on behalf of CCO.

Sincerely,

Dr. Dennis Mizel,
President
Elected Professional Member

Mr. Robert MacKay,
Vice-President
Appointed Public Member

From: Jo-Ann Willson <jpwillson@cco.on.ca>
Sent: Thursday, October 10, 2019 12:02 PM
To: Wayne MacPhail <wmacphail@gmail.com>; paul benedetti <pbenedetti16@gmail.com>
Subject: Response to your Inquiry Received October 7, 2019

Please see response attached.

Jo-Ann Willson, B.Sc., M.S.W., LL.B.
Registrar & General Counsel
*Note Address Change
College of Chiropractors of Ontario
77 Bloor St. West, Suite 600
Toronto, ON M5S 1M2
Tel: (416) 922-6355 ext. 111
Fax: (416) 925-9610
E-mail: jpwillson@cco.on.ca
Web Site: www.cco.on.ca

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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: Wayne MacPhail [mailto:wmacphail@gmail.com]
Sent: Wednesday, October 09, 2019 3:56 PM
To: paul benedetti <pbenedetti16@gmail.com>; Jo-Ann Willson <jpwillson@cco.on.ca>
Cc: Dennis Mizel (drmizel@stcatharineschiropractic.com) <drmizel@stcatharineschiropractic.com>; Joel Friedman <JFriedman@cco.on.ca>
Subject: RE: TIME SENSTIVE MEDIA REQUEST - National Post Story on By-law Amendment

Thanks for your response. Due to deadline pressure we would require we hear back from you by noon tomorrow at the latest. Hope that works for you.

All the best,
Paul Benedetti and Wayne MacPhail

Wayne Macphail
On Oct 9, 2019, 2:55 PM -0400, Jo-Ann Willson <jpwillson@cco.on.ca>, wrote:

We received this request on Monday, October 7, 2019, but I do not anticipate having an answer for you by the end of today given it is the Jewish High Holidays. I may be able to provide a response by Thursday, October 10, 2019, end of day. Thank you.

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

Registrar & General Counsel

*Note Address Change

College of Chiropractors of Ontario

77 Bloor St. West, Suite 600

Toronto, ON M5S 1M2

Tel: (416) 922-6355 ext. 111

Fax: (416) 925-9610

E-mail: jpwillson@cco.on.ca

Web Site: www.cco.on.ca

CONFIDENTIALITY WARNING:

This e-mail including any attachments may contain confidential information and is intended only for the person(s) named above. Any other distribution, copying or disclosure is strictly prohibited. If you have received this e-mail in error, please notify me immediately by reply e-mail and delete all copies including any attachments without reading it or making a copy. Thank you.

From: Georgia Allan <allangeorgia@hotmail.com>
Sent: Friday, December 6, 2019 2:11 PM
To: cco.info <cco.info@cco.on.ca>
Subject: Re: Message from the CCO President - December 6, 2019

Good afternoon

Thank you Dennis for your positive message and Happy Holiday Greeting . The same to all of my Colleagues at CCO that you have a wonderful holiday season. This has been such an exciting year with our moves and especially the move into 59 Hayden. I know we are the luckiest College of the extensive Group of Colleges and probably the envy of most. A great big thanks to including Jo-Ann, Cliff and all the others who made this move possible. I sure hope that"Santa" finds the wonderful , devoted staff who spent untold hours organizing three moves.

May Peace and Love surround you all this Holiday Season

Georgia

Sent from my iPad

On Dec 6, 2019, at 11:31 AM, College of Chiropractors of Ontario <cco.info@cco.on.ca> wrote:

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

President's Message - December 6, 2019

In my ongoing commitment to communicate with stakeholders, including members, I am updating you on some recent initiatives at CCO. I am interested in ensuring CCO is open and responsive, and receptive to modernizing and strengthening its efforts to serve and protect the public interest.

National Meeting - November 16, 2019, Calgary, Alberta

From: Paul Groulx <drgroulx@mynepeanchiropractor.com>
Sent: Friday, December 6, 2019 12:35 PM
To: Dennis Mizel <drmizel@stcatharineschiropractic.com>; Rob MacKay (mackayrob@tbaytel.net) <mackayrob@tbaytel.net>; Jo-Ann Willson <jpwillson@cco.on.ca>
Subject: President's Message.

Dennis.

Thanks for preparing and sending out your message today.
I have only been in practice for 16 years, so my observations are limited. Given those 16 years, you are the first CCO president to consistently communicate with the membership in a way that reassures me, as a member, that the CCO is in good hands in difficult times. I am glad that you are chairing council. The bulk of the membership is under the age of 45 and it has been implied that "younger" men and women are better equipped to lead this profession into the future. While fresh ideas from young minds are richly valued, there has never been a time (in my memory) where experience, nuance and maturity are more relevant than today. Your style of leadership is steady and sober-minded. You do the right thing – even when unpopular. Your brand of leadership will be critical in the coming season as the initiative in BC regarding amalgamating regulatory boards is almost certainly going to come to Ontario.

Regarding recent media attention. The timing is almost identical to last year –appearing to precede another election season and stoke the fires of division. I hope you persist in your communication with the membership and continue to bring clarity when disinformation (*intentional* falsehood/propaganda) seems so prevalent. They will not stop, and I hope you won't either. The membership is comprised of intelligent people. Continue to lead with integrity and I believe they will "see" it.

-Paul

Dr. Paul Groulx
E.M.C.A., B.Sc.N., D.C.
Crestview Family Chiropractic
613-224-5400

From: Georgia Allan <allangeorgia@hotmail.com>
Sent: Friday, December 6, 2019 2:00 PM
To: cco.info <cco.info@cco.on.ca>
Subject: Re: Message from the CCO President - December 6, 2019

Thank you for your very positive message as President. I wish you and your family a very Happy Holiday Season too. Especially enjoy those wee ones. They are so precious and grow up so fast

Cheers

Georgia

Sent from my iPad

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From: Tracy Kish <tracykish@gmail.com>
Sent: Friday, December 6, 2019 11:54 AM
To: cco.info <cco.info@cco.on.ca>
Subject: Re: Message from the CCO President - December 6, 2019

After so much bad press for chiropractors, I hope the CCO can move beyond subluxations and vitalism to ensure that chiropractors limit themselves to rehab and musculoskeletal issues.

Tracy Kish.

Tracy Kish BScN RN DC
Owner Westwood Health
Advanced Practice Clinician ISAEC
Shift Concussion Management Provider
959 Pape Ave
416 422 1515
WestwoodHealthTO.com

On Dec 6, 2019, at 11:31 AM, College of Chiropractors of Ontario <cco.info@cco.on.ca> wrote:

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National Meeting of Canadian Chiropractic Regulators and CCPA - November 16, 2019

Every chiropractic regulator in Canada has examples of best practices from which we can all learn and consider adopting and adapting in our own provinces. I look forward to the ongoing dialogue and action plan developed in conjunction with other regulators, many of whom have taken important steps to enhance public protection

From: Gauri Shankar <docshankar99@gmail.com>
Sent: Tuesday, December 10, 2019 9:24 AM
To: cco.info <cco.info@cco.on.ca>
Subject: RE: Message from the CCO President - December 6, 2019

Thank you for your commitment to communicate with the membership in such a fulsome and transparent manner.
Our whole membership owes the CCO a huge debt of gratitude for your ongoing efforts on behalf of our profession.
With many thanks and blessings for the new year.

Gauri

Dr.Gauri Shankar
Prescott Family Chiropractic
114 King St. W.
Prescott, On.
K0E 1T0
613-925-3436
613-925-4974 fax
docshankar99@gmail.com
www.prescottfamilychiropractic.ca

From: College of Chiropractors of Ontario [mailto:cco.info@cco.on.ca]
Sent: Friday, December 06, 2019 11:31 AM
To: docshankar99@gmail.com
Subject: Message from the CCO President - December 6, 2019

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

President's Message - December 6, 2019

From: Liz Anderson-Peacock <drliz@bellnet.ca>
Sent: Friday, December 6, 2019 1:35 PM
To: cco.info <cco.info@cco.on.ca>
Subject: Re: Message from the CCO President - December 6, 2019

President Mizel and the whole of CCO,

Greatly appreciate the "update" message and links to accurate information.

Thank you and a big congrats on the new location.
Wishing you all a safe and healthy holiday season.
All the best,
Liz

Sent from my BlackBerry - the most secure mobile device - via the Rogers Network

From: cco.info@cco.on.ca
Sent: December 6, 2019 10:31 AM
To: drliz@bellnet.ca
Reply-to: cco.info@cco.on.ca
Subject: Message from the CCO President - December 6, 2019

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

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National Meeting - November 16, 2019, Calgary, Alberta

From: Derek Nash <dnash01@uoguelph.ca>
Sent: Friday, December 6, 2019 12:39 PM
To: cco.info <cco.info@cco.on.ca>
Subject: Re: Message from the CCO President - December 6, 2019

70+% of us responded with a resounding NO to the last CCO proposal regarding electoral riding reform and faculty members.

The college put through the motion anyway. How is that listening to members?

This is just the tip of the iceberg, you want a real reform? Get ready for the next election. This house is about to be cleaned. Its currently an embarrassment to our profession and public image

Dr. Derek Nash

On Fri., Dec. 6, 2019, 11:31 a.m. College of Chiropractors of Ontario <cco.info@cco.on.ca> wrote:

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L'Ordre des Chiropraticiens de l'Ontario

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From: Peter Amlinger <dr.peteramlinger@me.com>
Sent: Friday, December 6, 2019 1:03 PM
To: cco.info <cco.info@cco.on.ca>
Subject: Re: Message from the CCO President - December 6, 2019

Awesome message.

Dr PJ Amlinger, DC
Chiropractor

On Dec 6, 2019, at 11:31 AM, College of Chiropractors of Ontario <cco.info@cco.on.ca> wrote:

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From: Alan Cranton <ac@tbaywellness.com>
Sent: Monday, December 9, 2019 1:15 PM
To: cco.info <cco.info@cco.on.ca>
Subject: Re: Message from the CCO President - December 6, 2019

Thank you Dennis
I appreciate the love and leadership you pour into our profession. Your tact and discretion when dealing with adverse situations are signs of your great leadership in our profession.
I am proud to be a chiropractor under your and councils leadership.
Cheers to 2020
Sincerely
Alan Cranton DC
Member since 1985.

Sent from my iPhone

On Dec 6, 2019, at 11:31 AM, College of Chiropractors of Ontario <cco.info@cco.on.ca> wrote:

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National Meeting - November 16, 2019, Calgary, Alberta

On November 16, 2019, CCO co-hosted, with the Canadian Chiropractic Protective Association (CCPA), a meeting of all chiropractic regulators

ITEM 4.1.9

January 27, 2020, at 12:17 PM, College of Chiropractors of Ontario <cco.info@cco.on.ca> wrote:

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

President's Message - January 27, 2020

Happy New Year!

All members will have received CCO's election documents for the Spring 2020 elections to CCO Council. During and following the Spring 2019 elections, we heard from many stakeholders, including members, that the level of discourse between and among colleagues was not as professional and respectful as it should have been. **We listened to your feedback.** You will note some important changes in the election documents for Spring 2020 to encourage and facilitate the smooth running of a fair election process, focused on a clear understanding by all candidates that communications should reflect a commitment to CCO's role and mandate to regulate chiropractic in the public interest. Some of these changes include:

- Adopting some of the guiding principles from the Royal College of Dental Surgeons relating to appropriate conduct during elections;
- Establishing an Election Review Committee to include an individual with expertise on another health regulatory college to guide the process and provide prompt feedback about general compliance with CCO's advertising standards and policies;
- Ensuring CCO maintains control over the distribution of approved material (rather than releasing the e-mail addresses of individuals in the district); and
- Amending the candidate undertaking to include a requirement to review social media postings to ensure compliance with

CCO's standards and to remove any potentially embarrassing content or content inconsistent with CCO's standards, policies and guidelines.

It is important not only for candidates, but for anyone campaigning on a candidate's behalf, to make all efforts to ensure all communications are both professional and respectful. CCO is fully aware of the actions by other regulators to suspend and reprimand members who are unprofessional on social media.

I trust everyone would agree that chiropractors who reflect CCO's core values of integrity, inclusivity, professionalism and high standards of conduct should be both encouraged and inspired to be a candidate for CCO's Council. We are at an exciting time in our history. CCO has moved to new space, there are many changes on the horizon for the regulation of the health professions, and there are many opportunities to help shape the future of chiropractic regulation in Ontario.

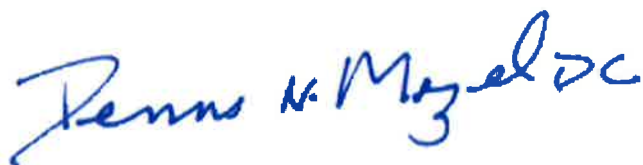
I look forward to communicating with each of you further in the months to come about CCO's ongoing commitment to stay the course and to ensure members' dues are focused on matters directly related to public interest protection. I am excited to see how these elections transpire with a dedicated academic position for a faculty member from CMCC, whom I anticipate will bring to CCO discussions the perspective of CMCC as an important stakeholder.

One of the changes on the regulatory horizon is a movement towards smaller more nimble boards to reflect governance best practices, and a new system of eligibility requiring that all appointments to health regulatory councils (both professional and public) are based on competencies and skill-set selection criteria which reflect a commitment to public interest rather than professional or self-interest.

Important leaders in regulation including for example the College of Nurses and College of Teachers, have made convincing submissions as to why change is necessary. CCO supports these changes in principle and looks forward to working with government and others to bring about enhancements to the self-regulation of the

professions including chiropractic. Until changes are considered and reflected in government action, I trust and hope that the chiropractic profession will rise to the challenge and stay focused on ensuring the best candidates are elected. CCO would like to be well positioned to adapt and adopt to any government policy changes, and to help influence positive changes to enhance public protection.

I have confidence that the over 5,000 chiropractors in Ontario will be able to meet this challenge, and I look forward to your ongoing engagement in all of CCO's work, including on Council, as a non-Council committee member, peer assessor, or simply an engaged and interested member of the profession. I too am passionate about this profession. I look forward to the new composition of Council and an ongoing demonstration of our accountability to the public we all serve.



Dr. Dennis Mizel, President

January 25, 2020 - Peer Assessor Training Day

Congratulations to the Quality Assurance Committee for its first Peer Assessor training day at CCO's new premises. Thank you to CCO's Peer Assessors, 33 members in good standing from across the province, for being inspirational and focused on continuous quality improvement to ensure **high quality, competent chiropractic care for the public of Ontario!**

From: Georgia Allan <
Sent: Monday, January 27, 2020 1:09 PM
To: cco.info <cco.info@cco.on.ca>
Subject: Re: Message from the CCO President - January 27, 2020

Good message and group picture

Georgia

Sent from my iPad

On Jan 27, 2020, at 12:17 PM, College of Chiropractors of Ontario <cco.info@cco.on.ca> wrote:

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From: Mo Bayegan
Sent: Monday, January 27, 2020 1:08 PM
To: cco.info <cco.info@cco.on.ca>
Subject: Re: Message from the CCO President - January 27, 2020

Thanks for forwarding

Mo

Sent from my iPhone

On Jan 27, 2020, at 12:17 PM, College of Chiropractors of Ontario <cco.info@cco.on.ca> wrote:

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From: Gauri Shankar
Sent: Monday, January 27, 2020 2:22 PM
To: cco.info <cco.info@cco.on.ca>
Subject: RE: Message from the CCO President - January 27, 2020

Dear Dr. Mizel,

Thank you for taking steps to ensure a cleaner election process with your upcoming changes to the election process.
Incorporating an elections review committee with the expertise of another regulatory board is transparent and trustworthy for the candidates and their supporters.
Your continued commitment to the current on goings in other professions keeps our professional board upto date and well informed.
The public of Ontario is in good hands with your guidance at CCO.

Yours truly,

GS

Dr.Gauri Shankar
Prescott Family Chiropractic
114 King St. W.
Prescott, On.
K0E 1T0
613-925-3436
613-925-4974 fax
docshankar99@gmail.com
www.prescottfamilychiropractic.ca

From: College of Chiropractors of Ontario [mailto:cco.info@cco.on.ca]
Sent: Monday, January 27, 2020 12:17 PM
To: docshankar99@gmail.com
Subject: Message from the CCO President - January 27, 2020

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

From: Ivone De Marchi
Sent: Monday, January 27, 2020 2:48 PM
To: cco.info <cco.info@cco.on.ca>
Subject: Re: Message from the CCO President - January 27, 2020

Thank you Dennis for the competency you brilliantly espouse to and for our profession.
Ivone

On Jan 27, 2020, at 12:17 PM, College of Chiropractors of Ontario <cco.info@cco.on.ca> wrote:

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From: Lezlee Detzler
Sent: Monday, January 27, 2020 5:56 PM
To: cco.info <cco.info@cco.on.ca>
Subject: Re: Message from the CCO President - January 27, 2020

Great newsletter!!!
Thank you CCO council , Jo Ann and support staff!!
Another informative, productive annual Peer Assessor
Meeting!
Regards,
Dr Lezlee P Detzler

Sent from my iPhone

On Jan 27, 2020, at 12:17 PM, College of Chiropractors of Ontario <cco.info@cco.on.ca> wrote:

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From: Rob MacKay
Sent: Monday, January 27, 2020 7:45 PM
To: cco.info <cco.info@cco.on.ca>
Subject: RE: Message from the CCO President - January 27, 2020

Great Job Dennis.

It's so important the members see how seriously we take the integrity of our elections. And that we not only listen to feedback, we act on it.

Well done,
Rob

From: College of Chiropractors of Ontario <cco.info@cco.on.ca>
Sent: January 27, 2020 12:17 PM
To: mackayrob@tbaytel.net
Subject: Message from the CCO President - January 27, 2020

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L'Ordre des Chiropraticiens de l'Ontario

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From: Paul Groulx
Sent: Monday, January 27, 2020 8:11 PM
To: cco.info <cco.info@cco.on.ca>
Subject: Re: Message from the CCO President - January 27, 2020

Dr Mizel,

Thanks for this message.
It is an exciting time indeed for our profession. Emerging research is compelling, the percentage of people seeking out Chiropractic care is increasing, chiropractors are being invited to rapid assessment teams etc. Very exciting indeed.

I am particularly heartened by your comments about maintaining professional and respectful behavior discussions between members. Disagreement is an important part of growth. The most rewarding aspect of serving on CCO has been to exercise and expand my ability to be "skeptical" of my own beliefs. However, it seems that some (in the greater membership) have taken on a "if you aren't with us you are against us" stance which is harmful to the public and demoralizes and silences members.

I am double-minded about the impending election. It is exciting that people of high character with unique points of view are eligible to muster their time and talent and throw their hat into the ring to contribute to our great profession in the public interest! I am also crestfallen that some will choose not to because of the low standard of behavior so evident in the last election.

I believe the CCO has an important role in protecting the public by laying out clear policies and guidelines on what is considered acceptable (fair comment) and unacceptable behavior (innuendo, shaming, ad hominem attacks etc) amongst members. The CCO has begun this process. Further, the CCO has a duty to demonstrate that there are consequences to these behaviors. You have made it clear that the CCO has taken notice of behaviors within our membership (and we have) and I hope this will help protect the election process, which in turn, protects the public.

Dr Paul Groulx

From: College of Chiropractors of Ontario <cco.info@cco.on.ca>
Reply-To: <cco.info@cco.on.ca>
Date: Monday, January 27, 2020 at 12:18 PM
To: Paul Groulx <drgroulx@mynepeanchiropractor.com>
Subject: Message from the CCO President - January 27, 2020

From: Elizabeth Anderson-Peacock
Sent: Tuesday, January 28, 2020 9:55 PM
To: cco.info <cco.info@cco.on.ca>
Subject: Re: Message from the CCO President - January 27, 2020

It is wonderful to read this message.
Nothing is more in the public interest than speaking for what one is for and the merits of skill sets in a professional way rather than something "different". Removing bias in election materials, innuendo and words shared behind hidden rooms, shaming and external influence from an election is in my mind, in the public interest.

Thank you, thank you, thank you!

Elizabeth Anderson-Peacock
drliz@bellnet.ca
CONFIDENTIAL COMMUNICATION: This email and any files transmitted with it are intended only for the person or entity to which it is addressed and may contain confidential and/or privileged material. Any review, retransmission, dissemination or other use of, or taking any action in reliance upon this information by persons or entities other than the intended recipient is strictly prohibited. If you received this message in error, please contact Dr. Liz Anderson-Peacock immediately and delete the material.

On Jan 27, 2020, at 12:17 PM, College of Chiropractors of Ontario <cco.info@cco.on.ca> wrote:

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

President's Message - January 27, 2020

Happy New Year!

PRINTABLE VERSION

ITEM 4.1.11

182

Tjandrawidjaja, Michael Clarence

CPSO#: 97487

MEMBER STATUS	Active Member as of 07 May 2012
CPSO REGISTRATION CLASS	Independent Practice as of 07 May 2012

Summary

Former Name: No Former Name
Gender: Male
Languages Spoken: English, Indonesian
Education: University of Alberta, 2004

Practice Information

PRIMARY LOCATION OF PRACTICE
William Osler Health System Brampton Civic Hospital 2100 Bovaird Drive East Brampton ON L6R 3J7 **Phone:** (905) 494-6221 **Fax:** (905) 494-6717 **Electoral District:** 05

VIEW PROFESSIONAL CORPORATION INFORMATION

Hospital Privileges

HOSPITAL	LOCATION
William Osler - Peel Memorial Centre,for Integrated Health and Wellness	Brampton
William Osler Health Centre Etobicoke General Site	Toronto
William Osler Health Centre-Brampton Civic Hospital	Brampton

Specialties

SPECIALTY	ISSUED ON	TYPE
Internal Medicine	Effective: 30 Jun 2008	RCPSC Specialist
Cardiology	Effective: 16 Sep 2010	RCPSC Specialist

Terms and Conditions

(1) Dr. MICHAEL CLARENCE TJANDRAWIDJAJA may practise only in the areas of medicine in which Dr. TJANDRAWIDJAJA is educated and experienced.

183

Registration History

ACTION	ISSUE DATE
First certificate of registration issued: Independent Practice Certificate	Effective: 07 May 2012

Previous Hearings

Committee: Discipline
Decision Date: 25 Jun 2018
Summary:

On June 25, 2018, the Discipline Committee found that Dr. Michael Clarence Tjandrawidjaja committed an act of professional misconduct, in that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

Dr. Tjandrawidjaja is a physician who currently practises as a cardiologist in Brampton. He received his certificate of registration authorizing independent practice in Ontario in 2012. At the time of the incidents described below, Dr. Tjandrawidjaja was a member of the Ontario Medical Association ("OMA"), the association that represents the political and economic interests of physicians in Ontario. It is the exclusive representative of Ontario physicians in negotiations with the Province of Ontario.

Tentative Physician Services Agreement ("tPSA")

On July 11, 2016, the OMA and the Ontario government reached a tentative agreement dealing with government funding for physician services and changes to the physician fee schedule, among other issues, tPSA. The tPSA was to have a term of four years, and would have replaced a previous agreement, which terminated in 2014. The tPSA was endorsed by the OMA's Board, including by Dr. Virginia Walley, who was President of the OMA at the time. The OMA promoted the agreement in the weeks leading up to a General Meeting, which took place on August 14, 2016. On August 14, 2016, the OMA membership voted to reject the tPSA.

Dr. Tjandrawidjaja's email of July 31 and August 8, 2016

On July 30, 2016, OMA members received an email providing information regarding an upcoming vote to ratify the tPSA. The email encouraged members to vote in favour of the agreement. It was sent from an email address used by OMA staff to communicate publicly about the tPSA, and was signed by Dr. Walley. On July 31, 2016, Dr. Tjandrawidjaja replied by sending the following email to Dr. Walley: "You are a turd". On August 8, 2016, Dr. Tjandrawidjaja sent the following email directly to Dr. Walley's personal email address: "Virginia, how much are the liberals bribing you? It will likely come out at some point." The emails sent by Dr. Tjandrawidjaja were viewed by Dr. Walley as well as OMA staff who monitored the tPSA email address.

Dr. Tjandrawidjaja's response during investigation

Dr. Tjandrawidjaja provided a response during the investigation, acknowledging the emails were inappropriate, stating that he regretted sending them, and indicating he wished to apologize to Dr Walley, among other things. In November 2017, Dr. Tjandrawidjaja completed 4.5 hours of one-on-one Professional Communication coaching with Dawn Martin, Communications Specialist and Educational Consultant, to develop skills related to professional communication and collaboration with colleagues.

Disposition

On June 25, 2018, the Committee ordered and directed that:

- Dr. Tjandrawidjaja appear before the panel to be reprimanded.
- Dr. Tjandrawidjaja pay to the College its costs of this proceeding in the amount of $6,000 within thirty (30) days from the date of this Order.

Hearing Date(s): June 25, 2018

Indexed as: Ontario (College of Physicians and Surgeons of Ontario) v. Tjandrawidjaja.
2018 ONCPSD 39

THE DISCIPLINE COMMITTEE OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

IN THE MATTER OF a Hearing directed by
the Inquiries, Complaints and Reports Committee of the College of Physicians and Surgeons of Ontario pursuant to Section 26(1) of the **Health Professions Procedural Code** being Schedule 2 of the ***Regulated Health Professions Act, 1991***, S.O. 1991, c. 18, as amended.

2018 ONCPSD 39 (CanLII)

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. MICHAEL CLARENCE TJANDRAWIDJAJA

PANEL MEMBERS: **MR. P. PIELSTICKER (CHAIR)**
DR. M. GABEL
DR. P. HENDRY
MR. P. GIROUX
DR. M. DAVIE

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS R. AINSWORTH

COUNSEL FOR DR. TJANDRAWIDJAJA:

MS G. BURT

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MS Z. LEVY

Hearing Date: June 25, 2018
Decision Date: June 25, 2018
Release of Written Reasons: August 1, 2018

DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on June 25, 2018. At the conclusion of the hearing, the Committee released a written order stating its finding that the member committed an act of professional misconduct, and setting out the Committee's penalty and costs order with written reasons to follow.

2018 ONCPSD 39 (CanLII)

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Michael Clarence Tjandrawidjaja committed an act of professional misconduct:

1. under paragraph 1(1)33 of O. Reg. 856/93, in that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional; and

2. under paragraph 1(1)34 of Ontario Regulation 856/93, made under the Medicine Act, 1991 ("O. Reg. 856/93"), in that he has engaged in conduct unbecoming a physician.

RESPONSE TO THE ALLEGATION

Dr. Tjandrawidjaja admitted to allegation 1 in the Notice of Hearing, that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional. The College withdrew allegation 2.

THE FACTS

The following facts were set out in the Statement of Facts and Admission on Liability, which was filed as an exhibit at the hearing and presented to the Committee:

BACKGROUND

1. Dr. Michael Clarence Tjandrawidjaja ("Dr. Tjandrawidjaja") is a 40-year-old physician who currently practices as a cardiologist in Brampton, Ontario. He received his certificate of registration authorizing independent practice in Ontario in 2012.

2. At the time of the incidents described below, Dr. Tjandrawidjaja was a member of the Ontario Medical Association ("OMA").

3. The OMA is the association that represents the political and economic interests of physicians in Ontario. It is the exclusive representative of Ontario physicians in negotiations with the Province of Ontario.

4. On July 11, 2016, the OMA and the Ontario government reached a tentative agreement dealing with government funding for physician services and changes to the physician fee schedule, among other issues. This tentative Physician Services Agreement ("tPSA") was to have a term of four years, and would have replaced a previous agreement, which terminated in 2014.

5. The tPSA was endorsed by the OMA's Board, including by Dr. Virginia Walley, who was President of the OMA at the time. The OMA promoted the agreement in the weeks leading up to a General Meeting, which took place on August 14, 2016.

6. On August 14, 2016, the OMA membership voted to reject the tPSA.

EMAILS OF JULY 31 AND AUGUST 8, 2016

7. On July 30, 2016, OMA members received an email providing information regarding an upcoming vote to ratify the tPSA. The email encouraged members to vote in favour of the agreement. It was sent from an email address used by OMA staff to communicate publicly about the tPSA, and was signed by Dr. Walley.

2018 ONCPSD 39 (CanLII)

8. On July 31, 2016, Dr. Tjandrawidjaja replied by sending the following email to Dr. Walley:

   "You are a turd"

9. On August 8, 2016, Dr. Tjandrawidjaja sent the following email directly to Dr. Walley's personal email address:

   "Virginia,
   How much are the liberals bribing you? It will likely come out at some point."

   The emails sent by Dr. Tjandrawidjaja are attached at Tab 1 [to the Agreed Statement of Facts and Admission on Liability].

10. The emails sent by Dr. Tjandrawidjaja were viewed by Dr. Walley as well as OMA staff who monitored the tPSA email address.

ADMISSION

11. Dr. Tjandrawidjaja admits the facts set out above, and admits that the conduct described in paragraphs 8 and 9 constitutes an act of professional misconduct in that he engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all of the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional contrary to section 1(1)33 of O. Reg. 856/93 made under the *Medicine Act, 1991*.

FINDING

The Committee accepted as true all of the facts set out in the Statements of Facts and Admission on Liability. Having regard to these facts, the Committee accepted Dr. Tjandrawidjaja's

2018 ONCPSD 39 (CanLII)

admission and found that he committed an act of professional misconduct, in that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

AGREED STATEMENT OF FACTS ON PENALTY

The following Agreed Statement of Facts on Penalty was filed as an Exhibit at the hearing:

1. Dr. Tjandrawidjaja provided a response during the investigation. In his response, Dr. Tjandrawidjaja acknowledged the emails were inappropriate, stated he regretted sending them, and indicated he wished to apologize to Dr. Walley, among other things. Dr. Tjandrawidjaja's response is attached at Tab 1 [to the Agreed Statement of Facts on Penalty].

2. In November 2017, Dr. Tjandrawidjaja completed 4.5 hours of one-on-one Professional Communication coaching with Dawn Martin, Communications Specialist and Educational Consultant, to develop skills related to professional communication and collaboration with colleagues. Dr. Martin's report is attached at Tab 2 [to the Agreed Statement of Facts on Penalty].

PENALTY AND REASONS FOR PENALTY

Counsel for the College and counsel for Dr. Tjandrawidjaja made a joint submission as to an appropriate penalty and costs order.

The Committee is aware that a joint submission on penalty must be accepted by the Committee, unless to do so would bring the administration of justice into disrepute, or is otherwise contrary to the public interest (*R. v Anthony-Cook,* 2016 SCC 43).

2018 ONCPSD 39 (CanLII)

The Committee found that the jointly proposed penalty adequately addresses the penalty principles of specific deterrence of the member, general deterrence of the membership of the profession, public protection, maintenance of the public confidence in the integrity of the profession and the College's ability to regulate the profession in the public interest, as well as rehabilitation of the member.

The egregious and unacceptable communications by Dr Tjandrawidjaja to Dr. Walley, which were also received by staff at the Ontario Medical Association, undermine basic expectations of how professional interactions should occur. Counsel for the College introduced as evidence two College Policies that outline the expectations that the profession has of its members, which were ignored, or never read by Dr. Tjandrawidjaja. The College Policy "Physician Behaviour in the Professional Environment" states:

> "Physicians are expected to act in a respectful, courteous and civil manner toward their patients, colleagues and others involved in the provision of health care."

It further states:

> "Conversely, behaviour that is unprofessional and/or disruptive undermines medical professionalism and the trust of the public"

In addition:

> "Literature shows that these behaviours can negatively impact both the delivery of quality health care, and patient safety and outcomes by eroding the effective communication and collaboration that underpin good medical practice."

The College Policy "Social Media - Appropriate use by Physicians" provides guidance for physicians as to how to maintain professional obligations in the use of the internet. In the use of this modality, which includes emails, physicians are expected to:

2018 ONCPSD 39 (CanLII)

2018 ONCPSD 39 (CanLII)

"maintain professional and respectful relationships with patients, colleagues and other members of the health care team."

In addition, the following points are brought to the physicians' attention:

"Assume all content on the internet is public and accessible to all", and "Protect their own reputation, the reputation of the profession, and the public trust by not posting content that could be viewed as unprofessional."

Physicians, by the very nature of their privileged position and the respect given to them by society, are expected to act in a way that not only justifies this privilege and respect, but also set an example of how to deal with controversial issues and the stress of daily life.

There is no question that the issues related to the tPSA being debated were controversial and there were multiple beliefs that were passionately held by members of the medical profession. There is no question that Dr. Walley and the OMA staff were executing their duties, and were politely and reasonably expressing what they saw as the best course of action, given the situation they were facing. To debase the debate by *ad hominem*, bullying, juvenile and utterly disrespectful comments, not only brings Dr. Tjandrawidjaja into disrepute, but negatively impacts the respect the society has for the entire profession. The Committee must condemn this behaviour, which cannot be countenanced by the medical profession or the public.

Aggravating Factor

The Committee considered that the aggravating factor here, with respect to penalty, was the outrageous language of Dr. Tjandrawidjaja's communications.

Mitigating Factors

The Committee considered the following mitigating factors in this case:

- After being notified of the investigation into his conduct in this matter, Dr. Tjandrawidjaja acknowledged that the emails were inappropriate, he regretted sending them, and he wished to apologize to Dr. Walley.
- Dr. Tjandrawidjaja cooperated in the investigation, thereby sparing the witnesses from the inconvenience and stress of having to testify at the hearing, and also saving the time and cost of a contested hearing.
- Prior to the hearing, Dr. Tjandrawidjaja completed 4.5 hours of one-on-one Professional Communication coaching with a Communication Specialist acceptable to the College, in order to develop skills relating to professional communication and collaboration with colleagues. The Communication Specialist's report indicated that she was confident "he has the necessary awareness and skills to make sure this never happens again."

2018 ONCPSD 39 (CanLII)

Case Law

Counsel for the parties referred to previous cases, none of which, in the Committee's view, were directly relevant to the circumstances of Dr. Tjandrawidjaja's case. The Committee considered the previous cases put before it, but did not rely on them in determining the appropriateness of the proposed penalty and costs order as these cases did not deal with the same type of behaviour.

Conclusion

The Committee concluded that the ordering of a public reprimand was appropriate to express the profession's and the public's rejection of Dr. Tjandrawijaja's behaviour. A public reprimand and the posting on the public register of the Committee's finding and order serves as a specific deterrent to Dr. Tjandrawidjaja, and as a general deterrent to the profession. It also demonstrates to the public that such behaviour will not be tolerated by the medical profession.

Costs

The Committee considered this to be an appropriate case in which to award costs to the College, and that the amount agreed upon by the parties is appropriate for this half-day hearing.

ORDER

The Committee stated its finding of professional misconduct in paragraph 1 of its written order of June 25, 2018. In that order, the Committee ordered and directed on the matter of penalty and costs that:

2. Dr. Tjandrawidjaja appear before the panel to be reprimanded.

3. Dr.Tjandrawidjaja pay to the College its costs of this proceeding in the amount of $6,000 within thirty (30) days from the date of this Order.

At the conclusion of the hearing, Dr. Tjandrawidjaja waived his right to an appeal under subsection 70(1) of the Code and the Committee administered the public reprimand.

2018 ONCPSD 39 (CanLII)

ITEM 4.1.12

194

Local surgeon suspended over tweet as regulatory body starts eyeing online decorum

JENNIFER BIEMAN (HTTPS://LFPRESS.COM/AUTHOR/JBIEMANPOSTMEDIA) Updated: February 2, 2020

Ontario College of Physicians and Surgeons headquarters, in Toronto.

A local surgeon's one-month suspension over a

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regulatory body has started putting on online behaviour - not just clinical conduct, one expert says.

St. Marys general surgeon Angus Maciver has had his licence to practice medicine suspended for one month after making a vulgar tweet about two female physicians on his personal Twitter account in September 2018.

The 70-year-old past-president of the Perth County division of the Ontario Medical Association (OMA) – the group that represents and negotiates on behalf of Ontario's doctors – recently received a formal reprimand at the College of Physicians and Surgeons of Ontario disciplinary hearing. He was ordered to pay $6,000 in costs to the college.

Maciver's tweet took aim at Concerned Ontario Doctors board members Dr. Kulvinder Kaur Gill and Dr. Ashvinder Kaur Lamba, a physician advocacy group that has been critical of the OMA, the agreed statement of facts said. It referenced a slang term for female genitalia.

Other tweets by Maciver slammed the two Brampton doctors for blocking him on Twitter, the agreed statement of facts said.

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STORY CONTINUES BELOW

Maciver pleaded guilty to the college's charge he engaged in an act or omission regarded as disgraceful, dishonourable or unprofessional. The charge that Maciver engaged in conduct unbecoming of a physician was withdrawn.

Maciver declined comment Wednesday when reached by phone. In an email, his lawyer Jennifer McKendry said Maciver accepts the committee's decision and is looking forward to returning to practice "in the near future."

The prospect of regulated professionals being slapped for their online conduct is growing more common, said one lawyer who represents members of regulatory colleges in disciplinary actions.

"It's certainly something that is a growing area in our practice," said Josh Koziebrocki, founder of Toronto-based Koziebrocki Law.

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rise of social media is expanding the scope of discipline-worthy actions off the job.

"Regulatory colleges can regulate conduct of health professionals outside of the patient setting," Koziebrocki said. "The proliferation of social media has created increased scrutiny on the comments of regulated professionals in these types of mediums."

Since 2018, the College of Physicians and Surgeons of Ontario has had at least four disciplinary cases stemming from doctors' online comments. In 2016, a Saskatchewan nurse was disciplined for criticizing her grandfather's end-of-life care in a Facebook post. Her case is under appeal in the province's highest court.

Earlier this month, the Law Society of Ontario reprimanded a Toronto lawyer after he failed to adequately supervise his former articling student, who made a series of uncivil comments on social media.

The public – and members of regulated professions in Ontario – should expect more discipline cases over social media conduct in the future, Koziebrocki said.

"Colleges are examining what professionals are putting on mediums like Twitter and other social media," he said.

"I think the members of these professions need to be mindful that when they post something on social media."

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198

Surgeon gets one-month suspension for abusing colleagues on Twitter

Liz Braun
More from Liz Braun

Published:
January 24, 2020

Updated:
January 25, 2020 9:40 AM EST

Filed Under:
Toronto SUN › News › Toronto & GTA

Dr. Angus Maciver. (CNW Group/Humber River Regional Hospital)

A prominent Ontario surgeon has had his licence suspended for one month over an unprovoked Twitter attack on two female colleagues.

Dr. Angus Maciver admitted at a disciplinary hearing that he used shocking and sexualized language to bully and humiliate the other doctors on the public forum in the fall of 2018.

The College of Physicians and Surgeons suspended his licence for one month Friday and ordered him to pay $6,000 toward the cost of

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the hearing.

The female Sikh physicians he was insulting — Ashvinder Lamba and Kulvinder Gill — had no prior conversation with Maciver and had never met him, the hearing heard.

DAILY HEA

Email

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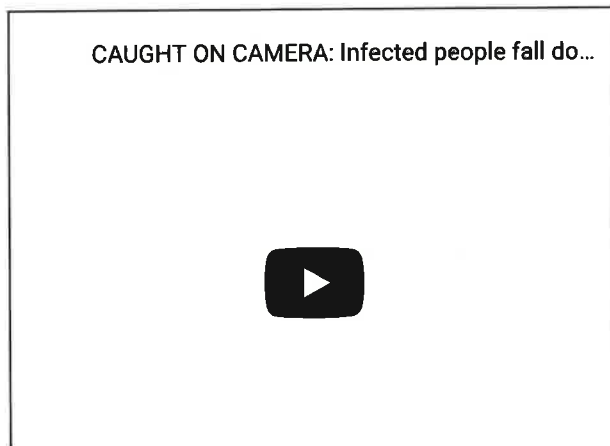
Maciver tweeted they were, "overpaid but whining cork soakers" — a thinly disguised sexual reference. He also tweeted about, "their lack of the qualities we all expect in a physician, let alone a colleague," and their selfishness and intolerance.

STORY CONTINUES BELOW

Gill and Lamba are members of a nonprofit called Concerned Ontario Doctors, which has asked hard questions of the Ontario Medical Association (OMA) and urged the government to undertake a forensic review of the medical organization.

Maciver is a senior Ontario surgeon and the former president of the Ontario Association of General Surgeons. He has held positions of

power, trust and authority with both the OMA and the College of Physicians and Surgeons of Ontario (CPSO).



At the time of the Twitter attack, Gill tweeted she expected such governing bodies as the OMA, CMA, Federation of Medical Women of Canada and The Ontario Association of General Surgeons to reprimand Dr. Maciver, but that did not happen.

Gill tweeted of Maciver at the time: "Glimpse of OMA's toxicity. He feels so empowered that he now publicly makes his racist, sexist & misogynistic comments."

Although Maciver's apology via Twitter to both doctors was raised at the hearing, Gill has previously stated that neither she nor Dr. Lamba has ever seen an apology.

3 Comments
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FINDING SONIA'S KILLER: It's not a cold case - It's an ongoing investigation

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THIS WEEK'S FLYERS

ITEM 4.1.13

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

Pursuant to By-law 6: Election of Council Members, elections to CCO Council will be held in Districts 1, 5, 6 and 7 in March 2020.

Please review the documents below for further details. Nomination papers, candidate undertakings and biographical information must be received by CCO by **February 14, 2020 at 4 p.m.**

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

Notice of Election

Nomination Paper

Candidate Undertaking

College of Chiropractors of Ontario, 59 Hayden Street, Suite 800, Toronto, Ontario M4Y0E7 Canada

SafeUnsubscribe™ {recipient's email}

Update Profile | About our service provider

Sent by cco.info@cco.on.ca in collaboration with

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2020 Notice of Election and Nomination Guide for Districts 1, 5, 6 and 7

College of Chiropractors of Ontario (CCO)

January 2020

Notice

Pursuant to By-law 6: Election of Council Members, notice is hereby given that elections to CCO Council will be held in Districts 1, 5, 6 and 7. **Please note**: the election in District 1 will be a by-election for a term of approximately 1 year. Elections in all other districts will be for a term of approximately 3 years, including the newly-created academic position in District 7 for a member of faculty of the Canadian Memorial Chiropractic College (CMCC), elected by the full membership in Ontario.

One member will be elected from each of the following districts:

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

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

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

District 7: **Academic** comprised of the entire province of Ontario (member of faculty of CMCC).

ELECTION TIMETABLE

January 21, 2020: Notice of Election and Nomination Guide sent electronically to all members.

February 14, 2020: Nomination Date: Nomination papers, candidate undertakings and biographical information in a format suitable for distribution to voters must be received by CCO by 4 p.m.

February 21, 2020: Deadline for candidates to withdraw from the election by 4 p.m. Additional campaign material to be circulated by CCO must be submitted to CCO by 4 p.m.

March 3, 2020: CCO posts on its website and distributes by email a list of candidates and biographical information to eligible voters in each district.

March 6, 2020: CCO distributes by email additional campaign material submitted by candidates and reviewed and approved by CCO.

March 9, 2020: List of candidates, biographical information, and voting procedures sent by email to all eligible voters.

March 16, 2020: CCO distributes by email additional campaign material submitted by candidates and reviewed and approved by CCO.

March 30, 2020: Votes for Districts 1, 5, 6 and 7 must be received by CCO by 4 p.m.

March 30, 2020: Unofficial election results announced for Districts 1, 5, 6 and 7.

April 14, 2020: Deadline to make a written request for a recount with a $150 deposit, which must be received by CCO by 4 p.m.

April 14, 2020: Election results posted on CCO's website at www.cco.on.ca.

Election Procedures

- Unlike years past, CCO will not be providing candidates with a list of members in their districts or mailing labels. However, CCO will distribute additional campaign material to members in their districts on behalf of candidates, in accordance with the election timetable and campaign guidelines.

- The elections are carried out by electronic vote and secret ballot. The Registrar supervises all aspects of the election.

- Candidates are required to submit their nomination papers, candidate undertakings and biographical information in a format suitable for distribution on or before February 14, 2020 at 4 p.m. If a candidate wishes any additional campaign material to be distributed by CCO, it must be received by CCO on or before February 21, 2020 at 4 pm to ensure fairness in the electoral process. CCO will review all materials for general consistency with the campaign guidelines for elections, the biographical information guidelines, the principles of fair, accurate and appropriate election statements and, by analogy, Standard of Practice S-016: Advertising, and will forward a response to the candidate as soon as possible. If you have any questions about any campaign material, contact CCO.

- **Reminder**: CCO has recently moved and any documents sent by mail must be mailed to the new address: 59 Hayden Street, Suite 800, Toronto, ON M4Y 0E7 (continued in next column).

Acronyms

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

- Any additional campaign material and communications, including written material, oral presentations/speeches and general decorum of candidates must comply with the campaign guidelines for elections in this document. Material should be promptly submitted to the CCO Election Review Committee in advance.

- Elections are conducted in a fair and transparent manner, consistent with democratic principles. Failure to comply with the principles of fairness by candidates and others may jeopardize the election process and results.

Eligibility to Nominate and/or Vote

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

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

Eligibility to Stand for Election

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

- the member has his/her primary practice of chiropractic located in the electoral district in which he/she is nominated or, if the member is not engaged in the practice of chiropractic, has his/her primary residence located in the electoral district in which he/she is nominated, or the member is on faculty of CMCC and primarily practices in or lives in Ontario (District 7 only); (continued on next page)

- the member is not in default of payments of any fees prescribed by by-law or any fine or order for costs to CCO imposed by a CCO committee or court of law;
- the member is not in default in completing and returning any form required by CCO;
- the member is not the subject of any disciplinary or incapacity proceeding;
- a finding of professional misconduct, incompetence or incapacity has not been made against the member in the preceding three years;
- the member is not, and has not been in the 12 months before the date of election, an employee, officer or director of any professional chiropractic association such that a real or apparent conflict of interest may arise, including but not limited to being an employee, officer or director of the OCA, CCA, CCPA, AFC, CCEB, CSCE or the Council on Chiropractic Education (Canada) of the FCC; (continued in next column)
- the member is not an officer, director, or administrator of any chiropractic educational institution, including but not limited to, CMCC and UQTR, such that a real or apparent conflict of interest may arise;
- the member has not been disqualified from the Council or a committee of the Council in the previous three years;
- the member is not a member of the Council or of a committee of the college of any other health profession;
- the member has not been a member of the staff of CCO at any time within the preceding three years;
- for District 7 only, the member is a member of the faculty of CMCC; and
- for any district other than District 7, the member is not eligible for election in District 7 (i.e. not a member of the faculty of CMCC).

Mission

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

Vision

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

Values

Integrity, Respect, Collaborative, Innovative, Transparent, Responsive

Strategic Objectives

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

Developed at the Strategic Planning Session: September 2017

Term of Office

The term of office of a member elected to Council is approximately three years (approximately one year for the member elected in District 1), commencing with the first regular meeting of Council immediately following the election (currently scheduled on April 15, 2020). Further By-law amendments are anticipated to bring District 1 in sync with a three year cycle. Incumbents continue to serve in office until the first regular Council meeting, unless otherwise disqualified from Council. By-law 6: Election of Council Members outlines the circumstances in which a member may be removed from Council.

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

Role of CCO and Council Members

CCO is the regulatory body for chiropractors in Ontario, governed by a 15-16 member Council comprised of 6-7 public members appointed by the provincial government and 9 registered chiropractors elected by the membership.

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

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

Time Commitments

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

Compensation

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

Campaign Guidelines for Elections to CCO Council

The following guidelines are for candidates for election or re-election to CCO Council and any member who produces or distributes campaign material on behalf of a candidate. These guidelines are intended to apply to the candidate biography, additional material distributed by CCO, any other written campaign materials distributed by any means, including email, websites or social media, oral presentations/speeches and general decorum of candidates. It is each candidate's responsibility to ensure that his/her campaign material and behaviour complies with the campaign guidelines:

Do the following:

- Be respectful, polite, dignified and professional in everything you do;
- Announce your qualifications rather than denouncing another candidate's qualifications;
- Rely on and promote information that is both factual and provable;
- Focus on your ideas and the positives that you have to offer;
- Ensure the words you use are inclusive and would not offend any specific group;
- Remember the public interest mandate of CCO and don't make any promises that could be viewed as inconsistent with that mandate;
- Comply with CCO regulations, standards of practice, policies and guidelines, including, but not limited to: CCO's Code of Ethics, CCO's Code of Conduct, the Candidate Undertaking, the Professional Misconduct Regulation, Policy P-011: Conflict of Interest for Council and Committee Members, Standard of Practice S-016: Advertising, Guideline G-016: Advertising and common law; and

(continued on next page)

- Remember that you are a professional and a member of a regulated health profession and so are other candidates.

Do not do the following:

- Include any information or material that is false or misleading, not readily comprehensible by the persons to whom it is intended, or disgraceful, dishonourable or unprofessional;
- Compare yourself to another member's or other health care provider's practice, qualification or expertise;
- Imply, in any way, that CCO or any CCO Council or committee member supports your candidacy; or
- Mount a personal or professional attack on any candidate.

Non-compliance with the guidelines may result in a private or public direction issued by CCO during the election and a review as to whether the election is valid after the votes are counted. Non-compliance may result in the election of a district being recalled.

Professional, respectful discourse is essential to a fair election process!

Guidelines to Candidates for Providing Biographical Information

In addition to the guidelines above, a candidate's biographical information must meet the following guidelines.

Biographical information must:

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

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

In addition to the candidate biography, candidates may submit two additional pieces of campaign material that CCO will distribute to eligible voters in their district in accordance with the election timetable. This additional campaign material must comply with CCO election guidelines, be received by CCO on or before February 21, 2020, 4 pm, and only be written material typewritten on one 8.5" x 11"-page white bond paper with a minimum of one-inch margins on all four sides, in portrait format (not landscape).

CCO Committees

Statutory:

- Executive
- Inquiries, Complaints and Reports
- Discipline
- Fitness to Practise
- Paticnt Rclations
- Quality Assurance
- Registration

Non-Statutory:

- Advertising

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

Current CCO Council

ELECTED MEMBERS

Name	District	Term of Office (April to April)
*Dr. Kristina Peterson, *Thunder Bay*	1	2017-2020
Dr. Paul Groulx, *Stittsville*	2	2019-2022
Dr. Steven Lester, *Pickering*	3	2019-2022
Dr. Brian Budgell, *Toronto*	4	2018-2021
Dr. Janet D'Arcy, *Toronto*	4	2019-2022
**Dr. David Starmer, *Toronto*	4	2017-2020
**Dr. Peter Amlinger, *Mississauga*	5	2017-2020
Dr. Dennis Mizel, *St. Catharines*	5	2018-2021
***Dr. Clifford Hardick, *London*	6	2017-2020

**Term of office expires April 2020. Eligible for re-election. District 1 will have a by-election in 2020 for a one-year term.*
***Term of office expires April 2020. Eligible for re-election in District 7 (Dr. Starmer) and in District 5 (Dr. Amlinger).*
****Term of office expires April 2020. Not eligible for re-election having reached nine consecutive years.*

PUBLIC MEMBERS

Name	Date Order-in Council Expires
Ms Georgia Allan, *Smiths Falls*	September 2020
Ms Karoline Bourdeau, *Toronto*	July 2020
Ms Robyn Gravelle Michelutti, *Burlington*	May 2020
Mr. Rob MacKay, *Thunder Bay*	November 2021
Mr. John Papadakis, *Scarborough*	June 2022
Ms Sheryn Posen, *Toronto*	November 2021

Elections Questions & Answers

Q. What is the purpose of the election of professional members to the Council?

A. The *RHPA* and the *Chiropractic Act, 1991* provide for the election of the majority of the Council from among the membership of the profession. Since chiropractic is a self-regulating profession, it is important that the majority of the Council be members of the profession. While there could be a number of ways for the professional members to be chosen, the legislation requires an election system to ensure that Council members have the confidence and respect of those whom they regulate.

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

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

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

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

A. No, a Council member does not have constituents. A Council member is somewhat like the trustee of an estate: he/she acts in the best interest of the beneficiary, not the persons who selected him/her as Trustee. The beneficiary under the *RHPA* and the *Chiropractic Act, 1991* is the public interest. If a chiropractor from a Council member's district has a problem with CCO, it would be inappropriate for the Council member to intervene on the chiropractor's behalf with the pertinent committee or CCO staff person.

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

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

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

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

A. Perspective. Having Council members elected from various districts ensures that the perspective of all chiropractors, not just those from one region (e.g., the Greater Toronto Area), is reflected on Council. Some issues might have a different impact on the public from rural or northern areas, small towns, medium-sized cities and Toronto. It is important that all perspectives are heard, including the perspective of the newly created District 7, Academic.

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

CCO ELECTORAL DISTRICTS

[map not to scale, illustrative of districts only]

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

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

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

NORTHERN ONTARIO

1

Thunder Bay

Sudbury

Sault Ste Marie

Ottawa

2

3

Peterborough

4

Toronto

5

Hamilton

London

6

Windsor

SOUTHERN ONTARIO

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

District 7: Academic Member of faculty at CMCC (elected by all members in Ontario).

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

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

UNDERTAKING TO THE CCO REGISTRAR FROM CANDIDATE

College of Chiropractors of Ontario (CCO) January 2020

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

I, ______________________, candidate for CCO Council in District _______, undertake to the Registrar as follows:

1. **Districts 1, 5 and 6**
   - (a) I am not a member of faculty at CMCC. ☐

     – AND – **AND**
   - (b) My **primary practice of chiropractic** is located in the electoral district for which I was nominated. ☐

     – OR – **OR**
   - (c) I am not engaged in the practice of chiropractic and my **primary residence** is located in the electoral district for which I was nominated. ☐

   District 7
   - (a) I am a member of faculty of CMCC (attach document to confirm). ☐

     - AND- **AND**
   - (b) I primarily practise in or live in Ontario. ☐

2. I am **not**: ☐
   - in default of payments of any fees prescribed by by-law or any fine or order for costs to CCO imposed by a CCO committee or court of law.
   - in default in completing and returning any form required by CCO.
   - the subject of a disciplinary or incapacity proceeding.
   - an employee, officer or director of any professional chiropractic association such that a real or apparent conflict of interest may arise, including but not limited to being an employee, officer or director of the AFC, OCA, CCA, CCPA, CCEB, CSCE or the Council on Chiropractic Education (Canada) of the FCC[1].
   - 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 faculty member of CMCC (except for District 7)[2].
   - 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.

[2] The effective date on which the candidate must not be a faculty member of CMCC (except for District 7) 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).

212

4. If applicable, I have taken all reasonable and necessary steps to ensure I am not reflected in any documents or on any websites as an employee, officer or director of any professional chiropractic association or an officer, director or administrator of any chiropractic educational institution such that a real or apparent conflict of interest may arise. ☐

5. I undertake to maintain all confidentiality within the election process, including but not limited to, maintaining confidentiality with respect to which members voted or did not vote and which members may have submitted spoiled ballots. ☐

6. I have **not**: ☐
   - been disqualified from the Council or a committee of the Council in the previous three years.
   - served on Council for nine consecutive years without a full three-year term passing since I last served on Council.
   - been a member of the staff of the College at any time within the preceding three years.

7. A finding of professional misconduct, incompetence or incapacity has not been made against me in the preceding three years. ☐

8. I confirm I have reviewed my active personal and business communications, including those on social media, and there is no current content that could embarrass or harm the reputation of CCO or give cause to consider that I am unable or unwilling to comply with CCO's mission, vision, values, strategic objectives and by-laws, and the duty to be fair and impartial in all considerations. ☐

9. I undertake to: ☐
   - review and comply with CCO's provisions, including the Code of Conduct, CCO Internal Policy I-015: Policy to Avoid Abuse, Neglect and Harassment and CCO's mission, vision, values and strategic objectives,
   - review CCO's orientation material and attend any relevant training workshop,
   - participate in CCO's Peer and Practice Assessment Program within six months of my election (if I have not already been peer assessed by that time), and
   - participate as a member of a discipline panel or fitness to practise panel if selected by the Chair of the Discipline or Fitness to Practise Committee, unless I have a conflict of interest.

10. I confirm that I have access to and agree to use the following confidential e-mail address for any and all CCO matters:

    ____

11. **I confirm** all the information in this undertaking is accurate, complete and true. ☐

12. I further undertake to advise the Registrar forthwith of any change in the above-noted statements. ☐

13. I understand it is an act of professional misconduct to fail to comply with an undertaking to the Registrar. ☐

Candidate's Name	Candidate's Signature	Date
Witness' Name	Witness' Signature	Date

ELECTION NOMINATION PAPER – ELECTORAL DISTRICTS 1, 5, 6 AND 7

College of Chiropractors of Ontario (CCO) January 2020

The Election Nomination Paper must be received with the Candidate Undertaking Form at CCO by 4 p.m. on February 14, 2020. Please type or print neatly, using black ink. Forms may be faxed to CCO at 416-925-9610.

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

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

as a candidate for the March 2020 election to CCO Council.

Candidate's Registration Number: ______________________________

Business Phone: ( ) ______________________________

Business Address: ______________________________

Confidential E-mail Address: ______________________________

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

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

Candidate's Name **Candidate's Signature** **Date**

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

From: Joel Friedman
Sent: Friday, February 14, 2020 4:04 PM
To: Jo-Ann Willson
Subject: Elections Update: Close of Nominations - February 14, 2020 at 4 p.m.
Attachments: MemorandumElectionFeb142020.pdf

Good afternoon:

I am forwarding this on behalf of Ms Jo-Ann Willson, Registrar and General Counsel.

Please see attached memo for details at the close of nominations for CCO Council today, February 14, 2020 at 4 p.m.

Joel D. Friedman, BSc, LL.B
Director, Policy and Research
College of Chiropractors of Ontario
59 Hayden Street, Suite 800
Toronto, Ontario M4Y 0E7
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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MEMORANDUM

COLLEGE OF CHIROPRACTORS OF ONTARIO

To: Candidates
CC: Council
Non-Council Committee Members
Mr. Joel Friedman, Director, Policy and Research

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

Date: February 14, 2020

Subject: Elections Update: Close of Nominations – February 14, 2020 at 4 p.m.

Close of Nominations

Please note that as of the close of nominations at 4 p.m. today, the following candidates had submitted nomination papers for election to CCO Council:

District	Candidates
1: Northern	Dr. Kristina Peterson Dr. Michael Staffen
5: Central West	Dr. Dwight Chapin Dr. Sarah Green
6: Western	Dr. Michelle Campbell Dr. Colin Goudreau
7: Academic	Dr. David Starmer

Candidates

Please note that CCO encourages candidates to forward proposed campaign material (including two additional pieces of campaign material to be distributed by CCO and any other campaign material) to CCO via e-mail (jfriedman@cco.on.ca) or fax (416-925-9610) by **February 21, 2020, 4 pm** to ensure fairness in the election process. CCO will review all material for general consistency with the campaign guidelines in the notice of election and the principles of fair, accurate and appropriate election statements and, by analogy, Standard of Practice S-016:

Advertising, and will forward a response to the candidate following review. If you have any questions about any campaign material or campaign activities, contact CCO.

Please note that the deadline for candidates to withdraw from the election is **February 21, 2020 by 4 p.m**. (please refer to the notice of election and nomination guide dated January 2020). Thank you to all candidates for expressing an interest in participating in the self-regulation of the chiropractic profession by serving on CCO Council.

Council and Committee Members

Please note that Policy P-011: Conflict of Interest for Council and Committee members provides in part:

> *It is considered a conflict of interest for a Council member or non-Council Committee member to use his/her position on Council or a committee to:*
>
> *Campaign publicly for or on behalf of any person, other than himself/herself:*
> - *in any election to CCO Council ...*
>
> *[e.g., it would be inappropriate for a candidate to use election material which includes comments such as "endorsed by Dr. X, CCO Committee Chair," etc.]. ...*

Please contact me if you have any questions or concerns. Thank you.

DANIEL FAULKNER

LAKEVIEW REGULATORY CONSULTANTS INC.

ABOUT LAKEVIEW

Founded in June 2019 by Daniel Faulkner, Lakeview Regulatory Consultants Inc. specializes in health and non-health professional regulation

SKILLS

Extensive experience in strategy development and execution, governance, partnership building, program development and growth

Collaborative, persuasive leadership with an entrepreneurial spirit

Key change improvements include measuring regulatory effectiveness, pan-Canadian initiatives (international physicians, physician assessment) with sustainable results, and program launch

CONSULTING EXPERIENCE

EXECUTIVE LEAD • MEDICAL COUNCIL OF CANADA • CURRENT
Launching a Pan-Canadian, standardized multisource feedback program for practising physicians

INTERIM PROGRAM DIRECTOR • FEDERATION OF MEDICAL REGULATORY AUTHORITIES OF CANADA • CURRENT
Launching a Pan-Canadian program using evidence-informed physician risk and support factors to achieve regulatory excellence

CONSULTANT • HEALTH PROFESSION REGULATOR • CURRENT
Revitalizing Quality Assurance strategy and program by advising and facilitating with the Board, Committee and Registrar of health professional regulator in Vancouver, BC

CONSULTANT • HEALTH PROFESSION REGULATOR • SEPT – NOV 2019
Completed a compliance audit of the Quality Assurance Program of a health professional regulator in Toronto, Ontario

BOARD MEMBER • TOUCHSTONE INSTITUTE • 2017 - CURRENT
Touchstone Institute provides competency evaluation expertise for licensure and practice decisions with many health disciplines across Canada

FAULKNERDAN1@BELL.NET

@FAULKNERDAN1

416-459-7182

WWW.LINKEDIN.COM/IN/DANIEL-FAULKNER1

LEADERSHIP

Co-Chair, College Performance Measurement Framework, Ministry of Health and Long Term Care Dec 2018 – Jan 2020

Member, International Regulatory Expert Working Group, Australia (AHPRA) April 2019 - Current

Member, Work Group to Study Risk & Support Factors Affecting Physician Performance, USA (FSMB) Dec 2019 - Current

Co-Chair, Pan-Canadian Steering Committee for Physician Risk and Support Factors 2014 – 18

Chair, Practice Ready Assessment Steering Committee, Canada (International Medical Graduate Assessments) 2012 – 2017

WORK EXPERIENCE

INTERIM CEO & REGISTRAR • COLLEGE OF PHYSICIAN & SURGEONS OF ONTARIO • MARCH – JUNE 2018

Successfully led media relations for Toronto Star investigative report on transparency; launch of an internal governance review; and regulation development with MOHLTC for sexual abuse and transparency in Bill 87

DEPUTY REGISTRAR • COLLEGE OF PHYSICIANS & SURGEONS OF ONTARIO • 2012 - 2019

Founding member of Quality Management Partnership with Cancer Care Ontario, built evaluation unit for regulatory effectiveness, developed multi-year evaluation of physician licensure pathways, staff oversight and internal lead of four Government reviews of CPSO; accountable for all operational support areas and research & evaluation

DIRECTOR QUALITY MANAGEMENT • COLLEGE OF PHYSICIANS & SURGEONS OF ONTARIO • 2007 - 2012

Oversight of core regulatory functions (assessment, registration) managing significant volumes (eg. 2500 assessments/year; 4500 licenses issued/year) with growth mandate and major issue management (Fairness Commission mandate, cosmetic surgery overhaul)

NUMEROUS MANAGEMENT ROLES • COLLEGE OF PHYSICIANS & SURGEONS OF ONTARIO • 1994 – 2007

Guideline G-009

Quality Assurance Committee
Approved by Council: February 28, 1998
Amended: February 14, 2012, November 29, 2018

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

Intent

To advise members of their obligation to act competently and ethically in the practice of their profession.

Description of Guideline

Chiropractors have been granted the privilege of self regulation, a privilege that obliges them to act competently and ethically in the practice of their profession. In so doing, they shall maintain recognized standards of practice of chiropractic care while also observing professional values. Their commitment to such practice shall ensure public trust, collaboration with their colleagues, and the integrity and dignity of the profession.

The ethical values that guide the profession are identified here. These principles are intended to aid chiropractors individually and collectively in maintaining a high level of ethical conduct.

Chiropractors shall:

1. practise only within the limits of professional and personal competence;
2. practise in surroundings that shall not compromise the quality of care offered;
3. act always with personal integrity while also trying to acquire and maintain the confidence and respect of their patients;
4. render care to those who seek it, without discrimination on the basis of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status, socio-economic status or disability, and interact truthfully with their patients;
5. have the well-being of patients as their paramount objective and shall:
    - provide appropriate and necessary care;
    - not offer to guarantee a cure to his/her patients, either verbally or in writing;

- clearly communicate to patients all fees and practices related to chiropractic care, including policies and procedures related to billing arrangements, billing of insurance companies and third-party payors;

- neither exaggerate nor minimize the gravity of a patient's condition, nor apply pressure or duress to a patient;

- collaborate with other recognized health care practitioners so the patient shall have the benefit of coordinated team care;

- never abandon patients without due regard for their welfare once they have been accepted into the practice. If, for any reason, a member wishes to withdraw from a case (e.g., an issue of self-respect or dignity, or the need for assistance for the patient of someone more skilled), the member shall give the patient sufficient notice of withdrawal of care so as to permit them to secure an alternate care provider, if appropriate;

- avoid conflict of interest in caring for their patients (i.e., they shall not take physical, mental, social, sexual, cultural or financial advantage of patients); and

- endeavour to ensure, in advance of any examination or care, that patients understand any legal responsibility of the member to third parties (so as to protect the patient's interests);

6. ensure that the capable patient has an ongoing opportunity to make an informed and voluntary choice for chiropractic intervention or non-intervention, and ensure that the non-capable patient has a capable substitute decision maker who acts for the patient in making choices that are informed, voluntary, continuing and non-contrary to the previously expressed wishes of the patient. In the absence of such previously expressed wishes, or in the ignorance of them, the member shall ensure that any decision taken by the substitute decision-maker is in the best interest of the patient; and

7. respect and maintain privacy and confidentiality with regard to personal health information obtained from patients or from colleagues concerning patients. Such information shall be disclosed only with the consent of the patient (except when the law requires the member to do otherwise), in circumstances of inter-professional consultation or when the harm of keeping confidentiality is greater than the harm that results from breaching confidentiality.

8. not judge fellow members, their qualifications or the procedures they use, except as may be required in the interests of the health of patients;

9. not take over a case which, or recently has been, under the care of another member, except:

   - in an emergency;
   - in consultation with the previous member;
   - when the previous member has relinquished the case; or
   - the patient has stated he/she no longer wishes to attend the previous member;

10. work collaboratively with other members and health professionals in terms of patient care (e.g., information sharing, care, consultation and education);

11. Not engage in any in-person or online bullying, intimidation or harassment; and

12. only enter contractual agreements, regarding his/her professional services, which have terms that are equitable and agreeable to all parties and maintain professonial integrity and offer high quality care.

13. conduct him/herself with dignity so as to bring honour to the profession;

14. have one level of billing, except on compassionate grounds or when professional bodies have negotiated fee schedules with different payor agencies. They shall bring their practice to public attention only in accordance with acceptable professional standards of practice and within applicable legislation;

15. encourage ongoing professional and public education regarding chiropractic practice, and assist in educating new members of the profession; and

16. recognize that ongoing professional research is necessary so as to advance the practice of the profession.

17. claim only qualifications possessed, represent accurately the nature of chiropractic treatment, and convey correct information when interpreting scientific knowledge;

18. comply with all governing legislation (with ongoing attention given to current requirements under the *Regulated Health Professions Act, 1991*, as amended, *Chiropractic Act, 1991*, the *Healing Arts Radiation Protection Act*, and the regulations under those acts); and

236

19. endeavour to improve the standards of chiropractic services within the community.

20. comply with the code of ethics, by-laws, standards of practice, policies and guidelines duly approved by CCO and report unprofessional conduct on the part of other members to the appropriate review body of CCO; and

21. cooperate and assist CCO in a timely manner and assist CCO in its professional work.

From: Jo-Ann Willson
Sent: Monday, January 20, 2020 9:51 AM
To: Rose Bustria
Subject: FW: CV
Attachments: CV 2020.docx

Executive (January 29, 2020) and Council.

Jo-Ann Willson, B.Sc., M.S.W., LL.B.
Registrar & General Counsel
*Note Address Change
College of Chiropractors of Ontario
59 Hayden St., Suite 800
Toronto, ON M4Y 0E7
Tel: (416) 922-6355 ext. 111
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From: Hanno Weinberger <weinbergerhk@gmail.com>
Sent: Monday, January 20, 2020 9:34 AM
To: Jo-Ann Willson <jpwillson@cco.on.ca>
Subject: CV

Good morning Jo-Ann.
Attached please find my CV.
Thanks and have a good day...Hanno

Hanno Weinberger
weinbergerhk@gmail.com

Education:
- BA/BSW 1975 McMaster University
- BEd 1976 Hamilton Teachers" College

Employment:
- Halton District School Board 1976 – 2014
  - Teacher - elementary panel

College of Denturists of Ontario:
- Council member (appointed) 2012 – 2019
- Quality Assurance Committee (chair 2017 - 2019) 2012 – 2019
- Registration Committee 2012 – 2015
- Professional Practice Committee 2013 - 2015
- Discipline Committee, chair 2014 – 2019
- Executive Committee, chair 2015 - 2017, 2019
- Council President 2015 - 2017, 2019
- Qualifying Exam Review Committee 2018
- Patient Relations Committee 2018 - 2019

College of Massage Therapists of Ontario:
- Presentation to Council on the role of Committee Chair and Discipline Hearing Panel Chair - June 2019

College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario:
- Pre Hearing presiding officer 2017 - 2018

College of Naturopaths of Ontario:
- Pre Hearing presiding officer 2015 -

Ontario College of Trades:
- Discipline Committee 2014 -
- Pre Hearing presiding officer 2014 -
- Chair, Discipline Hearing Panels 2014 -

Ontario College of Teachers:

Council (elected) 2006 – 2012
Discipline Committee 2006 – 2012
Fitness to Practise Committee 2006 – 2012 (chair 2009 – 2012)
Nominations Committee 2006 – 2012
Stakeholder Relations Committee, chair (ad hoc) 2008-2009
Executive Committee 2009 – 2012
Scholarship Committee (ad hoc) 2011 – 2012
Discipline and Fitness to Practise Committees, roster member 2012 – 2015

College of Dental Hygienists of Ontario:

Facilitated/Chaired Council Meeting discussion re: proposed By-Law amendments – February 2015

Art Gallery of Hamilton:

Docent 2012 –
Volunteer Committee Executive, Docent Liaison 2013 – 2015
Volunteer Committee Executive, Vice Chair 2015 - 2017
Volunteer Committee Executive, Chair 2017 - 2019
Volunteer Committee Executive, Past Chair 2019 -
Board of Directors 2017 - 2019
Acquisition Committee, Vice Chair 2018 -

359

RTHERN ONTARIO | NEWS

ITEM 4.1.29

Animal chiropractic becoming more common place with Canadian pet owners

Ian Campbell
CTV News Northern Ontario Videojournalist
@CTVIanCampbell | Contact

Published Tuesday, January 21, 2020 9:12AM EST

The ad will end in 13 seconds

SHARE 6

¯UDBURY -- Sudbury chiropractor Dr. Sherrie Guillet has been treating spines in the City of Greater ͜udbury for 15 years now and some of her best clients don't exactly walk on two feet.

"When I was in chiropractic college, there was an animal chiropractor that came in to do a presentation on what she does, and I was really fascinated by the stories that she told of the animals that she helped, and I thought I'd like to do that as well," said Guillet.

360

The Sudbury practitioner is one of only a handful in the country who has the special certification.

"There are definitely some differences, but there are a lot of similarities as well," she said. "The same general idea, that we're affecting the spine. For the animals, I will do it on the floor or a little table I have for them."

Guillet admits she catches some people off guard when telling them she can treat dogs and cats.

"The most common response is that people are surprised that it even exists as a profession, most people have never heard about it. They're surprised and then they're really excited that there is such a thing," she said.

Marina Mogensen began visiting Guillet's home office six years ago after getting referred to her through a natural health store.

"I was shocked that it even existed. I looked at the lady and said 'you've got to be kidding me right?'" said Mogensen.

Her dachshund had stopped walking and she was told by a vet that she could either deal with a $5,000 surgery, with no guaranteed chance of success, or the dog would have to be put down.

Devastated, she began to visit Guillet's office in hopes of finding a homeopathic miracle.

"She started treating the dog, within a week she was walking again, and that was six years ago," said Mogensen.

Guillet now treats Mogensen's two dachshunds, ages 16 and 14 respectively, once a month.

"They're almost as old as my daughter. You're attached, they're like my children," she added.

"This one still chases chipmunks. They're not very happy when they have the treatment done," Mogensen laughed. "But, like I said, it keeps them mobile."

The long-time chiropractor, who also treats humans out of her Westmount Ave. office, says while it's possible to treat anything with a spine, she's only treated cats, dogs and the odd horse.

"I've heard of other stories that treated other animals, like cows or things like that. I haven't myself, no one's asked me to adjust their cows, but mainly it's dogs, cats and horses that are the main animals," said Guillet.

The Ontario Chiropractic Association has issued a statement:

"Animal chiropractic does not replace traditional veterinary medicine or surgery, but provides an integrative method of care. Often, veterinarians and animal chiropractors work together to best serve the needs of an animal."

The association adds that animals can have similar issues and injuries.

Chiropractors who treat animals must also have completed a post-graduate training program, which is open to both chiropractors and veterinarians.

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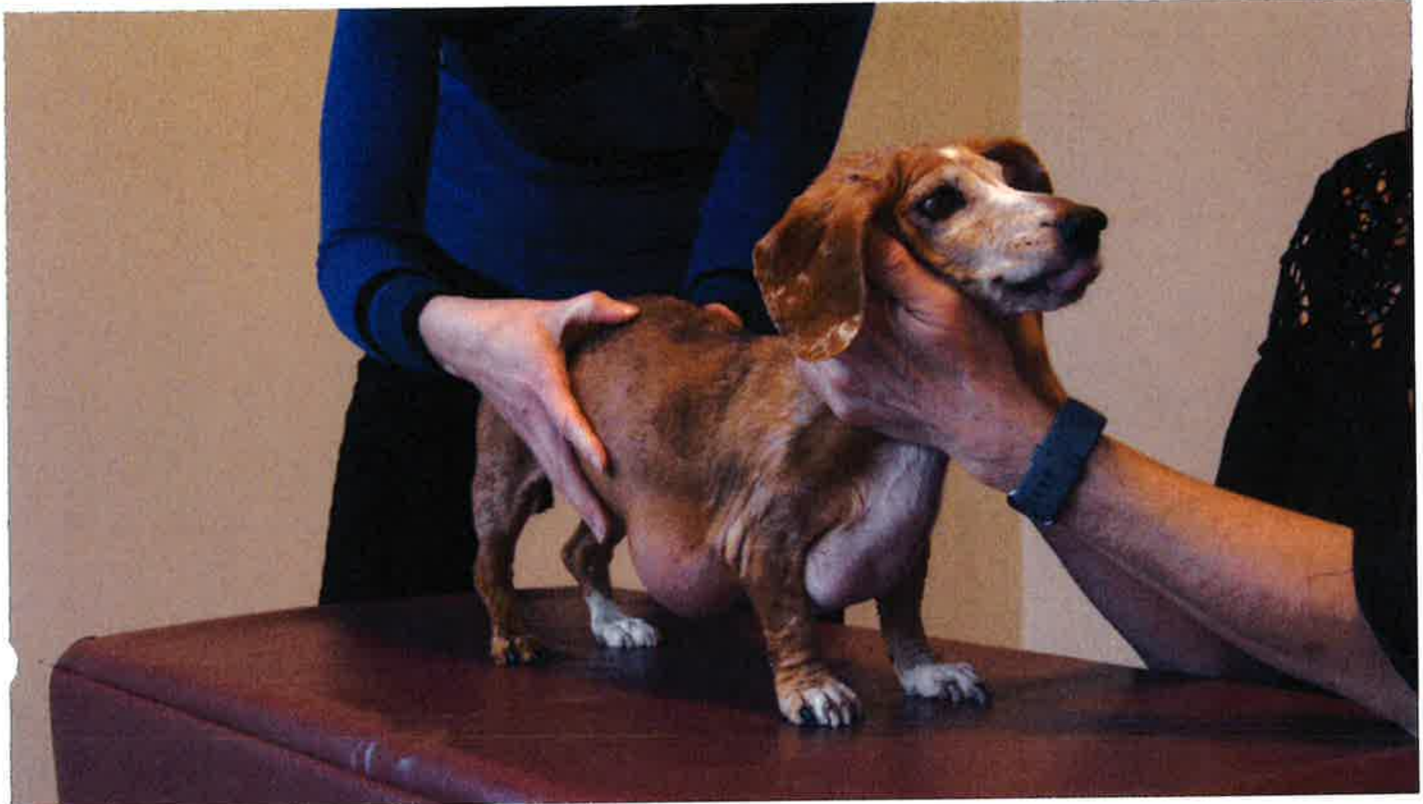

Sudbury chiropractor Dr. Sherrie Guillet adjusts Marina Mogensen's dachshund (Ian Campbell/CTV Northern Ontario)

SHARE 6

Report Error

Editorial standards and policies

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LABOUR MOBILITY | MOBILITÉ MAIN-D'OEUVRE

A Guide for Regulatory Authorities

Best Practice Checklist for Certifying Labour Mobility Applicants*

Developed initially by the Labour Mobility Coordinators under the Forum of Labour Market Ministers (FLMM) in the context of the labour mobility provisions of the Agreement on Internal Trade (AIT). The Canadian Free Trade Agreement (CFTA) which came into force on July 1, 2017 replaces the AIT. This checklist has been updated to reflect the minimal changes made to Chapter 7 (labour mobility) under the CFTA.

Each regulatory authority has established an application process in order to certify workers in its regulated occupation. The intent of this document is to outline guiding principles for requesting information, as part of this application process, from workers who are currently certified in another Canadian province or territory in order to certify them in a regulated occupation. The Principles and Best Practice Checklist is meant to identify and guide best practices for regulatory authorities.

Guiding Principles for Certifying Labour Mobility Applicants

1. Certificate-to-certificate recognition is the fundamental principle of labour mobility in Canada. Regulatory authorities recognize that due diligence is applied by other jurisdictions in Canada in certifying their workers to practice their occupations.
2. Information requested from a labour mobility applicant who is currently certified in another Canadian province or territory must only be asked to complete the registration certification and/or licensure process, not to reassess the applicant's competencies or abilities to practice his/her occupation.
3. The application process for labour mobility applicants should be transparent and processed promptly.
4. Regulatory authorities can ask labour mobility applicants to meet requirements to be registered, certified and/or licensed in their jurisdiction; however, these requirements must not be more burdensome than those required by first-time applicants from that jurisdiction. Material requirements for additional training, experience, examinations or assessments must not be required of a labour mobility applicant unless a labour mobility exception has previously been approved by government and publicly posted.
5. Regulatory authorities may create licensure and/or certification categories to regulate an occupation in their jurisdictions; however, these authorities cannot deny certification to a labour mobility applicant that is practicing the same scope of practice for that occupation in another jurisdiction regardless of differences in these certification categories. If a material difference exists in the scope of practice, then an exception to labour mobility based on a legitimate objective must be approved by a government.
6. Regulatory authorities should work together with other provinces and territories to understand, and where possible and practical, take steps to reconcile differences in occupational standards. To further streamline labour mobility, where possible and practical, regulatory authorities may consider coordinating licensure and/or certification categories and scopes of practice for an occupation.
7. If a labour mobility applicant has been given a practice limitation, restriction or condition, regulatory authorities are encouraged to, where possible and practical, make a reasonable effort to certify the applicant with an equivalent practice -limitation, restriction or condition.

* This document does not constitute a legal interpretation of Chapter 7 of the AIT or the CFTA and does not supersede provincial/territorial legislation.

LABOUR MOBILITY | MOBILITÉ DE LA MAIN-D'OEUVRE

☐ **Criminal Background Check**

Regulatory authorities can require a labour mobility applicant to provide a criminal background check, such as police and/or RCMP checks. This may include additions such as vulnerable sector checks or child abuse registry checks along with local, national or international checks.

A labour mobility applicant should not have to undergo a more onerous criminal background check than that which a province or territory's own applicants are required to undergo.

☐ **Evidence of Good Character**

Regulatory authorities can require a labour mobility applicant to provide evidence of good character.

A regulatory authority could consider evidence of a labour mobility applicant's good character. This could be satisfied through the following:

- Criminal record checks, including vulnerable sector check and or child abuse registry check;
- Disclosure of any disciplinary issues; and,
- Disclosure of regulatory history (including formal proceedings).

A national scan of jurisprudence decisions in the area of good character has shown that courts will often consider certain factors when determining if denial of licensure based on good character is warranted. Such factors could include how recent the offence was and how relevant it is to an applicant's conduct in his/her practice of the occupation. To further streamline labour mobility, where possible and practical, regulatory authorities may consider working together on defining good character in the regulated occupation. A labour mobility applicant should not have to provide more onerous evidence of good character than that which a province or territory's own applicants are required to provide.

☐ **Evidence of Good Standing**

Regulatory authorities can require a labour mobility applicant to provide evidence that he/she is in good standing in other Canadian provinces and territories where the applicant is currently certified.

Examples of what a regulatory authority might provide on behalf of an applicant's good standing in another jurisdiction may include:

- Fees have been paid;
- Continuing education/competency requirements have been met within the required timeframe;
- Practice hour requirements have been met within the required timeframe; and
- An applicant has practiced in his/her jurisdiction or has not had a substantial break in his/her practice.

To further streamline labour mobility, where possible and practical, regulatory authorities may consider working together on defining good standing in the regulated occupation.

A regulatory authority may not ask a labour mobility applicant to provide evidence of good standing from a jurisdiction where the applicant was previously, but is no longer, certified.

A generally acceptable understanding of good standing is that a member of an occupation who has unfulfilled obligations to his/her regulatory authority (e.g., outstanding fees, outstanding requirements to provide information, unfulfilled continuing competency requirements, lack of practice in that jurisdiction, lack of proof of professional liability insurance) is not in good standing until the obligations are satisfied. A regulatory authority's definition of good standing must be the same for all of its certified workers.

Additional Information Requests Not Explicitly Mentioned in Chapter 7

As per the obligations of Chapter 7, information not explicitly mentioned in the Chapter must not be used to reassess an applicant's competencies or abilities to practice his/her occupation as a condition of certification. A regulatory authority should contact its Labour Mobility Coordinator regarding any other information it is considering requesting from labour mobility applicants to see if the request follows the principles of Chapter 7.

Regulatory Authorities sometimes request that applicants (including labour mobility applicants) provide other information that is not explicitly mentioned in Chapter 7, as part of the application process (resumes, job descriptions, self-assessments (often online), transcripts, employment history/verification of employment).

Keeping in mind that the purpose of Chapter 7 is to enable any worker certified for an occupation by a regulatory authority to be recognized as qualified by all other Parties, regulatory authorities should consider the purpose of requesting the information and whether it is actually necessary to certify a labour mobility applicant. As a guiding principle, this additional information should only be requested to facilitate the registration process.

For more information: www.workersmobility.ca

To further facilitate labour mobility, where possible and practical, regulatory authorities could also consider working together to transfer a certified worker's file to other regulatory bodies In Canada, upon request and approval by the certified worker.

From: Jo-Ann Willson
Sent: Thursday, February 13, 2020 9:53 AM
To: Rose Bustria; Joel Friedman; Bruce Walton
Subject: Fwd: Notice: Elimination of Billing Arrangements

Council.

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

College of Chiropractors of Ontario
59 Hayden St., Suite 800
Toronto, ON M4Y 0E7
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Begin forwarded message:

> **From:** Michelle Da Roza <michelle@chirobc.com>
> **Date:** February 12, 2020 at 9:25:26 PM GMT+2
> **To:** John Sutherland <jsutherland@pathfinder-group.com>, Darrell Wade <nlcbregistrar@gmail.com>, "Dean Wright (dwright@ccpaonline.ca)" <dwright@ccpaonline.ca>, Frances LeBlanc <fleblanc@nbchiropractic.onmicrosoft.com>, "jfhenry@ordredeschiropraticiens.qc.ca" <jfhenry@ordredeschiropraticiens.qc.ca>, Philippe Larivière <PLariviere@ordredeschiropraticiens.qc.ca>, Jo-Ann Willson <jpwillson@cco.on.ca>, "denise@saskchiro.ca" <denise@saskchiro.ca>, Todd Halowski <thalowski@albertachiro.com>, "chiro.whitty@pei.aibn.com" <chiro.whitty@pei.aibn.com>, "registrar@mbchiro.org" <registrar@mbchiro.org>
> **Cc:** Alex MacDonald <amacdonald@pathfinder-group.com>, Johnny Suchdev <jjsuchdev@gmail.com>, David Hayes <david.hayes@dr.com>, Theressa Mah <Theressa@chirobc.com>, Doug Wright <deputyregistrar@chirobc.com>
> **Subject: Notice: Elimination of Billing Arrangements**
>
> Hello colleagues,
>
> In light of increased media scrutiny of the profession and regulation, we wanted to share the following update with you from the CCBC.

On February 5, 2020, the CCBC Board approved amendments to Part 5 of the Professional Conduct Handbook (PCH) which relate to Billing Arrangements.

Effective February 13, 2020, registrants must not enter into arrangements with patients for the billing or payment of fees for professional services that cover more than one patient visit.

For more information, please see the public notice on our website: https://www.chirobc.com/amendments-to-the-professional-conduct-handbook-part-5-and-billing-arrangements/

Thank you,

Michelle Da Roza
Registrar
College of Chiropractors of BC
900-200 Granville Street, Vancouver BC V6C 1S4
T: (604) 742-6470 | **F:** (604) 742-6471 | **Toll-free:** (877) 742-6470
Direct line: (604) 742-6362
www.chirobc.com

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From:	Suzette Martin-Johnson <admin1@cceb.ca>
Sent:	Tuesday, February 11, 2020 11:37 AM
To:	Gemma Beierback
Subject:	CCEB attendance at member AGMs in 2020

Dear members,

We were thrilled to visit and speak with you last year about the CCEB and its activities. From a stakeholder connection and transparency perspective, we would be delighted to come again this year to present a CCEB update and to speak to you about progress on our blueprint development, with which you so ably assisted by engaging your members to participate in our survey. We have a revamped PowerPoint presentation but, naturally, we are happy to present in whatever format you deem appropriate.

For the moment, we are entering dates and venues, where available, into our calendar. Are you able to provide us with the 2020 AGM date and/or venue for your province, as well as confirmation regarding any interest in having the CCEB present this year?

Sincerely | Bien cordialement,

Suzette Martin-Johnson
Executive Assistant | Assistante de direction
230, 1209 – 59 Avenue SE, Calgary, AB T2H 2P6
T 403-230-5997 x 2 | **F** 403-230-3321 | www.cceb.ca

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From: Jo-Ann Willson
Sent: Monday, January 6, 2020 5:10 PM
To: Rose Bustria
Subject: Fwd: Survey prize winners | Gagnants de prix du sondage

Registration and Council.

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

College of Chiropractors of Ontario
59 Hayden St., Suite 800
Toronto, ON M4Y 0E7
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Begin forwarded message:

> **From:** Suzette Martin-Johnson <admin1@cceb.ca>
> **Date:** January 6, 2020 at 4:54:27 PM EST
> **To:** Suzette Martin-Johnson <admin1@cceb.ca>
> **Subject: Survey prize winners | Gagnants de prix du sondage**
>
> *(Le français suit)*
>
> Dear Members,
>
> Thank you so much for your support with the CCEB national survey which closed in December.
>
> David Cane, PhD (Catalysis Consulting) has finalized his review of the survey data and provided the final completion table (below). We received a total of 1,513 valid survey responses, creating an approximate margin of error on survey data of +/- 3% with 90% confidence; this is an excellent starting point for the next step of our blueprint update.
>
> The work now moves over to Psychometrician Anthony Marini, PhD (Martek Assessments).
>
> **Drumroll....**
>
> We are excited to announce our prize winners, both from the provincial regulators as well as from the chiropractors who participated in the survey.
>
> **Provincial winners**

400

With an 84.5% response rate, **Newfoundland and Labrador** had the highest total percentage of completions.

Manitoba showed the greatest improvement in the final week.

	N practitioners	n valid survey responses	% practitioners
	(approx)	(final)	
BC	1247	266	21.3
AB	1123	194	17.3
SK	215	59	27.4
MB	296	71	24.0
ON	4935	623	12.6
QC	1356	166	12.2
NB	98	16	16.3
NS	168	55	32.7
PE	11	3	27.3
NL	71	60	84.5
Canada	9520	1513	15.9

Chiropractic winners:

The following participants were randomly selected to receive a survey participation prize. As the survey was completely anonymous, we need your help to connect with the winners.

Please provide us with the first and last name of the registrants from your province so that we may contact them to provide their prize.

	province	registration no.	prize
National grand prize winner	NL	26	$1000 Westjet gift ce
Provincial prize winner	BC	20482	$100 Amazon
Provincial prize winner	AB	1417	$100 Amazon
Provincial prize winner	SK	423	$100 Amazon
Provincial prize winner	MB	82	$100 Amazon
Provincial prize winner	ON	2565	$100 Amazon
Provincial prize winner	QC	51610	$100 Amazon
Provincial prize winner	NB	153	$100 Amazon
Provincial prize winner	NS	215	$100 Amazon
Provincial prize winner	PE	14	$100 Amazon
Provincial prize winner	NL	62	$100 Amazon
National secondary prize winner	BC	2904	$50 Petro-Canada
National secondary prize winner	BC	615	$50 Petro-Canada
National secondary prize winner	AB	1902	$50 Petro-Canada
National secondary prize winner	AB	1956	$50 Petro-Canada
National secondary prize winner	ON	1126	$50 Petro-Canada
National secondary prize winner	ON	1972	$50 Petro-Canada
National secondary prize winner	ON	4924	$50 Petro-Canada
National secondary prize winner	ON	7030	$50 Petro-Canada
National secondary prize winner	NS	242	$50 Petro-Canada
National secondary prize winner	NL	83	$50 Petro-Canada

Thank you all for your support in this initiative.

Bonjour,

Nous vous remercions de votre soutien. Le sondage national du CCEB a été fermé au mois de décembre.

Ayant terminé sa revue des données du sondage, le Dr. David Cane (Catalysis Consulting) a produit le tableau final des réponses (voir en bas). Nous avons reçu un total de 1513 réponses valides au sondage, représentant une marge d'erreur de +/- 3 % avec une marge de confiance de 90 % pour les données du sondage. Cela constitue un point de départ excellent pour la prochaine étape de notre mise à jour du plan directeur.

Le Dr. Anthony Marini de Martek Assessments va maintenant continuer ce travail.

Roulement de tambour...

Nous sommes ravis d'annoncer nos gagnants parmi les organismes de réglementation provinciaux et parmi les chiropraticiens ayant participé au sondage.

Gagnants provinciaux

La **Terre-Neuve-et-Labrador** a produit le plus grand pourcentage de participation (84,5 %).

Le **Manitoba** a démontré l'amélioration la plus marquée pendant la semaine finale.

	Nº praticiens	Nº réponses valides au sondage	% praticiens
	(approx)	(final)	
BC	1247	266	21,3

AB	1123	194	402	17,3
SK	215	59		27,4
MB	296	71		24,0
ON	4935	623		12,6
QC	1356	166		12,2
NB	98	16		16,3
NS	168	55		32,7
PE	11	3		27,3
NL	71	60		84,5
Canada	9520	1513		15,9

Chiropraticiens gagnants

Les participants suivants ont été sélectionnés au hasard pour recevoir un prix de participation au sondage. L'enquête étant totalement anonyme, nous avons besoin de votre aide pour nous connecter avec les gagnants.

Veuillez nous fournir le prénom et le nom des personnes inscrites de votre province afin que nous puissions les contacter pour leur remettre leur prix. (Voir tableau « *prize winner* » ci-dessus en anglais).

Nous vous remercions de votre soutien pour cette initiative.

Sincerely | Bien cordialement,

Suzette Martin-Johnson
Executive Assistant | Assistante de direction
230, 1209 – 59 Avenue SE, Calgary, AB T2H 2P6
T 403-230-5997 x 2 | **F** 403-230-3321 | www.cceb.ca

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Federation of Chiropractic Licensing Boards

ITEM 4.1.37

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Patricia Oliver

February 5, 2020

Ms. Jo-Ann Willson, Registrar and General Counsel
College of Chiropractors of Ontario
130 Bloor Street West, Suite 902
Toronto, Ontario M5S 1N5
CANADA

Dear Ms. Willson,

Congratulations! You have been awarded the NBCE's Administrator Scholarship! We are happy to help outstanding administrators such as yourself participate in this important meeting and educational experience. The scholarship covers up to $2,500 in meeting registration, travel, and hotel stay.

Here are your next steps:

- Let us know your plans for conference:
  - We'll register you and make sure you get signed up for the Chiropractic Board Administrators Committee meeting.
  - We are also happy to include you on the list for Friday night's social event (sponsored by the NBCE). Just let us know if you will be bringing a guest!
- Book your flight
  - We hope you can arrive in time for the Wednesday Board Member Training beginning at 1:00 pm on April 22. The official conference begins Thursday morning with a new attendee breakfast at 7:00 am and for veterans at 7:15.
  - The CBAC meeting will be Friday beginning at 7:30 with breakfast.
  - The educational sessions and annual business meeting continue until Saturday afternoon, so attendees generally plan departure any time Saturday evening or Sunday. Please see the enclosed agenda, and check out our website for hotel and travel information as well.
- Let us know your travel plans
  - Send us an email telling when you plan to arrive and depart and we'll make your hotel reservation.
- Save your receipts!
  - The NBCE will reimburse you for flight and transportation expenses up to that $2,500 limit (including hotel and conference registration).
  - Enclosed is a reimbursement form you can submit along with your receipts to FCLB for processing.

Please feel free to contact us if you have any questions. We are happy to help.

Sincerely,

Jon Schwartzbauer, D.C.
Executive Director

FCLB is a non-profit 501(c)(3) corporation.

Contributions are deductible as allowed under section 170 of the IRS Code.

Tax ID 83-0208564

Cc: FCLB Board of Directors

FCLB's 94th Annual Educational Congress

406

Refocus on REGULATION

NOW FORESIGHT IS 20/20 • DENVER, CO APRIL 22-26, 2020

Updated 02/04/2020 Agenda subject to change

Tuesday · April 21 FCLB Office - Blanca Peak ~ NBCE Office - Mt. Columbia

1:00 PM - 5:00 PM Mt. Harvard	**FCLB BOARD OF DIRECTORS MEETING**

Wednesday · April 22

8:00 AM - 5:00 PM Mt. Harvard	**FCLB BOARD OF DIRECTORS MEETING**
2:00 - 4:00 PM Mt. Yale	**FCLB COMMITTEE MEETINGS** - determined by chairs
1:00 - 5:00 PM Mt. Oxford	**BOARD MEMBER TRAINING** - Dale Atkinson, Esq.
2:00 - 4:00 PM Blanca Peak	**FCLB CONFERENCE CHECK-IN**
	Wednesday evening on your own.

Thursday · April 23

7:00 - 8:00 AM Blanca Peak	**FCLB CONFERENCE CHECK-IN**
7:15 AM Colorado Ballroom A Foyer	**BREAKFAST** Full breakfast for registrants.
7:00 AM Mt. Harvard	**NEW ATTENDEE ORIENTATION & BREAKFAST** Is this your first meeting? Learn more about the missions and work you are taking part in.

EDUCATIONAL PROGRAM - COLORADO BALLROOM A

8:15 AM **WELCOME & OPENING REMARKS**
Karlos Boghosian, D.C (CT) - FCLB President

8:30 AM **30th ANNUAL JOSEPH JANSE LECTURE**

ABOUT THE LECTURE SERIES...Speakers for the Janse Lecture series are chosen by a committee of the FCLB board based on their oratory skills, ability to envision future possibilities, and to encourage the audience of regulators to consider new points of view, new perspectives in their approaches to public protection.

The Janse Lecture is successful if the speaker presents a different viewpoint and rekindles passion.

9:15 AM **EDUCATIONAL SESSION -**
The Future of Regulation
Ms. Ronne Hines, Director, Division of Professions & Occupations, Colorado Department of Regulatory Agencies

10:00 AM **MIDMORNING BREAK**

10:15 AM **CONCURRENT PRESENTATIONS**
Chiropractic Fraud Case Study. Success, Pitfalls & Common Hurdles
Mr. Ian Kildow, Financial Fraud Investigative Supervisor
Colorado Department of Law - Criminal Justice Section

CONCURRENT SESSION
Healthcare Professional Remediation Education
Dr. Catherine Caldicott, Senior Faculty
PBI Education

11:00 AM **EDUCATIONAL SESSION**

ATTORNEY PANEL -
Mr. Ajay Gohill, Ms. Mona Baskin, Mr. Christopher Gerard, Ms. Amy Richardson & Mr. Sean Dingle

The panel will discuss:

- Sexual Boundary Violations - (trends, policies and new developments, with a focus on what state chiropractic boards should know in light of this challenging issue)

12:00 PM	**NATIONAL UPDATES -** ChiroCongress - CCE-US - ICA - ACA - FCC - ICRS - ACCR - ABCA - ACC
12:45 PM	**LUNCH ON YOUR OWN**

AFTERNOON SESSIONS -

2:00 - 2:45 PM	**Occupational Licensing Policy Learning Consortium: State-Based Solutions to Licensing Reforms** Mr. Carl Sims, Policy Analyst, The Council of State Governments
2:45 - 3:30 PM	**Chiropractic College President**
2:00 PM	**FCLB FINANCE COMMITTEE MEETING** Keita Vanterpool, D.C. (DC) - FCLB Treasurer, Chair
2:30 - 3:30 PM	**WORKSHOP: FCLB SERVICES** Ms. Kelly Webb and Ms. Janelle Grier - FCLB Staff Discover the services your board may access through FCLB membership. Learn more about CIN-BAD, PACE, CCCA, PowerPolls, meetings, and more.
3:30 - 4:30 PM	**MEMBERSHIP FORUM** Moderator: • Review proposed bylaws and resolutions • Meet the candidates for Districts I & II Director and Alternate Director, as well as Nominating Committee candidates • Learn about committee and task force service
5:30 - 7:00 PM	**RECEPTION** Come catch up with your regulatory friends for a light reception! Presentation by the Friends of the FCLB **The reception is generously sponsored by the NBCE**

Friday · April 24 NATIONAL BOARD DAY

7:30 - 8:00 AM	**FCLB COMMITTEE MEETINGS** - determined by chairs of the standing Committees or Task Forces.

7:30 AM	**CHIROPRACTIC BOARD ADMINISTRATORS COMMITTEE (CBAC) BREAKFAST & MEETING**
See separate Agenda	Ms. Beth Kidd (OK) - Chair & Ms. Patricia Oliver (LA) FCLB Board Liaison
7:30 AM	**BREAKFAST**
Foyer	Full breakfast for registrants
8:00 AM	**FCLB CREDENTIALS COMMITTEE MEETING**
	Staff support: Ms. Vicki Young (FCLB)

EDUCATIONAL PROGRAM - NATIONAL BOARD DAY - COLORADO BALLROOM A

8:30 AM	**WELCOME and OPENING REMARKS**
	Daniel Côté, D.C. (OR), NBCE President
8:40 AM	**KEYNOTE ADDRESS:**
	Roger Hall, PhD.
9:50 AM	**BREAK**
10:00 AM	**NBCE PLENARY SESSIONS:**
	Dr. Norman Ouzts, NBCE Chief Executive Officer - Facilitator
	• EBAS Panel
	• NBCE Executive Team Panel
12:15 – 2:15 PM	**NBCE LUNCHEON and ANNUAL BUSINESS MEETING**
2:30 - 4:30 PM	NBCE AFTERNOON SESSION:
Colorado Ballroom A	A two-hour presentation offering 2 CE credits
2:30 - 4:30 PM	**CHIROPRACTIC BOARD LEGAL ADVISORS COMMITTEE MEETING (CBLAC)**
See separate Agenda	Mr. Ajay Gohill, Esq., (DC) and Ms. Mona Baskin, Esq., (AZ) Co-Chairs

2:15 - 3:15 PM	**FCLB COMMITTEE MEETINGS -** determined by chairs of the standing Committees or Task Forces
4:30 - 5:00 PM	**FCLB RESOLUTIONS & BYLAWS COMMITTEE MEETING** Kevin Fogarty, D.C. (FL), Chair Open session review of proposed bylaws amendments and resolutions.
5:30 - 10:00 PM	**NBCE Friday Event:** Join the NBCE for dinner and an evening of dueling piano fun

Saturday · April 25

7:00 AM	**DISTRICT BREAKFASTS** **ELECTIONS** Hosts: FCLB District Directors • District Director & Alternate Director elections for Districts I & II • Updates from your district director • Fall District Meeting information

EDUCATIONAL PROGRAM CONTINUED -

	GUEST HOST:
7:45 AM	**INTRODUCTION - WELCOME BACK TO THE FCLB PROGRAM** Karlos Boghosian, D.C. (CT), FCLB President
8:00 AM	**ANNUAL AWARDS PRESENTATION** Karlos Boghosian, D.C. (CT), FCLB President
8:30-9:45 AM	**Chiropractic College President**
9:15 AM	**Regulation Through Punishment or Remediation: Changing the Conversation** Drs. Nancy Kirsch & Richard Woolf, President and Vice President of the Federation of State Boards of Physical Therapy
10:00 AM	**PRESENTATION: Call to Action** Terry Yochum, D.C. Now that you've learned the information, commit to use it. Transform education in action.
10:30 AM	**MIDMORNING BREAK**

ANNUAL MEETING OF THE DELEGATE ASSEMBLY -

10:45 AM	**DISTRIBUTION OF VOTING PADDLES** - Tellers Committee
11:00 AM	**FCLB ANNUAL BUSINESS MEETING** Karlos Boghosian, D.C. (CT), FCLB President, Meeting Chair • Seating of the Delegates • Financial Report • Resolutions & Bylaws • Elections: Nominating Committee • Announcements • New Business • Installation of the New FCLB Board of Directors
12:45 PM	**LUNCH ON YOUR OWN**
1:30 - 2:00 PM Riviera	**POST-CONFERENCE BOARD OF DIRECTORS MEETING** FCLB Board of Directors

Sunday · April 26

8:30 - 9:30 AM	**WEEK IN REVIEW** - Karen Campion, D.C., (TX) will be your host

Plan for 2021 in West Palm Beach, Florida · April 25 - May 2, 2021
Hilton West Palm Beach · Room rate: $238/night + taxes - single/double

Ontario

414

Ministry of Health

Office of Chief Medical Officer of Health, Public Health
393 University Avenue, 21st Floor
Toronto ON M5G 2M2

Tel.: 416 212-3831
Fax: 416 325-8412

Ministère de la Santé

Bureau du médecin hygiéniste en chef, santé publique
393 avenue University, 21e étage
Toronto ON M5G 2M2

Tél. : 416 212-3831
Téléc. : 416 325-8412

January 23, 2020

Dear Health System Partners,

I am writing to continue sharing information about the novel coronavirus (2019-nCoV). This outbreak of 2019-nCoV continues to evolve, and there have been some significant developments that I want to bring to your attention.

1. Case Counts:
Firstly, the case counts in China (Wuhan, Beijing, Shanghai plus several other provinces) and the surrounding region (Thailand, Japan, South Korea, Hong Kong, Macau) have dramatically increased, from 44 on January 17th, 2020, to more than 500 reported today. The United States Centers for Disease Control and Prevention announced earlier this week (January 21) the first confirmed case of the novel coronavirus in a patient in Seattle who had recently travelled to Wuhan. Among the cases reported to-date, we continue to see a spectrum of illness, with the majority of cases reported as having mild illness. We have seen some individuals listed as in severe or critical condition and, sadly, there have been 17 deaths, all in Hubei Province (Wuhan).

2. Infections in Health Workers:
We have learned that several health workers in China have contracted 2019-nCoV. To date, we lack key information needed to interpret this report. For example, we do not know when these health workers first became ill or the Infection Prevention and Control/ Occupational Health and Safety precautions and practices they were using at the time of infection.

3. Human-to-human transmission:
There is now evidence of human-to-human transmission of this virus, and the World Health Organization has said that there may now be sustained human-to-human transmission. More information and analysis are needed on this new virus to understand the full extent of the human-to-human transmission and other important details.

4. Reportable to Public Health:
Yesterday, the Minister of Health announced an update to the *Health Protection and Promotion Act* (HPPA) that adds "diseases caused by novel coronaviruses, including SARS and MERS" to the list of Diseases of Public Health Significance under the Designation of Diseases regulation (O. Reg. 135/18) in Ontario. As of yesterday, novel coronaviruses, including Severe Acute Respiratory Syndrome (SARS) and Middle East Respiratory Syndrome (MERS-CoV) and 2019-nCoV, must be reported to local public health officials by those who have a Duty to Report under the HPPA (including physicians, hospitals, laboratories). This new Disease of Public Health Significance has also been designated as communicable, providing Medical Officers of Health with powers under the HPPA to ensure appropriate case and contact management.

.../2

With yesterday's addition of the novel Coronavirus to the regulations, please see the attached case definitions for 2019-nCoV.

5. Infection Prevention and Control/ Occupational Health and Safety:
At this time, consistent with the guidance in place for MERS-CoV, the ministry is recommending the following for acute care settings. Please note that the ministry is reviewing guidance for other settings and will provide further updates in the coming days:

Routine Practices and Additional Precautions (Contact, Droplet, Airborne) by health care workers at risk of exposure to a confirmed case, presumptive confirmed case, probable case or person under investigation (or PUI) and/or the patient's environment. These precautions include:

- hand hygiene
- use of airborne infection isolation rooms when possible
- masking the patient with a surgical mask when outside of an airborne infection isolation room
- use of gloves, gowns, fit-tested, seal-checked N95 respirators and eye protection by health care workers when entering the same room as the patient or when transporting or caring for the patient

For more information on Routine Practices and Additional Precautions, health care workers should refer to (PIDAC's) Routine Practices and Additional Precautions in All Health Care Settings and Annex B: Prevention of Transmission of Acute Respiratory Infection in all Health Care Settings.

Note: The use of Airborne Precautions is a higher level of precaution than is being recommended by the Public Health Agency of Canada or the World Health Organization (WHO), or that is normally recommended for coronaviruses. The ministry is recommending at this time that health care workers apply Airborne Precautions based on the application of the precautionary principle to this novel virus for which little information about transmission and clinical severity is available.

I want to reiterate that even as this outbreak has grown, the risk to Ontarians remains low. It would not be unexpected for us to see a case in Ontario, but I am confident that we have the processes, skilled clinicians and dedicated health workers we need to identify and manage a case safely and effectively.

As new information becomes available, I will continue to share it with you. We will be ready to launch a regular communications cycle with system partners as the situation evolves and will keep you apprised of these details. In the meantime, health sector partners are encouraged to contact the Health System Emergency Management Branch at 1-866-212-2272 (24/7) or during business hours at eocoperations.moh@ontario.ca if they have any questions or concerns.

Yours truly,

Original signed by

Barbara Yaffe, MD, MHSc, FRCPC
Associate Chief Medical Officer of Health

Attachments

c: Peter Donnelly, President and Chief Executive Officer, Public Health Ontario

Case Definition for Novel Coronavirus (2019-nCoV)

Person under Investigation for 2019-nCoV

A person with fever and acute respiratory illness, or pneumonia

AND any of the following:

Travel to Wuhan, China in the 14 days before onset of illness

OR

Close contact with a confirmed or probable case of 2019-nCoV

OR

Close contact with a person with acute respiratory illness who has been to Wuhan, China within 14 days prior to their illness onset

Probable Case for 2019-nCoV

A person:

with fever (over 38 degrees Celsius) AND new onset of (or exacerbation of chronic) cough or breathing difficulty AND evidence of severe illness progression *e.g.* acute respiratory distress syndrome (ARDS) or severe influenza-like illness (may include complications such as encephalitis, myocarditis or other severe and life-threatening complications)

AND any of the following:

Travel to Wuhan, China in the 14 days before onset of illness

OR

Close contact with a confirmed or probable case of 2019-nCoV

OR

Close contact with a person with acute respiratory illness who has been to Wuhan, China within 14 days prior to their illness onset

AND

in whom laboratory diagnosis of 2019-nCoV is not available or negative (if specimen quality of timing is suspect)

Presumptive Positive Case for 2019-nCoV

A person in whom the laboratory screening test for 2019-nCoV was positive from the Public Health Ontario Laboratory but not confirmed by the National Microbiological Laboratory.

Confirmed Case for 2019-nCoV

A person with laboratory confirmation of infection with 2019-nCoV which consists of positive real-time PCR on at least two specific genomic targets or a single positive target with sequencing AND confirmed by NML by nucleic acid testing.

Case Definition Footnotes

1. The incubation period of 2019-nCoV is unknown. SARS-CoV demonstrated a prolonged incubation period (median 4-5 days; range 2-10 days) compared to other human coronavirus infections (average 2 days; typical range 12 hours to 5 days). The incubation period for MERS-CoV is approximately 5 days (range 2-14 days). Allowing for variability and recall error and to establish consistency with the World Health Organization's 2019-nCoV case definition, exposure history based on the prior 14 days is recommended at this time.
2. A close contact is defined as a person who provided care for the patient, including healthcare workers, family members or other caregivers, or who had other similar close physical contact OR who lived with or otherwise had close prolonged contact with a probable or confirmed case while the case was ill.
3. Other exposure scenarios not specifically mentioned here may arise and may be considered at jurisdictional discretion (*e.g.* history of being a patient in the same ward or facility during a nosocomial outbreak of 2019-nCoV).
4. There is limited evidence on the likelihood of 2019-nCoV presenting as a co-infection with other pathogens. At this time, the identification of one causative agent should not exclude 2019-nCoV where the index of suspicion may be high.
5. Laboratory confirmation may not be available due to no possibility of acquiring samples for laboratory testing of 2019-nCoV.
6. Laboratory tests are evolving for this emerging pathogen, and laboratory testing recommendations will change accordingly as new assays are developed and validated.

From: Jo-Ann Willson
Sent: Tuesday, February 11, 2020 9:02 AM
To: Rose Bustria
Cc: Joel Friedman
Subject: Fwd: Report that Cabinet has appointed new Fairness Commissioner

Council.

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

College of Chiropractors of Ontario
59 Hayden St., Suite 800
Toronto, ON M4Y 0E7
Tel: (416) 922-6355 ext. 111
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Begin forwarded message:

> **From:** "bakenny@regulatedhealthprofessions.on.ca" <bakenny@regulatedhealthprofessions.on.ca>
> **Date:** February 11, 2020 at 3:01:43 PM GMT+2
> **To:** Beth Ann Kenny <bakenny@regulatedhealthprofessions.on.ca>
> **Subject: Report that Cabinet has appointed new Fairness Commissioner**
> **Reply-To:** <bakenny@regulatedhealthprofessions.on.ca>
>
> Hi All:
>
> There is a report ("Queen's Park Briefing" of February 10th) that Irwin Glasberg, Acting Deputy Attorney General, has been appointed as the new Fairness Commissioner.
>
> I haven't seen an announcement yet and the Fairness Commissioner's website has not been updated to note that appointment.
>
> Just a heads up for a pending announcement.
>
> Take care!
> Beth Ann

Beth Ann Kenny, Executive Coordinator
Health Profession Regulators of Ontario (HPRO)
301-396 Osborne St, PO Box 244, Beaverton ON L0K 1A0
Email: bakenny@regulatedhealthprofessions.on.ca
Web: www.regulatedhealthprofessions.on.ca
Phone: 416-493-4076 / Fax: 1-866-814-6456

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From: Jo-Ann Willson
Sent: Monday, February 3, 2020 11:01 AM
To: Rose Bustria
Subject: Fwd: Legislative Update - What Happened in January 2020?
Attachments: Legislative Update - January 2020.pdf; ATT00001.htm

Council.

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

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Begin forwarded message:

> **From:** "bakenny@regulatedhealthprofessions.on.ca" <bakenny@regulatedhealthprofessions.on.ca>
> **Date:** February 3, 2020 at 4:45:32 PM GMT+2
> **To:** Beth Ann Kenny <bakenny@regulatedhealthprofessions.on.ca>
> **Cc:** Richard Steinecke <rsteinecke@sml-law.com>
> **Subject: Legislative Update - What Happened in January 2020?**
> **Reply-To:** <bakenny@regulatedhealthprofessions.on.ca>
>
> Hi All:
>
> Attached is the 93rd *Legislative Update* from Richard Steinecke, letting us know what happened in January 2020. All *Legislative Updates* are available in the vRoom and our Policy Network members have access to it as well.
>
> Remember, too, that "HPRO" was formally approved by the Government of Ontario on January 15, 2020.
>
> Take care!
> Beth Ann

Beth Ann Kenny, Executive Coordinator
Health Profession Regulators of Ontario (HPRO)
301-396 Osborne St, PO Box 244, Beaverton ON L0K 1A0
Email: bakenny@regulatedhealthprofessions.on.ca
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Prepared by Richard Steinecke

422

In this Issue:

- Bill 159 to permit competency-based selection of Board members for delegated administrative authorities (DAAs), see p. 1
- Regulation authorizes nurses to self-initiate controlled act of psychotherapy, see p. 1
- Regulation authorizes occupational therapists to perform psychotherapy, see p. 2
- Numerous regulations made implementing new animal welfare legislation, see p. 2

Bonus Features:

- Restraining Illegal Practice, see p. 2
- Using the *Competition Act* to Engage in Unauthorized Practice, see pp. 2-3
- Does Bankruptcy Extinguish an Administrative Penalty?, see p. 3
- Expanded Remedies in Judicial Review, see pp. 3-4

Ontario Bills

(See: https://www.ola.org)

Bill 159, *Rebuilding Consumer Confidence Act, 2019* – (*government Bill – consideration by the Standing Committee on Justice Policy*). The Bill reforms the delegated administrative authorities (DAA) scheme that applies to many professions and businesses including:

- allowing the Minister to revise the composition of the Board of Directors of a DAA (e.g., requiring a certain percentage of public members);
- allowing the Minister to establish competency criteria for being elected or appointed to the Board of Directors of a DAA;
- requiring disclosure of compensation of Board and staff members of a DAA; and
- authorizing the appointment of an administrator to take over the operation of a DAA.

The Bill also establishes an administrative penalty scheme for the *Consumer Protection Act*.

Proclamations

(See www.ontario.ca/en/ontgazette/gazlat/index.htm)

There were no relevant proclamations this month.

Regulations

(See www.ontario.ca/en/ontgazette/gazlat/index.htm)

Nursing Act – The regulation prescribing controlled acts for nurses was amended, effective January 1, 2020, to permit nurses to self-initiate the controlled act of psychotherapy. (Ontario Regulation 473/19 Gazetted January 11, 2020).

Occupational Therapy Act – A controlled acts regulation authorized occupational therapists to perform the controlled act of psychotherapy and establishes standards of practice for doing so. (Ontario Regulation 474/19 Gazetted January 11, 2020).

Provincial Animal Welfare Services Act, 2019 – Numerous regulations implementing the new regulatory scheme were enacted. For example, the regulations deal with the standard of care for animals, a Code of Conduct for animal welfare inspectors, exemptions from some requirements and administrative details. (Ontario Regulation 442/19 and 448/19 Gazetted January 4, 2020).

Proposed Regulations Registry

(See http://www.ontariocanada.com/registry)

There are no relevant consultations pending.

Bonus Features

(Includes Excerpts from our Blog and Twitter feed found at www.sml-law.com)

Restraining Illegal Practice

One of the most notorious disbarred lawyers is Harry Kopyto. Despite being disbarred more than 30 years ago, he continues to practise. The regulator sought a permanent injunction against his continuing to practise law or holding himself out as a legal representative. The Court had little difficulty concluding that Mr. Kopyto was acting illegally and would continue to do so. The injunction was granted: *Law Society of Ontario v Harry Kopyto*, 2020 ONSC 35, http://canlii.ca/t/j4f8s.

In doing so the Court affirmed that where a regulator's statute authorizes the granting of a restraining order, the usual requirements for obtaining such an order are relaxed. The regulator does not have to demonstrate that there would be irreparable harm. The regulator also does not have to prove that any harm could not be compensated for in damages. In addition: "Hardship from the imposition and enforcement of an injunction will generally not outweigh the public interest in having the law obeyed."

However, there remains discretion to refuse to grant an injunction where granting it "would be of questionable utility or inequitable".

Using the *Competition Act* to Engage in Unauthorized Practice

Can someone engaging in the unauthorized practice of a profession rely on the *Competition Act* to continue their conduct? The answer is "no" according to the case of *Maddock v Law Society of British Columbia*, 2020 BCSC 71, http://canlii.ca/t/j4sjv. The Court held that it was the Competition Bureau and not the courts acting in an individual case that determined whether a regulator of a profession, or its restrictive enabling legislation, was breaching the *Competition Act*. It was no defence to an injunction application by the regulator for the unauthorized practice of the profession.

The Court also interpreted the exception for individuals practising in the employment of and under the supervision of another registered practitioner as referring to an intense level of control over the unregistered person. For example, just because the client of the unregistered person happened to be a lawyer did not provide the intended level of oversight to engage the exception for the unregistered person to practise law.

The Court also looked at all of the circumstances of the case to ascertain whether it was likely that the unregistered person would continue their conduct if no injunction was granted. Prominent in that analysis was the fact that the regulator had issued many warnings, and the manner in which the unregistered person resisted the application for the injunction by raising unconvincing arguments. The Court concluded that, in the absence of the injunction, the unregistered person would find additional justifications to continue his conduct.

Does Bankruptcy Extinguish an Administrative Penalty?

Regulators are, with increasing frequency, authorized to impose administrative penalties. Administrative penalties are similar to fines but often imposed through a less formal process than that usually associated with fines. In *Alberta Securities Commission v Hennig*, 2020 ABQB 48, http://canlii.ca/t/j4rnk, Mr. Hennig had a $400,000 administrative penalty imposed for, among other things, "improper financial disclosure and misrepresentations". The order was filed with the court. Mr. Hennig declared bankruptcy and the regulator received less than $1,000 from the estate.

The regulator asserted that the administrative penalty was not extinguished by Mr. Hennig's bankruptcy as it fell into the exceptions related to debts incurred through fraud, dishonesty or other reprehensible conduct. The Court agreed:

> A purposive interpretation of the subsection in view of the intention of section 178 - to preclude dishonest debtors from benefitting from their dishonesty - would surely extend to a decision of a securities commission, charged with enforcing securities laws in order to protect the interesting public and promoting the integrity of the capital markets, in circumstances that would otherwise fit within the subsection.

The decision turned somewhat on the particular conduct underlying the payment order which may not apply to every administrative penalty. But the case does clarify that bankruptcy does not extinguish all administrative penalties.

Expanded Remedies in Judicial Review

Judicial review has traditionally been narrower than an appeal. This is so particularly when it comes to the remedies that can be granted by the Court. Generally, when an order is made by a court on judicial review quashing a tribunal decision, the court sends the matter back for a new decision. However, recently courts have indicated that where "a particular outcome is inevitable and that remitting the case would therefore serve no useful purpose" a court will exercise broader remedies.

An example of this newer approach is found in *Gogek v Real Estate Council of Ontario*, 2020 ONSC 486, http://canlii.ca/t/j4wt6. In that case an internal appeal tribunal for the regulator refused to extend the time for initiating an appeal. However, the chairperson of the appeal panel making that decision had presided over the pre-hearing conference in the matter. It is generally accepted that, in order to promote candid resolution discussions, a person presiding over a pre-hearing conference will not later hear the case. The regulator acknowledged the error and not only agreed that the decision refusing the extension of time should be set aside, but that an extension of time was reasonable in the circumstances. The Court directly ordered that permission to initiate the appeal late be granted rather than sending the matter back to the appeal tribunal to make that order.

Prepared by Richard Steinecke

In this Issue:

- Bill 161 to enhance the regulatory powers and transparency of the Law Society, see p. 1
- Bill 159 to permit competency-based selection of Board members for delegated administrative authorities (DAAs), see pp. 1-2
- Bill 138 to amend *PHIPA* and administration of review of physician billing and independent health facilities, see p. 2
- Bill 136 to create complaints system about the animal welfare regulator, see p. 2
- Bill 116 to establish centre of excellence for mental illness and addictions, see p. 2
- *Animal Welfare Act* proclaimed for January 1st, see p. 2
- Regulation expands scope of funding for therapy for sexual abuse by educators, see p. 2
- Regulation expands eligibility for funding for therapy for sexual abuse by early childhood educators (ECEs), see p. 3

Bonus Features:

- A Non-Lawyer's Guide to Change in Court Scrutiny of Administrative Decisions, see p. 3
- Mild Cognitive Impairment, see p. 4
- Incapacity Restrictions, see pp. 4-5
- Discernment and Insight, see p. 6
- Uncertainty Continues for Regulators Defending their Reputations, see pp. 6-7
- Incarceration for Regulatory Offences, see p. 7

Ontario Bills

(See: https://www.ola.org)

Bill 161, *Smarter and Stronger Justice Act, 2019* – (*government Bill – passed first reading*). The Bill, amongst other things, provides the legal regulator, the Law Society of Ontario, with the authority to perform entity regulation. It also:

- authorizes the regulator to disclose information during an investigation where necessary to protect the public interest;
- expands the power of investigators to obtain information from former practice colleagues;
- simplifies the interim order powers in discipline matters; and
- increases the maximum fine at discipline to $100,000 from $10,000.

Bill 159, *Rebuilding Consumer Confidence Act, 2019* – (*government Bill – passed second reading and referred to the Standing Committee on Justice Policy*). The Bill reforms the delegated administrative authorities (DAA) scheme that applies to many professions and businesses including:

- allowing the Minister to revise the composition of the Board of Directors of a DAA (e.g., requiring a certain percentage of public members);
- allowing the Minister to establish competency criteria for being elected or appointed to the Board of Directors of a DAA;
- requiring disclosure of compensation of Board and staff members of a DAA; and

- authorizing the appointment of an administrator to take over the operation of a DAA.

The Bill also establishes an administrative penalty scheme for the *Consumer Protection Act*.

Bill 138, *Plan to Build Ontario Together Act, 2019* – (*government Bill – passed third reading and received Royal Assent*). This omnibus Bill enacts and amends a number of Acts including:

- Changing the way that claims for physician services are reviewed
- Changing the way that independent health facilities are licensed and regulated
- Amending the *Personal Health Information Protection Act* to prohibit anyone from trying to re-identify persons whose personal health information has been de-identified and allowing the Information and Privacy Commissioner to order that personal health information be returned where it has been improperly collected, used, or disclosed.

Bill 136, *Provincial Animal Welfare Services Act, 2019* – *(government Bill – passed third reading and received Royal Assent).* Bill 136 replaces the privately-run Ontario Society for the Prevention of Cruelty to Animals with a government official, the Chief Animal Welfare Inspector. The Chief Animal Welfare Inspector has numerous administrative powers (e.g., inspections, demand for information, right to take action to protect animals) and provincial offence enforcement powers. Of broader interest is the complaints mechanism available for anyone who thinks the new agency is acting contrary to its Code of Conduct.

Bill 116, *Foundations for Promoting and Protecting Mental Health and Addictions Services Act, 2019* – *(government Bill – passed third reading and received Royal Assent).* The Bill establishes a centre of excellence to address mental illness and addictions and makes it easier for the government to sue manufacturers and wholesalers of opioids.

Proclamations

(See www.ontario.ca/en/ontgazette/gazlat/index.htm)

Provincial Animal Welfare Services Act, 2019 – January 1, 2020 is the date in which most of this *Act* comes into force.

Regulations

(See www.ontario.ca/en/ontgazette/gazlat/index.htm)

Ontario College of Teachers Act and ***Early Childhood Educators Act*** – Regulations describe expanded coverage for funding for therapy and counselling for sexual abuse including:

- Therapy for immediate family members of the abused student;
- Drugs related to treatment; and
- Transportation, accommodation, child care and translation services related to therapy and counselling.

(Ontario Regulation 438/19 and 439/19 Gazetted December 28, 2019).

Early Childhood Educators Act – Regulations outline an additional ground of eligibility for funding for therapy and counselling for sexual abuse of a child where, even though the practitioner did not supervise the child nor was the practitioner responsible for the child, the practitioner's practice facilitated the relationship with or access to the child. (Ontario Regulation 440/19 Gazetted December 28, 2019).

Proposed Regulations Registry

(See http://www.ontariocanada.com/registry)

There are no relevant consultations pending.

Bonus Features

(Includes Excerpts from our Blog and Twitter feed found at www.sml-law.com)

A Non-Lawyer's Guide to Change in Court Scrutiny of Administrative Decisions

The Supreme Court of Canada made an important decision changing the way courts will review the actions or decisions of administrative bodies, including regulators of professions. The phrase "standard of review" describes in words how closely courts will scrutinize regulatory action. Before the decision of *Canada (Minister of Citizenship and Immigration) v Vavilov*, 2019 SCC 65, http://canlii.ca/t/j46kb, courts would give a lot of deference to how regulators interpreted their own statutes and to the decisions regulators made. This is called the "reasonableness standard of review". Only where the legal issues raised were of a general nature (e.g., interpreting the Canadian Constitution, applying to legal system as a whole), or where procedural unfairness occurred, would the courts closely scrutinize regulatory action. This close scrutiny is called the "correctness standard of review".

The above approach by the courts will remain much the same for actions by regulators where there is no formal right of appeal to the courts. For example, many regulators can make decisions on complaints and, often, on registration matters, without a formal right of appeal to the courts. Regulators will probably notice little change in those activities. However, where a regulator's statute provides for a formal right of appeal to the courts, as is often the case in discipline matters, courts will now show little deference when it comes to all legal issues (e.g., how to interpret one's enabling statute; the scope of the committee's authority). For issues of fact (e.g., what the evidence proved) or mixed fact and law (e.g., whether the conduct amounts to professional misconduct), deference will likely still be provided by courts.

Of course, there is much more to the *Vavilov* decision than this brief overview can cover. However, this summary should help regulators prepare for more frequent legal challenges, particularly where there is a formal right of appeal to the courts.

Mild Cognitive Impairment

Regulators are likely to see increasing numbers of concerns about practitioners with mild cognitive impairment. When do these concerns call for an aggressive incapacity intervention?

In *College of Physicians & Surgeons of Alberta v Collett*, 2019 ABCA 461, http://canlii.ca/t/j3n6m, an Alberta court stated that an interim suspension of a physician's right to practice was invalid. The Court first held that the matter was not moot even though the practitioner's registration had since been reinstated. The Court said that it "accepts that a professional's reputation is a fragile thing and can easily be diminished." The Court's ruling might go some small way to repairing that damage.

The Court's finding that the interim suspension was invalid was made on two grounds. First, there was an insufficient basis for finding that the practitioner's condition impaired "his ability to provide professional services in a safe and competent manner". None of the medical reports expressed that opinion but rather suggested further inquiries ought be made at a later time. The College representative expressed "concerns" about the practitioner's cognitive status but did not actually state a belief of impairment to the degree required by the legislation.

The second basis of the finding was that there had been procedural unfairness. A period of four months elapsed between the medical report raising the concerns and notification of an intention to suspend the practitioner's registration. No medical updates were sought during that period. The notification then only provided two clear business days to retire or be suspended. Given the enormity of the impact of the decision on his life and the mild medical evidence, that period of notice was unreasonable. The Court suggested a notice period of some weeks, a month perhaps, was appropriate in the circumstances. The medical concerns were not such as to necessitate "a firehall-like response".

This case suggests that regulators need to carefully examine the full circumstances of an individual with suspected cognitive impairment, obtain clear evidence of its likelihood to affect a practitioner's practice, explicitly state the findings they are making, apply the legal test contained in the legislation, and provide a proportionate time for a response in light of the significance of the concerns.

Incapacity Restrictions

Incapacity cases ideally result in terms, conditions and limitations (TCLs) imposed on a certificate as opposed to suspension. This permits the practitioner to practise while still providing the necessary reassurance to the regulator. However, regulators and practitioners regularly disagree as to the breadth of such TCLs. Obviously, applicants for registration and members wish to have as few restrictions as possible as TCLs have a significant impact on a practitioner's life. As such practitioners may view the restrictions proposed by a regulator as excessive and based on speculation, or even faulty assumptions, as opposed to being grounded in evidence.

In an older case, *D.W.C. v College of Physicians and Surgeons of Ontario*, 2017 CanLII 55551 (ON HPARB), http://canlii.ca/t/h5mvg, an independent Board provided a detailed review of numerous restrictions proposed for a former physician who was re-applying for registration after a period of substance abuse and related psychiatric symptoms. At the time of the hearing, the applicant had not

used cocaine for seven years and reported moderate amounts of alcohol use. The primary, but not entire, dispute related to the monitoring restrictions proposed by the regulator. In upholding the proposed restrictions, the Board made the following determinations:

- While the onus is on the applicant to demonstrate that they meet the requirements for registration, regulators must still "scrupulously exercise their mandate when determining whether an individual qualifies for registration".
- There is no appearance of bias on the part of experts who assessed the applicant because they came to a diagnosis that the applicant disputes through a fair process.
- The constitutionally protected freedom of expression does not prevent medical experts from using the applicant's statements, including some that appeared to be bizarre, in diagnosing the applicant's condition.
- The applicant's human rights do not prevent the regulator or appeal Board from considering issues related to the applicant's disability. Rather, those human rights are required to be considered within the process.
- On the evidence before them, the Board did not find evidence that the medical experts or the regulator had relied on assumptions based on the applicant's Indigenous status or had otherwise discriminated against the applicant on that ground.
- The Board did not find it to be inappropriate for a regulator to require the applicant to participate in a support group whose philosophy was, in some aspects, contrary to the applicant's personal beliefs.
- While the Board accepted the proposition that the regulator had a duty to accommodate the applicant's disability by only imposing restrictions necessary to protect public health and safety, the Board found on the evidence that the following restrictions were necessary to protect the public:
    - monitoring by a psychiatrist and an addictions medicine physician and compliance with their treatment recommendations;
    - unannounced biological testing for alcohol and any substance of abuse at an independent laboratory rather than at the applicant's office;
    - total abstinence from drugs and alcohol despite the contested evidence as to whether complete abstinence from alcohol was necessary in the applicant's case;
    - communication by the regulator with family members, workplace monitors and support group leaders about the applicant's behaviour;
    - the restrictions would be in place for at least five years; and
    - "it would generally be in accordance with the established principles of professional regulation for a registrant to bear the ongoing cost of conditions on his or her certificate of registration."

These determinations were based on the evidence in the individual case and do not necessarily apply to all cases. However, this decision provides a precedent and gives guidance as to the kinds of evidence that might be necessary to support these sorts of restrictions.

Discernment and Insight

Regulators can refuse registration to applicants who demonstrate a pattern of lacking "discernment and insight" even if, individually, the events might not be disqualifying.

In *I.B. v College of Massage Therapists of Ontario*, 2018 CanLII 142416 (ON HPARB), http://canlii.ca/t/j0vzz, a former practitioner applied for re-registration. The regulator declined to register him because of a history that included:

- Seven previous suspensions of registration for both administrative lapses (e.g., not carrying insurance, non-payment of fees) and discipline;
- Revocation of registration for non-payment of fees;
- A discipline finding for practising while suspended;
- Failing to pay all of the costs ordered at that discipline hearing despite it being a joint submission; and
- Inaccurately describing and minimizing the nature of four criminal convictions (most related to impaired driving) including minimizing his personal responsibility for the conduct.

The appeal Board upheld the refusal to register him. In doing so it noted the following:

- The applicant required the regulator to "expend considerable resources to administer his membership".
- The applicant "has not meaningfully demonstrated that he appreciates the nature of professional expectations and governability standards".
- The applicant has not demonstrated that he "possesses insight into the seriousness of his previous conduct and how such conduct can have significance in regard to a health professional's responsibilities to the public and to the College". On this point the Board noted that patients, insurance companies, and others rely on practitioners to accurately provide information, including about their registration status.

Uncertainty Continues for Regulators Defending their Reputations

How should a regulator respond to a practitioner making repeated public accusations that it is acting with dishonesty and bad faith and was abusing its authority? While such statements might, in some circumstances, constitute professional misconduct, disciplining such practitioners can sometimes create an unsatisfactory appearance. Doing nothing or responding publicly to such communications can give the allegations more credence than they deserve. In *Ontario College of Teachers v Bouragba*, 2019 ONCA 1028, http://canlii.ca/t/j49mq, the regulator opted to sue the practitioner for defamation.

However, there is protection from defamation suits by individuals who comment on a matter of public interest. This protection, called anti-Strategic Lawsuits Against Public Participation (SLAPP) legislation is intended to prevent well-resourced entities from using the courts to stifle criticism. Anti-SLAPP protections have three criteria:

1. His comments were on a matter of public interest.
2. The defamation suit can still proceed where it has substantial merit and there is no defence.
3. The public interest in permitting the proceeding to continue outweighs the public interest in protecting the comment.

The regulator argued that the practitioner's comments were private grievances about proceedings that had not gone the practitioner's way. The Court held that while there was some truth to this, the comments also contained a public interest element about whether the regulator was acting appropriately. For example, some of the communications were to relevant Ministers in the government calling for a public inquiry. On this portion of the SLAPP criteria, the motives of the practitioners were irrelevant (although those motives were relevant to the third part of the test).

As such the Court held that the first portion of the test should be resolved in favour of the practitioner. The Court returned the matter to the lower court to evaluate the second and third parts of the test. Thus, uncertainty continues for regulators as to how best to respond to unfair criticism that undermines its reputation for integrity.

Incarceration for Regulatory Offences

Provincial offences for unauthorized practice or holding out usually result in fines, not jail, especially for first offenders. However, that is not always the case. In *Ontario (Travel Industry Council) v Robinson*, 2019 ONCJ 888, http://canlii.ca/t/j45cz, the defendant was sentenced to 75 days and 45 days, respectively, for two convictions for acting as a travel agent without registration.

In imposing these sentences, the Court expressed concern about the dishonesty of the defendant in promoting two trips. She took money from over 100 people and did not keep the funds in trust. When difficulties arose, she concealed them and continued to promote the trips. For one trip she provided only one-way tickets to Florida and the travellers only learned they had no flight back after arriving. The other trip never occurred. The victims were out a total of $65,000. The victims had no recourse to the regulator's compensation fund because the defendant was not registered.

The Court held that, in these circumstances, a fine was insufficient to protect the public.

Prepared by Richard Steinecke

In this Issue:

- Bill 145 to allow real estate regulator to impose administrative penalties, see p. 1
- Bill 138 amends *PHIPA* and administration of review of physician billing and independent health facilities, see p. 1
- Bill 136 to create complaints system about the animal welfare regulator, see pp. 1-2
- Bill 116 to establish centre of excellence for mental illness and addictions, see p. 2
- *Medical Radiation and Imaging Technology Act* proclaimed for January 1st, see p. 2
- Minor amendments to the *RHPA* to facilitate CMRITO proclamation , see p. 2
- Paramedic standards incorporated by reference to Ministry document, see p. 2
- Consultation on CASLPO registration regulation amendments, see p. 2

Bonus Features:

- Responsibilities of a Designated Manager, see p. 3
- Judicial Scrutiny of Delegated Regulation, see p. 4
- The Legality of Government Directives, see pp. 4-5

Ontario Bills

(See: https://www.ola.org)

Bill 145, *Trust in Real Estate Services Act, 2019* – (*government Bill – passed second reading and referred to the Standing Committee on General Government*). The Bill amends the regulation of real estate practitioners including expanding the criteria the Registrar can consider when determining eligibility for registration (e.g., past conduct, public interest), allowing the imposition of administrative penalties for non-compliance, expanding the authority of the discipline process to including suspension and revocation of a practitioner's registration, allowing the regulator to collect data to identify enforcement risks, creating a specialist certification program and allowing seller representatives to disclose competing offers to potential buyers.

Bill 138, *Plan to Build Ontario Together Act, 2019* – (*government Bill – passed second reading and referred to the Standing Committee on Finance and Economic Affairs*). This omnibus Bill enacts and amends a number of Acts including:

- Changing the way that claims for physician services are reviewed
- Changing the way that independent health facilities are licensed and regulated
- Amending the *Personal Health Information Protection Act* to prohibit anyone from trying to re-identify persons whose personal health information has been de-identified and allowing the Information and Privacy Commissioner to order that personal health information be returned where it has been improperly collected, used or disclosed.

Bill 136, *Provincial Animal Welfare Services Act, 2019* – *(government Bill, passed second reading and under consideration by the Standing Committee on Justice Policy).* Bill 136 replaces the privately-run Ontario Society to Prevent Cruelty to Animals with a government official, the Chief Animal Welfare Inspector. The Chief Animal Welfare Inspector has numerous administrative powers (e.g., inspections,

demand for information, right to take action to protect animals) and provincial offence enforcement powers. Of broader interest is the complaints mechanism available for anyone who thinks the new agency is acting contrary to its Code of Conduct.

Bill 116, *Foundations for Promoting and Protecting Mental Health and Addictions Services Act, 2019* – (*government Bill – in second reading).* The Bill establishes a centre of excellence to address mental illness and addictions and makes it easier for the government to sue manufacturers and wholesalers of opioids.

Proclamations

(See www.ontario.ca/en/ontgazette/gazlat/index.htm)

Medical Radiation and Imaging Technology Act, 2017 – January 1, 2020 is the date in which most of this *Act* comes into force. On the same date the *Medical Radiation Technology Act, 1991* will be repealed. Minor related amendments will also be made to the *Healing Arts Radiation Protection Act* and the *Regulated Health Professions Act* will also occur then.

Regulations

(See www.ontario.ca/en/ontgazette/gazlat/index.htm)

Regulated Health Professions Act – Minor amendment are made to the controlled acts regulation in recognition of the new name of the College of Medical Radiation and Imaging Technologists of Ontario. In addition, a French version of the regulation is also now available. (Ontario Regulation 360/19 Gazetted November 16, 2019).

Ambulance Act – Regulations are amended to incorporate by reference a Ministry document setting out the standards of care, reporting and documentation by ambulance service operators and paramedics (Ontario Regulation 364/19 Gazetted November 16, 2019).

Proposed Regulations Registry

(See http://www.ontariocanada.com/registry)

Audiology and Speech-Language Pathology Act, 1991 – Amendments are proposed to the registration regulation to facilitate third party administration of entry to practise examinations and third-party evaluation of education and practicum requirements. Comments are due by December 30, 2019.

Bonus Features

(Includes Excerpts from our Blog and Twitter feed found at www.sml-law.com)

Responsibilities of a Designated Manager

Some professions require that a registrant be responsible for the overall policies and procedures of a practice. For example, the Ontario College of Pharmacists imposes responsibilities on a designated manager. Each pharmacy must have one. The case of *Jaffer v Ontario (Health Professions Appeal and Review Board)*, 2019 ONSC 6770, http://canlii.ca/t/j3lh5, raises the issue of the duties of the designated manager where a serious error was made by another registrant. In this case, if the other registrant had followed the policies and procedures in place in the pharmacy at the time, the error would not have occurred. The regulator imposed remedial measures on the designated manager because he had not used the error as an opportunity to review the policies and procedures to see whether improvements could be made to prevent future mistakes. The designated manager challenged the decision on the basis that he should not be held accountable for the human error of another registrant who had not followed existing policies. The Divisional Court upheld the remedial measures as reasonable. Designated managers are accountable for their own role where mistakes occur.

There were also issues about whether the regulator had been procedurally fair in giving adequate notice that the communications of the designated manager were in issue in the complaint and whether the prior history, including instances related to communications issues, would be considered. The Court concluded that the designated manager had been given adequate notice of the scope of the complaint and a sufficient opportunity to respond to the prior history.

The designated manager also challenged the failure of the regulator to address in its reasons the generally favourable inspection report that was released contemporaneously with the incident in issue. The Court indicated that a regulator's reasons need not cover every point raised by the practitioner. The basis for the directed remediation was clear. The fact that the policies and procedures of the practice were generally acceptable did not detract from the need for the designated manager to respond appropriately to the error in this case.

The Court also provided some procedural guidance on judicial review of decisions by the Health Professions Appeal and Review Board (HPARB) in complaints matters under the *Regulated Health Professions Act*. The Court indicated that while the Inquiries, Complaints and Reports Committee can generally provide submissions on the merits of the decision (at least where the complainant does not appear), HPARB should not do so. The Court also indicated that where an inappropriate affidavit is filed on an application for judicial review, the party opposing its admission should bring a motion before the hearing to determine the affidavit's admissibility so that the record before the Court can be finalized.

Judicial Scrutiny of Delegated Regulation

The Ontario Court of Appeal has rejected the proposition that courts should closely scrutinize the general transparency, accountability and adequacy of funding of delegated regulators: *Ontario (Attorney General) v Bogaerts*, 2019 ONCA 876, http://canlii.ca/t/j3d8n. In particular, the Court overruled the creation of a novel constitutional principle expanding the scope of the review of delegated regulation under "fundamental justice" principles:

> I have no doubt that it would be a good idea and sound public policy to make all law enforcement bodies subject to reasonable standards of transparency, accountability and adequate funding and that they be properly funded. But not all good ideas and sound public policies are constitutionally protected or mandated. Our task is not to decide what would be sound policy. We are charged with the more specific task of deciding what the Constitution requires ….

The Court concluded that all three requirements for establishing a novel constitutional principle requiring delegated regulators to be transparent, accountable and adequately funded were not met in this case:

1. To be a legal principle it must provide meaningful content; and avoid the adjudication of policy matters;
2. It must be "vital or fundamental to our societal notion of justice"; and
3. It must be "capable of being identified with precision and applied to situations in a manner that yields predictable results".

The Court also found that the specific provisions relating to entry onto premises to help animals in distress were constitutional under existing legal principles. In the regulatory context involving a pressing social need, the provisions relating to search and seizure were reasonable. In addition, the "interference with bodily integrity or serious state-imposed psychological stress" did not rise to the level where the constitutional protections of liberty and security of the person were engaged to create a broader judicial authority to review search and seizure provisions.

This decision reinforces the concept of judicial restraint preventing the courts from intervening in legislative policy decisions unless those decisions also infringe on established legal principles.

The Legality of Government Directives

With increasing frequency, governments have been using informal directives to implement policy rather than the more traditional and formal instruments like regulations and by-laws. A recent decision constraining the authority of government to rule through directives has important implications for autonomous agencies.

In *Canadian Federation of Students v Ontario*, 2019 ONSC 6658, http://canlii.ca/t/j3hcc, the Cabinet of Ontario issued a mandatary guideline that universities ensure the fees it charges students for student organizations be optional. The Divisional Court found that universities were independent of

government and there was no authority under the enabling legislation for the Cabinet to issue a directive on this matter. The fact that a significant portion of the funding of universities came from government did not authorize government to impose this restriction on its funding without statutory authority. The Court was unwilling to imply the authority of government to impose this sort of restriction where the enabling statutes were silent on the point.

The enabling statute of many regulators provides some authority for the relevant Minister to intervene in the affairs of the regulator. However, according to this case, that authority (and whether it is to be exercised informally or formally) likely goes no further than what is expressly described in the statute.

From: Jo-Ann Willson
Sent: Tuesday, December 3, 2019 6:08 PM
To: Rose Bustria
Subject: Fwd: Spinal Stenosis Bootcamp, Research Committee EOIs, AGM & Proxy Voting, Sport Med 2020 + Webinars

Exec and Council.

Jo-Ann Willson, B.Sc., M.S.W., LL.B.
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> **From:** OCA <OCA@chiropractic.on.ca>
> **Date:** December 3, 2019 at 4:23:17 PM EST
> **To:** Jo-Ann Willson <jpwillson@cco.on.ca>
> **Subject: Spinal Stenosis Bootcamp, Research Committee EOIs, AGM & Proxy Voting, Sport Med 2020 + Webinars**
> **Reply-To:** OCA <OCA@chiropractic.on.ca>

We're Here For You. View this email in your browser

Ontario Chiropractic Association

In this Issue:

Spinal Stenosis Bootcamp

Research Committee: Call for EOIs

Reminder re AGM/Proxy Voting

OMA Sports Med 2020 Conference

Upcoming Webinars

BOOT CAMP PROGRAM FOR LUMBAR SPINAL STENOSIS

DATE: SATURDAY, JANUARY 25, 2020 **TIME:** 9:00AM **CITY:** TORONTO

Help patients suffering from spinal stenosis restore mobility and maintain independence.

Back by popular demand, Dr. Carlo Ammendolia's next Boot Camp Program for Lumbar Spinal Stenosis© will take place on Saturday, Janurary 25, 2020. Help patients suffering from spinal stenosis restore mobility and maintain independence. Seats are limited, so register early!

Date: Saturday, January 25, 2020

Time: 9:00 AM to 4:00 PM (Registration/Continental Breakfast: 8:30 AM)

Location: Lecture Hall 2 and Technique Labs 2 & 3
CMCC, 6100 Leslie Street, Toronto

Early bird pricing ends on January 10, 2020. For full program pricing and learning objectives click here.

Workshop attendees will receive 6.5 CE structured credit hours. Participants who complete the workshop will be listed on www.spinemobility.com the official website for The Boot Camp Programs.

To register, please click on the button below while using Google Chrome as your browser.

Register Today!

Call for expressions of interest for membership in the OCA Board Research Committee

The *OCA Strategic Plan 2017-2022* includes a significant focus on the role of research in the advancement of our profession in Ontario. The Research Committee assists the OCA Board of Directors in fulfilling its oversight responsibilities regarding all research-related activities.

We are inviting three OCA members to participate in the work of the Board Research Committee.

Collaboration is a hallmark of our approach to advancing the profession on behalf of our members. The Research Committee will support the OCA to amplify the work of the Canadian Chiropractic Research Foundation (CCRF), the Canadian Chiropractic Guideline Initiative (CCGI) and others that have research as their core mission, ensuring that OCA investments in research are optimized to enhance care for patients in Ontario.

The Research Committee conveys its findings and recommendations to the Board of Directors for consideration, and where required, decision by the Board of Directors.

Research Committee Composition

- Up to four OCA Board directors
- Up to three OCA members who are engaged in research and who are not Board directors
- The OCA Chair (Ex-officio)
- Chief Executive Officer (Ex-officio)
- A non-OCA member with research expertise (NTD: Advisor - non-voting member of the Committee)

To support the activities associated with understanding the future needs for developing and supporting research capacity in Ontario, the following tasks will comprise the work plan of the Research Committee:

- Review OCA strategic initiatives
- Identify those elements within the strategic initiatives focused on research
- Identify how those elements within the strategic initiatives may impact the OCA strategic plan
- Review current and future research commitments
- Prioritize and make recommendations for funded research to present to the Board of Directors on a semi-annual basis
- Participate in planning to prioritize areas of investment for Ontario input into the national research agenda
- Identify priority research forums/conferences for OCA attendance

If you are interested in becoming part of the Research Committee, please send an email no later than **December 17** to dgibson@chiropractic.on.ca.

In your email, please outline:

1. Why you believe this work is important.

2. Contributions you can make through previous experience.

Thank you. We will connect by phone with each member who expresses interest.

Members of the Research Committee will be confirmed in early January, 2020.

Important message from Ayla Azad, Chair, OCA Governance and Nominating Committee of the Board of Directors

Thank you for voting in this year's Board of Directors election! Please see the important message about the next steps you need to take before nominees can be appointed to the Board at the Annual General Meeting this **Saturday, December 7**. Find out how to confirm your attendance at the meeting or submit your proxy vote if you can't attend.

OMA Sports Med 2020

Early bird registration is now open for the OMA Sport Med conference on January 24 and 25 at the Westin Prince Hotel, 900 York Mills Rd, Toronto (map).

This year, attendees may choose from three interactive sessions on Friday, January 24 (afternoon):

449

- Foot & Ankle
- Neuro Physical Exam: Beyond the Basics
- Science Behind Yoga: Consideration

You may also choose two morning workshops on Saturday, January 25. Here are few of the topics to choose from:

- Core Stability Assessment
- Pedorthics and the Hypermobile Patient: Prehab
- Assessment
- Medical Issues

See the draft conference program and group room booking rate here. Register on or before **January 3, 2020** to take advantage of early bird registration rates. Hurry - rates will increase by 15 per cent after January 3, 2020!

We want to help Ontario move better.

Click here to support change now by sending a letter to the Ontario government.
#redtaperelief

Upcoming Webinars

CHRONIC PAIN IN OLDER ADULTS: COMPREHENSIVE ASSESSMENT AND MANAGEMENT

HST: REAL CASE SCENARIOS (REBROADCAST)

Wed. Dec. 11, 12-1 PM
Rishabh Khamersa, SRJ Chartered Accountants

Wed. Dec. 4, 12-1 PM

Carlo Ammendolia D.C., Ph.D

Managing chronic pain in older adults can be challenging, with multiple pain sites, comorbidities, cognitive decline and polypharmacy. In this webinar, Dr. Carlo Ammendolia will outline an extensive, practical approach to assessing and managing the expanding problem of chronic pain in older adults.

Register Now

This webinar will dive into the details of how to file a return with real case common errors and mistakes made by practitioners.

Register Now

Visit our **Webinars On Demand** web page to access our collection of previously broadcast sessions.

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Update your OCA membership preferences or unsubscribe from this list

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Canada

Add us to your address book

From: Jo-Ann Willson
Sent: Tuesday, December 10, 2019 7:05 PM
To: Rose Bustria
Subject: Fwd: 2019 AGM & Board Election, OCA Award Recipients + Webinars

Exec and Council.

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> **From:** OCA <OCA@chiropractic.on.ca>
> **Date:** December 10, 2019 at 5:29:52 PM EST
> **To:** Jo-Ann Willson <jpwillson@cco.on.ca>
> **Subject: 2019 AGM & Board Election, OCA Award Recipients + Webinars**
> **Reply-To:** OCA <OCA@chiropractic.on.ca>

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Ontario Chiropractic Association

In this Issue:

Annual General Meeting Update

OCA Gala Awards Recipients

Upcoming Webinars

Update on 2019 Board Elections and the OCA Annual General Meeting

Congratulations for engaging in your OCA Board election process. We are pleased to report that 31 per cent of eligible members voted, the highest participation rate since the OCA started third-party online voting.

At our AGM, 44 members attended in person and 282 attended by proxy. This is an unprecedented level of member engagement.

At the AGM, members approved the slate of three new members to the OCA Board of Directors:

Dr. Anjelica Mazzella

Dr. Paolo De Ciantis

Dr. Jenny Elliott

Celebrating Excellence at the 2019 OCA Awards Gala

OCA celebrated the following members at the ***OCA 90 Years Strong*** dinner and awards gala, held Saturday, December 7, 2019. These outstanding individuals were honoured for their contributions to the profession.

Ms. Debbie Kerr,

2019 OCA Chiropractic Health Assistant

This award recognizes a clinic staff member whose work has enhanced patient satisfaction and the reputation and credibility of chiropractic.

Ms. Debbie Kerr started her work at a solo practice with just pen and paper. She made her job look effortless as the practice grew to a fully computerized, complex office serving 12 practitioners. Throughout her career spanning 28 years, she trained, mentored and educated numerous office administrators allowing them to advance their careers.

Ms. Kerr treated each patient like a member of her family and as a result, they felt comfortable confiding in her.

Though Ms. Kerr is retired now, she still volunteers at *Hope House* and the *Heart & Stroke Foundation* and continues to promote chiropractic care to the public.

Dr. Alena Russo,

2019 OCA Recent Graduate of the Year Award

Winners of this award develop relationships with other health care providers and contribute to innovative patient-centred care.

Dr. Alena Russo graduated from CMCC in 2018. Her achievements there, and her work since, have demonstrated incredible promise.

At CMCC, she facilitated the Soft Tissue Club, served on the Ontario Committee for the Student Canadian Chiropractic Association (OCSCCA) and volunteered in the Dominican Republic in alumni outreach. After graduating, Dr. Russo continued volunteering with OCSCCA and mentoring those she helped through the mentorship program.

Dr. Russo is an author on the topic of pregnancy care and the co-creator of a Prenatal Yoga and Learn program. She works at two chiropractic clinics, where she networks with health specialists and the community to promote chiropractic.

errors and mistakes made by practitioners.

Register Now

This webinar looks at the most common mistakes that business owners make when deducting expenses against their revenue, and covers the most popular expense categories for health care professionals and categories that are highly auditable.

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He received his Doctor of Chiropractic Magna Cum Laude in 2004 from CMCC and a diploma in Medical Acupuncture from McMaster University the same year.

Dr. Thistle served as Clinic Director for SHAPE Health and Wellness Centre and joined the ranks of CMCC's faculty where he guest lectures in the Orthopedics Department.

In 2006, Dr. Thistle launched RRS Education, where he writes on a variety of research topics. RSS Education helps practitioners who strive to enhance knowledge transfer from bench to bedside. Dr. Thistle is also a monthly columnist for Research Review Corner in Canadian Chiropractor Magazine.

Watch the video of Dr. Shawn Thistle, 2019 OCA Chiropractor of the Year.

Click here to support change now by sending a letter to the Ontario government.
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Upcoming Webinars

HST: REAL CASE SCENARIOS (REBROADCAST)

Wed. Dec. 11, 12-1 PM

Rishabh Khamersa, SRJ Chartered Accountants

This webinar will dive into the details of how to file a return with real case common

WHAT BUSINESS EXPENSES COULD YOU BE DEDUCTING? (REBROADCAST)

Wed. Jan. 8, 12-1 PM

Rishabh Khamesra, CA, CPA

SRJ Chartered Accountants

Professional Corporation

Dr. Ramsackal is passionate about patient education and was featured as a weekly health and wellness speaker on a local television program. She is also the author of a health and wellness column and provides presentations on chiropractic care and pregnancy.

Dr. James Laws, 2019 OCA Dr. Michael Brickman Heart & Hands Award

This award is given to a practicing chiropractor who best embodies a generous and giving spirit with an inspiring passion and dedication to chiropractic.

Dr. James Law is a world-renowned chiropractor and athletic therapist, bridging the gap between our profession and the sports world at all levels – from amateur to elite. He has taught countless students, including CMCC's fourth-year students in his course on athletic injury management.

Dr. Laws has had an enduring influence on the chiropractic profession, encompassing advocacy, education, service, leadership and clinical expertise. He has volunteered at OCA, CCO, CMCC, and the York-Peel Chiropractic Society.

For more than 40 years, Dr. Laws has contributed both with his heart, in giving to so many communities, and with his hands, in healing so many patients and helping to shape our profession.

Dr. Shawn Thistle, 2019 OCA Chiropractor of the Year Award

This award recognizes a practicing chiropractor for outstanding service, professional achievement and a significant contribution that influences and benefits the profession.

Dr. Shawn Thistle was recognized for his incredible work, advancing and disseminating research in chiropractic.

Dr. Evelyn Lock,

2019 OCA Community Relations Award

This award recognizes a chiropractor who has made a lasting, meaningful contribution to a community. Recipients educate those outside the profession and demonstrate the health care benefits of chiropractic to others.

Dr. Evelyn Lock has worked tirelessly with the humanitarian charity, Bridge to Health, building its MSK program from the ground up.

Dr. Lock visited rural Ugandan villages, providing care to individuals who had never seen an MSK expert. She educated local Ugandan clinical officers in how to conduct MSK-focused histories, examinations and treatments. Because of her work, a formal MSK team has been added to all African missions, alongside multidisciplinary health care providers.

Dr. Lock mentors undergraduate students at the University of Toronto and provides care and preventative health education to several community groups. She was involved in the Key Performance Target Committees with *Patients Canada*, where she worked to improve patients' hospital experiences. She feels that a multidisciplinary approach helps in her current work at Mount Sinai Hospital and the University of Toronto.

Dr. Lisa Ramsackal,

2019 OCA Patient Care Award

This award recognizes a chiropractor, clinic or organization that has excelled in providing exceptional patient experiences.

Dr. Lisa Ramsackal is the founder of Innova Integrated Wellness Centre, a clinic committed to delivering a high standard of patient-centred care. She leads a diverse, multidisciplinary team that focuses on patient goals through a team-based collaborative approach.

Dedicated to providing excellence in patient-centred care, she consults and communicates with her patients' extended health network to improve overall care, health management and treatment outcomes.

From: Jo-Ann Willson
Sent: Thursday, January 16, 2020 5:15 PM
To: Rose Bustria
Subject: Fwd: OCA Evidence-Based Advisory Council Launch

Exec and Council.

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

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> **Date:** January 16, 2020 at 5:07:06 PM EST
> **To:** Jo-Ann Willson <jpwillson@cco.on.ca>
> **Subject: OCA Evidence-Based Advisory Council Launch**
> **Reply-To:** OCA <OCA@chiropractic.on.ca>

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OCA holds its first meeting of *Evidence-based Framework Advisory Council*

Creating the future for chiropractic care in Ontario begins this weekend.

After careful planning and the selection of 13 exemplary practicing chiropractors, reflecting a broad base of practice styles and a patient, the ***OCA Evidence-based Framework Advisory Council*** members meet this weekend. The council will begin the important work of developing a comprehensive definition and understanding of chiropractic care - a definition that is founded on the universally accepted thee pillars of the evidence-based framework: best available evidence, clinical expertise and patient preference.

This unprecedented partnership with members recognizes that a comprehensive definition must be relevant to chiropractors' practices; and to explore patient preferences, a patient is a crucial member of the council and unique to the approach in establishing this council.

With a shared understanding and adoption of the evidence-based chiropractic care framework, the OCA will advance the profession and elevate patient care and practices in a consistent approach. By increasing the understanding and value of chiropractic care in Ontario, chiropractors will be recognized as the **trusted first choice** for the prevention, treatment and optimal health. This

comprehensive approach will advance chiropractic care with patients, the public, government, extended health insurers and other health professionals.

Through the advice of our outstanding advisory council, we will work with partners to ensure you are supported as the work evolves. Unanimously supported by the OCA Board of Directors, we recognized in early 2019 that a comprehensive and inclusive definition of chiropractic care was foundational to realizing a vision for the future of the profession in Ontario. On behalf of our members, we took on this essential leadership role.

Throughout 2019, we met with our member through 23 member-engagement sessions and five OCA ***90 Years Strong*** gala celebrations. The response was clear and overwhelming. Members value the approach and the goal of creating the future of the chiropractic profession in Ontario.

As key partners and beneficiaries of the work of the *OCA Evidence-based Framework Advisory Council*, we will share the recommendations of the council as they advance this decisive work. If you have any questions, please contact me at cbrereton@chiropractic.on.ca

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Introducing the *OCA Evidence-based Framework Advisory Council*

Dr. Sean Batte (Logan University graduate; practicing in London area)

Fast facts: Dr. Sean Batte is a graduate of Logan University's Chiropractic program. He earned an undergraduate and Master of Science degree in Medical Biophysics from the University of Western Ontario and a second undergraduate degree from Logan University. Dr. Batte has been practicing in the London, Ontario area for 19 years.

Dr. Batte is also a member of the Royal Canadian Navy with several command qualifications and is a graduate of the Canadian Forces Staff College.

Question: Why are you joining the ***OCA Evidence-based Framework Advisory Council***?

Dr. Batte: I think there is a real opportunity to unite the profession and make it stronger. This work belongs to the entire profession and we can see it made stronger if we all learn how use evidence and research to our profession's and patient's advantage. That's why I want to participate on this council. My hope is it will give chiropractors more social credibility as evidence is the currency of credibility when paired with an appropriate strategy. Existing and new research, when deployed with a comprehensive implementation plan is vital part of a larger vision to help better serve our communities and patients, inclining more to seek chiropractors out as their first choice for health care.

Question: As a leader in the profession, can you please share any other involvement, whether that is volunteering or mentoring others?

Dr. Batte: I volunteer with the Salvation Army Centre of Hope's chiropractic clinic. I have volunteered for the London Chiropractic Society and organized seminars. I also served as a chiropractor at the Canada Summer Games and serve as a chiropractic trainer at local amateur sporting events. I have had the pleasure to care for members of Team Canada's rowing team. I also enjoy mentoring students and new graduates from Logan University who have completed their externships in my clinic or shadowed me. I've been a guest lecturer at the University of Western Canada School of Medicine on several occasions to speak about chiropractic to medical students.

Outside the profession, I have raised money for the Soldier On organization for wounded veterans. A few years ago, I led the way to build the multi-million-dollar Battle of the Atlantic Memorial in London Ontario.

I serve in the Royal Canadian Navy Reserves part time. In 2017, I was appointed to Chief of Staff for Central Region (Ontario). In this role, I have 1500 sailors whose readiness and training I am responsible for to the Central Region Captain (Navy). In my ships' squadron I have seven Naval Reserve Divisions whose sailors must be operationally ready to serve domestically and overseas. The main focus of my mentorship is in 'leadership' and 'command.'

Question: Can you also share your involvement and experience with other parts of the of the broader health system?

Dr Batte: In addition to my work with the University, I am the Vice Chair of the WKY Viking Foundation, which is a multidisciplinary research foundation of health professionals from a number of fields, including chiropractors, physicians, naturopaths and others. Our aim is to conduct research that will demonstrate the benefits of including complementary and alternative health disciplines at a national level.

Introducing the *OCA Evidence-based Framework Advisory Council*

Dr. Ken Brough: (Palmer College of Chiropractic graduate and practices in Ottawa)

Fast facts: Dr. Ken Brough has been involved in the Ontario Chiropractic Association for 12 years in various roles, including his most recent position as Chair of the Board of Directors for the last two years. Dr. Brough was also involved with the Canadian Chiropractic Association (CCA) and the Canadian Chiropractic Clinical Guidelines Initiative (CCGI) as Chair of the Government and Inter-Professional Relations Committee and as a Steering Committee member respectively. Dr. Brough has practiced for 28 years in the Ottawa area, leading his clinics in collaborative care models of practice including chiropractors, physiotherapists and registered massage therapists. As the owner of CURAVITA, he employs a team of over 30 professionals in two locations.

Question: Why are you joining the ***OCA Evidence-based Framework Advisory Council***? What is your motivation?

Dr. Brough: As a member, I did not have a strong understanding of the concepts of evidence-based care; it was an emerging concept for me until I became more involved in the Canadian Chiropractic Association (CCA). I became very familiar when I sat on the committee for Canadian Chiropractic Guidelines Initiative (CCGI). When I fully understood Dr. Sackett's work in articulating the three pillars of evidence-based care: best available evidence, clinical expertise and patient preference, I saw how that framework was selectively applied. There is not a strong understanding of how the framework relates to daily clinical practice.. *Dr Sacketts intention was for all of the pillars of the framework to be applied and we need to support the application of all 3 pillars in patient care.*

Question: As a leader in the profession, can you please share any other involvement, whether that is volunteering or mentoring?

Dr. Brough: I was involved with CCA for nine years, largely as a Board member. I've served on the OCA Board of Directors for 13 years and have held executive positions, namely Chair, which is the position I hold now.

For four years, I served on the CCGI Steering Committee as the new guidelines initiative was being redeveloped. I was involved in the initial strategic planning for the initiative and helped lay the groundwork for where CCGI is today.

I operate two multidisciplinary practices. All of us work in full wellness-based model. I employ five chiropractors and we all work in a collaborative model. Mentoring my team is very important; I work with them to practice in the framework of the three pillars of evidence-based care. For our younger practitioners, we established a mentoring program in my clinics to leverage the experience of more established chiropractors; this is of great value to the younger associates who feel supported to grow and thrive.

Question: Can you also share your involvement and experience with other parts of the of the broader health system?

Dr. Brough: In clinical practice, we work with a spectrum of professionals, including the medical profession. Through my work with the CCA, I contributed to the foundational work with the Canadian Armed Forces to launch the chiropractic initiative. I presented to the Parliamentary Defence Committee about the potential involvement of chiropractic care for the military. I also worked with the Royal Canadian Mounted Police (RCMP) when it was re-aligning its health policy and utilization for employees.

Also, while working with the CCA, I participated in its efforts to launch a chiropractic program in Nunavut at one Community Health Centre. That work enabled the creation of a legal framework to enable chiropractors to practice legally in the territory.

Introducing the *OCA Evidence-based Framework Advisory Council*

Dr. Anita Chopra (New York Chiropractic College graduate and practices in Brampton, Oakville and Etobicoke)

Fast facts: Dr. Anita Chopra has been serving the Brampton, Oakville, and Etobicoke area since 2011 after graduating from the New York Chiropractic College. Dr. Chopra received her Bachelor of Arts in Psychology from the University of Western Ontario and is a certified Webster Technique and Rocktape practitioner. Dr. Anita Chopra actively engages her community through guest speaking events with various groups in the Peel region.

Question: Why are you joining the ***OCA Evidence-based Framework Advisory Council***?

Dr. Chopra: I believe that it's time to have good representation of the profession at hand. We are all busy in our practices, but we need to make time to shed light on what is going on our profession. With a lot of media coverage of our profession, it is important to understand what we do and how we do it.

Question: As a leader in the profession, can you please share any other involvement, whether that is volunteering or mentoring?

Dr. Chopra: I am a regular speaker on injury prevention at The Running Room and speak to pregnant and postpartum women on the importance of chiropractic care. I also have spoken to classes on what chiropractic care is.

Question: Can you also share your involvement and experience with other parts of the of the broader health system?

Dr. Chopra: I have tried setting up referral practices with other health care professionals. It is something that takes time and effort; but it does pay off. Establishing trust and competency is very important when building these practices.

Introducing the *OCA Evidence-based Framework Advisory Council*

Dr. Marco De Ciantis (CMCC Graduate and practices in North York)

Fast facts: Dr. Marco De Ciantis has served the North York area for seven years practicing with his twin Dr. Paolo De Ciantis at Sports Specialist Rehab Centre. Dr. Marco De Ciantis has an interest in working with both amateur and professional athletes and provides his services to local football, soccer, and rugby teams regularly as well as both youth and adult Taekwondo athletes at national competitions. Dr. De Ciantis also volunteered his services with the 2015 Pan Am/ParaPan Am games in Toronto.

Dr. Marco De Ciantis was recognized for his outstanding work with the Patient Care award from the Ontario Chiropractic Association in 2018. Dr. De Ciantis has worked to build a collaborative and patient-centred model of care in his career and has attempted to spread this model of care within his community. Dr. De Ciantis also actively engages his community by volunteering within hospitals, local social clubs, charity campaigns, and community health initiatives.

Question: Why are you joining the OCA Evidence based Framework Advisory Council?

Dr. De Ciantis: I've spent years since graduating in 2012, speaking with colleagues about potential changes I and we felt could help to steer the profession towards a direction of unification; unification between all the different "factions" so-to-speak in the various practice styles found under the chiropractic umbrella. Joining this Advisory Council is, on one level, putting foot to pavement and actively contributing to such a process. Moreover, this is a journey to help consolidate all the practice philosophies in our profession, improving professional cohesion and enhancing inter-professional collaborations.

Question: As a leader in the profession, can you please share any other involvement, whether that is volunteering or mentoring others?

Dr. De Ciantis: Last year, I joined the Toronto-based humanitarian group, Bridge to Health. I travelled to Uganda back in January/February of this year for two weeks where I worked in the field, in isolated villages in rural Uganda with medical doctors, speech pathologists, a dentist, dental hygienists, researchers, pharmacist and many local support staff delivering MSK (musculo-skeletal) care to individuals who have never received any care, whatsoever. Furthermore, I and another chiropractor worked, side-by-side, with local clinical officers (Uganda's version of medical doctors), teaching them how to perform proper histories, physical and neurological examinations for MSK conditions and how to treat them. On November 4 of this year, I presented research gained from this experience and previous trips at the American Public Health Associations (APHA) Conference in Philadelphia. We were the only Canadian representatives.

In my personal practice, I mentor undergraduate (chiropractic, naturopathic, kinesiologist) and secondary (high school) students. My clinic acts as a co-op learning facility with local high schools where grade 11-12 students come in and observe multiple days of the week for hours, earning credits. Moreover, I and other chiropractors at the clinic have established interprofessional networks with various physiatrists, medical doctors, personal trainers, pharmacists (local Shoppers Drug Mart), with orthopaedic surgeons in UHN and with private facilities (Pain & Wellness Centre) where interprofessional collaborations and rounds occur every month, bolstering patient-centred health care.

Introducing the *OCA Evidence-based Framework Advisory Council*

Dr. Peter Emary (New York Chiropractic College graduate and practices in Cambridge)

Fast facts: Dr. Peter Emary has served the Cambridge, Ontario region for 16 years after graduating from the New York Chiropractic College. Dr. Emary has also received a Master of Science in Clinical Sciences degree from Bournemouth University and has a special interest in clinical research and radiology.

Dr. Emary served as the President of the Waterloo Regional Chiropractic Society from 2011 to 2013, during which time the organization was awarded the Ontario Chiropractic Association's Society of the Year award in both 2011 and 2012. Dr. Emary has also been recognized for his community involvement with the Rotarian of the Year award in 2005 by the Rotary Club of Cambridge (Preston-Hespeler) of which he was a member of for 10 years.

Question: Why are you joining the ***OCA Evidence-based Framework Advisory Council***?

Dr. Emary: I've been wanting to get more involved in our profession for years but have often lacked the time to properly do so. However, I couldn't pass up the chance to be involved in this OCA initiative. Aligning the chiropractic profession with the principles of evidence-based practice is something I've been wanting to see happen for a very long time. I'm enthusiastically looking forward to getting involved and participating in the advisory council.

Question: As a leader in the profession, can you please share any other involvement, whether that is volunteering or mentoring?

Dr. Emary: I served on the Executive Board of the Waterloo Regional Chiropractic Society from 2007 to 2013. I served as President of the Society from 2011 to 2013. I worked with a fantastic group of Board Members and am proud that we were awarded the OCA's 'Society of the Year' during my two years as president. We built upon the successes of our previous society Presidents and I am pleased that the Waterloo Regional Chiropractic Society is still as strong today as ever.

Question: Can you also share your involvement and experience with other parts of the broader health system?

Dr. Emary: This past year, I started teaching part-time in the chiropractic department at D'Youville College and am thoroughly enjoying it. I'm teaching a course in evidence-based practice to third-year students; and am helping them to learn how to critically appraise research literature and apply it, combined with clinical experience and patient preference, to managing an individual patient. This year I've also started participating in the ISAEC program through Grand River Hospital. This has been a tremendous experience so far and my clinical skills are being greatly enhanced through this program.

We have a really great practice leader and a highly-skilled group of chiropractors on the ISAEC team here; I'm excited to see the impact that this program will have, not only in our region, but across Ontario, in terms of streamlining care and reducing referrals for advanced imaging and spine surgery.

This program is an evidence-based program and is placing Ontario chiropractors on the front line of primary interdisciplinary spine care.

In addition to my clinical practice at the Langs Community Health Centre (CHC) in Cambridge, I'm also fortunate to be working on a Ph.D. at McMaster University. For my thesis, I will be investigating the impact of chiropractic integration on opioid use among chronic back pain patients within the CHC setting.

Introducing the *OCA Evidence-based Framework Advisory Council*

Dr. Brian Gleberzon: (CMCC graduate and practices in Toronto)

Fast facts: Dr. Brian Gleberzon is a researcher, professor, and Chair of the Department of Chiropractic Therapeutics at the Canadian Memorial Chiropractic College in Toronto. Dr. Gleberzon was involved with the College of Chiropractors of Ontario from 2007 to 2016 and the Ontario Chiropractic Association since 2016 where he currently holds the position of Secretary-Treasurer and serves on the Finance and Audit Committee and the Research Committee

Dr. Gleberzon has a Master of Health Sciences from the University of Sydney and is completing his Ph.D. from the University of New South Wales. Dr. Gleberzon has practiced in the Toronto area for 30 years. He has also been recognized for his work in the profession and received the OCA's Professional Service in Research in Chiropractic Award, now known as Researcher of the Year and the OCA's Professional Service awards in Public Relations Award 2001 and 2008 respectively.

Question: Why are you joining the ***OCA Evidence-based Framework Advisory Council***?

Dr. Gleberzon: I want to ensure the voice of the patient and the voice of the clinician is heard, not just clinical research. I see it as a three-legged stool; we need to remember all three pillars. I want to resolve the friction at the researcher-practitioner interface. I'm a non-linear thinker who wants to deconstruct dogma. I speak truth to power and that is partly why I want to contribute as a member of the Council. I'm not afraid to address difficult conversations.

Question: As a leader in the profession, can you please share any other involvement, whether that is volunteering or mentoring others?

Dr. Gleberzon: I'm President and a founding member of local CUPE union at CCMC. I'm a strong advocate for natural justice and procedural fairness.

One of the small groups I work with is clinical education, deconstructing guidelines and looking at its content. I'm an advocate for challenging dogma. It is how I work and what I am interested in. This is the topic of my Ph.D. triangulation to understand what is really fair and just. To the individual patient, we must be responsible.

There are two areas of research I pioneered. I was the lead author of a study on student injuries. Initially, I received a lot resistance; now other professions are starting to publish similar articles. The second area of research concerns women chiropractors. I surveyed CMCC women whether they were ever sexually harassed by patients. For women, this is an issue. I was the first to publish data for the chiropractic profession. It is an important issue and I'm not afraid to ask the questions; get the data and publish. We learned that most of the harassment occurs in the first five years by male patients.

Question: Can you also share your involvement and experience with other parts of the of the broader health system?

Dr. Gleberzon: I teach at CMCC and run my practice, which is focused mainly on back pain and sports injuries; most of my patients are older adults.

I've published many research papers and contributed to various textbooks; I speak at scientific conferences globally. In 2008, I designed the Best Food Forward program for the Canadian Chiropractic Association and presented the program to members of Parliament and senior advisors of the Public Health Agency of Canada.

Introducing the *OCA Evidence-based Framework Advisory Council*

Sheila Gregory (patient member)

Fast facts: Sheila Gregory has been a chiropractic patient for more than 30 years. She lives in Newmarket, Ontario.

She has been treated by many different practitioners in the Greater Toronto Area, and has experienced diverse practice styles. Sheila started visiting a chiropractor because of neck and lower back pain experienced at work. She has maintained consistent and ongoing treatment over the years.

Sheila describes her experience with chiropractors as excellent. Their care and expertise has helped her reduce pain and maintain an active lifestyle. Throughout the years, Sheila's chiropractic needs have evolved and changed, therefore making her an excellent candidate to discuss her diverse set of experiences with chiropractic care. Sheila is motivated to provide insightful and meaningful input into the ***OCA Evidence-based Framework Advisory Council***.

Question: Why are you joining the ***OCA Evidence-based Framework Advisory Council***?

Ms. Gregory: When I learned about the Council from OCA, I realized how many chiropractors I have been treated by over the years (about six or seven) and, for the most part, how much they've helped me. I've a great respect for chiropractors. I've been exposed to a range of treatments and think I can offer an understanding of the patient's point of view. My personal motivation to contribute to the Council is related to my background in physical education and health promotion/community health.

Question: As our patient member, can you please share any other involvement in chiropractic or any other organizations, whether that is volunteering for an association or mentoring others? Specifically, have you served as a patient or representative with other organizations?

Ms. Gregory: I've not been involved in the chiropractic profession or as patient representative in any other organization. Past volunteer activities include serving as a board director for a homeless shelter and serving on the executive of my professional association.

Question: Can you also share your involvement and experience with other parts of the of the broader health system, for example, as a patient or as a health advocate for a family member or friend?

Ms. Gregory: As a health care advocate for my parents going through the aging process and the end of their lives, I'm familiar with the excellence and the challenges patients experience when navigating the health care system. As a former employee of Dying With Dignity Canada (DWDC), I worked with health care professionals who served as board directors and/or members of the Physicians Advisory Council. My experience at DWDC gave me an understanding of how, sometimes, health care provider beliefs, professional codes, institutional policies, and legislative restrictions can be in direct conflict with patients' desires and/or rights.

Dr. Glen M. Harris (CMCC Graduate and practices in mid-town Toronto)

Fast facts: Dr. Glen M. Harris has been active in the chiropractic sports care community after graduating from the Canadian Memorial Chiropractic College with his Doctor of Chiropractic and the Royal College of Chiropractic Sports Sciences (Canada)

Dr. Harris served on the Executive Board of the Royal College of Chiropractic Sports Sciences (Canada) from 2002 to 2016 and is also a past President of the organization from 2010 to 2012. Dr. Harris has also been the North American (Canada) representative on the International Federation of Sports Chiropractic /Fédération Internationale de Chiropratique du Sport (FICS) since 2012. Dr. Harris is an Assistant Professor at the Canadian Memorial Chiropractic College in the Division of Clinical Education where he supervises clinical interns Dr. Harris continues to practice in Toronto and is the President of MSK+, a continuing education company for chiropractors and allied health professionals.

Question: Why are you joining the ***OCA Evidence-based Framework Advisory Council***?

Dr. Harris: I'm committed to the advancement of the chiropractic profession. I've served in leadership positions at the national and international level through the Royal College of Chiropractic Sports Sciences (RCCSS Canada). I have served in leadership positions at the national and international level through the International Federation of Sports Chiropractic /Fédération Internationale de Chiropratique du Sport (FICS).

I've supervised chiropractic interns for twenty years; now this is an opportunity to assist and serve the profession at the provincial level.

Question: As a leader in the profession, can you please share any other involvement, whether that is volunteering or mentoring?

Dr. Harris: I've been involved with a significant amount of teaching in my clinician role at the CMCC. I've mentored and supervised over forty sets of interns, ranging in sizes of 7 to 9 interns per set. In that role, I supervise fourth-year students for six-month clinical internship rotations at the South Riverdale clinic where we have an inter-referral process with the clinic's physicians, nurse practitioners and others. I've been in this role for ten years.

I've been a supervisor on student research projects; I also served on the Research Ethics Board (REB) at CMCC.

I'm proud to volunteer as a member of the host medical services at the Canada Games with the Team Ontario men's softball team. For the 2010 Paralympic Winter Games, held in Vancouver, I served in the clinic for the duration of the games so that all athletes had access to healthcare services. I performed the same role for the 2015 Pan American and Para Pan American Games, held in Greater Toronto Area.

Question: Can you also share your involvement and experience with other parts of the of the broader health system?

Dr. Harris: In my work with the Canada Games, Vancouver 2010 Paralympic and Toronto 2015 Pan Am and Para Pan Am games, I worked in polyclinics with a full range of health professionals.

In my private practice, I work in an integrated multidisciplinary practice, alongside physiotherapists and registered massage therapists. I have a private company called, MSK+, which provides continuing education to physicians, nurses and all health professionals, specifically on manual therapy, soft tissue, therapeutic exercises and education. The company has been in operation for 10 years.

Introducing the *OCA Evidence-based Framework Advisory Council*

Dr. Deborah Kopansky-Giles (CMCC graduate working in Greater Toronto Area)

Fast facts: Dr. Deborah Kopansky-Giles, DC, FCCS(C), FICC (Hons), M.Sc., is a Professor at the Canadian Memorial Chiropractic College (CMCC), an Assistant Professor in the Faculty of Medicine, University of Toronto and a staff chiropractor at Unity Health Toronto (St. Michael's Hospital), Department of Family and Community Medicine.

Dr. Kopansky-Giles attained her Fellowship in Chiropractic Clinical Sciences in 1993 and completed her M.Sc. in 2010. She has served on the organizing committees for numerous conferences including, the World Federation of Chiropractic (WFC) 10th Biennial Congress in Montreal (2009) as conference Co-Chair, the *Bone and Joint Decade* World Network meetings in Vietnam (2012), Brazil (2013), London (2014) and Berlin (2017) in addition to her role as a member of the Health Services Committee, the XVI International AIDS Conference in Toronto in 2006 which attracted over 28,000 delegates.

Question: Why are you joining the ***OCA Evidence-based Framework Advisory Council***?

Dr. Kopansky-Giles: I've been involved for many years being on the policy/political side for my profession, including nine years on the OCA Board of Directors, six years on the CCA Board and 15 years on the World Federation of Chiropractic (WFC) as the Canadian representative. So, I bring provincial, national and international experience to the Council.

As an clinician, educator and researcher, I am motivated to help ensure that our profession is evidence-based, integrated into the health system and accessible to all Ontarians. I'm driven by how we can best serve people because I believe it is all about the patient. I want to continue to bring that perspective to this work. For me, it always comes down to helping people who are suffering and not about my profession's or my own motivation.

Question: As a leader in the profession, can you please share any other involvement, whether that is volunteering or mentoring?

Dr. Kopansky-Giles: I'm highly motivated to advance the profession believe in the importance of contributing to our communities through my work and through volunteerism.

In 2000, the United Nations declared 2000-2010 the Bone and Joint Decade to shine a light on this global issue and to seek specific attention to those areas. With the UN declaration, the World Health Organization (WHO) encouraged the development of the international Bone and Joint Decade (BJD), comprised of expert health professionals working to create an agenda and build momentum around advocacy for bone and joint conditions. For the past 15 years, I've been involved in this BJD work – (now known as the Global Alliance for Musculoskeletal Health) as a member of the International Coordinating Council and on the Executive Committee since 2010. In that capacity, I've had the privilege of working with global leaders from many professions and patient organizations. This has enabled me to broaden my perspective significantly with respect to global health issues and the integral role that chiropractors can have locally and around the world as primary spine care providers.

Over the past 35 years, I've had the privilege of being involved in a wide diversity of organizations (local, provincial, national and international), participating on various boards and committees. As a few examples: a research agenda council for the AIDS Bureau of Canada, The Ontario HIV Treatment Network,, the Ontario Rehabilitation Council, various Ministry of Health and Long-Term Care (MOHLTC) quality committees, the Financial Services Commission of Ontario Accident Benefits Advisory Committee, the World Spine Care (WSC) Canada board, the Global Spine Care Initiative Scientific Secretariat, and many others. Down the road, I am looking at 'retirement' plans for continuing work with WSC with our programs in Botswana, India, Ghana and Dominican Republic.

Question: Can you also share your involvement and experience with other parts of the of the broader health system?

Dr. Kopansky-Giles: I'm deeply involved in the education of chiropractors and other learners. As a Professor at CMCC; I supervise our CMCC graduate chiropractic training program at St. Michael's Hospital. I also teach in the Department of Family and Community Medicine at the University of Toronto (UoT) where my teaching involves educating family medince learners, teaching medical faculty (faculty development) and also international students in the Global Health Program.

For four years, I was privileged to co-chair a national working group for the College of Family Physicians Canada; where we developed teaching and assessment tools for the CanMEDS Collaborator Role competency. These tools are available open access on the CFPC website for all health professional educators.

Over the past 15 years, I've been actively engaged in the evolution of our integrative model of care in family medicine at St. Michael's Hospital. The St. Michael's Hospital program was the first time in Canada that chiropractors were integrated as clinicians and educators into an academic health science centre. This program was identified by the federal government as a exemplar for primary care innovation in 2012 and by the World Health Organization in 2016 as a global leading practice. I was honoured to co-lead a national webinar for Canada Human Health Resources about our model, reaching 65 ministry of health-related organizations across Canada. Our model of care is team-based and non-hierarchical, patient centred and continuing to evolve through a social determinants of health lens.

The St. Michael's Hospital model continues to evolve in creative ways; chiropractors are fully integrated team members, collaborating on an innovative primary care team which also includes dentists, psychologists, legal literacy services, income security services to help people navigate the our complex social support system and so forth; structured to minimize barriers to accessing care, including economic barriers.

I am fortunate to work with the WHO Global Health Workforce, Healthy Ageing and Integrated, People-Centred Health Services programs on behalf of the WFC and G-MUSC; to advocate for priority of musculoskeletal health and to ensure that chiropractors are seen as essential contributors to the global health workforce and in helping to reduce the burden of spine and musculoskeletal disorders on people around the world.

In the decades since my graduation, I have seen incredible advancement of chiropractic in Canada and I'm very excited to see this continue to evolve with the good work that chiropractors do every day in their practices, with the excellent education and research our profession contributes to and with the leadership that the OCA has given in strengthening chiropractic in Ontario.

Introducing the *OCA Evidence-based Framework Advisory Council*

Dr. Keshena Malik (CMCC Graduate and practices in the Hamilton area)

Fast facts: Dr. Keshena Malik has been in practice for 10 years in the Greater Hamilton area in a multidisciplinary, collaborative clinical setting, including chiropractors, physiotherapists and registered massage therapists.

Dr. Malik is an Advanced Practice Provider with the Low Back Pain Rapid Access Clinic (formerly ISAEC). Dr. Malik also completed her Master of Science in Rehabilitation Sciences from McMaster University. Dr. Malik is also the Co-chair of the McMaster Chiropractic Working Group and is a regular guest speaker with McMaster's Program for Interprofessional Practice, Education and Research. Dr. Malik is involved in the Ontario Chiropractic Association as a member of the Board of Directors, serving on the Research Committee, Strategic Planning Task Force and volunteering as a Chiropractic Educator for the OCA's Community Engagement and Leadership Program.

Question: Why are you joining the ***OCA Evidence-based Framework Advisory Council***?

Dr. Malik: I endorse evidence-based chiropractic care. I am motivated by and passionate about disseminating knowledge of this evidence-based framework to our colleagues, stakeholders and patients, as well as aiding in providing an inclusive understanding of this framework in support of its application to and shaping of our profession.

Question: As a leader in the profession, can you please share any other involvement, whether that is volunteering or mentoring?

Dr. Malik: For the past six years, I have been involved in mentoring through McMaster University's Program for Interprofessional Practice, Education and Research (PIPER) as a guest speaker, educating students (including medical, physiotherapy, occupational therapy, midwifery, nursing) about the chiropractic profession. I also volunteer as a group facilitator at Interprofessional Education (IPE) events, which include sessions facilitating students from the McMaster University Faculty of Health Sciences programs to learn from and about their colleagues training and scope of practice in each program.

Question: Can you also share your involvement and experience with other parts of the of the broader health system?

Dr. Malik: In my clinical practice, I have developed referral relationships with allopathic, allied and complementary and alternative health professionals in order to provide the most effective patient-centred care. I feel it is imperative to understand each profession's scope of practice while considering patient preferences to ensure the most appropriate care.

In terms of new approaches to interprofessional practice, in addition to guest speaking at various IPE events, I also have training in the Canadian Interprofessional Health Collaborative (CIHC) Competency Framework. I feel that interprofessional collaboration should be the hallmark of every profession.

Dr. Bernadette Murphy (CMCC Graduate and practices in the Greater Toronto Area)

Fast facts: Dr. Bernadette Murphy is involved in patient care and the advancement of the chiropractic profession in both Canada and New Zealand. Dr. Murphy received her BA in Life Sciences from Queen's University and Doctor of Chiropractic from the Canadian Memorial Chiropractic College before heading to New Zealand to complete her Master of Science and Ph.D. in Human Neurophysiology from the University of Auckland. While in New Zealand, Dr. Murphy was the Director of Research at the New Zealand College of Chiropractic and then accepted a lectureship in the Department of Sport and Exercise Science at the University of Auckland. Dr. Murphy developed a Master of Science in Exercise Rehabilitation at the University of Auckland. Throughout this time, Dr. Murphy maintained a clinical practice.

In 2008 Dr. Murphy returned to Ontario as a faculty member at the University of Ontario Institute of Technology to expand its Bachelor of Health Science degree with a Kinesiology program.

Question: Why are you joining the ***OCA Evidence-based Framework Advisory Council*?**

Dr. Murphy: As a clinician, I have a firm commitment to evidence-based practice. As a basic science researcher, I understand the challenges of running the studies to collect the data to create the evidence. It's important to understand that "absence of evidence" is not "*evidence of absence*." I bring that dual expertise to my work with the ***OCA Evidence-based Framework Advisory Council.***

Question: As a leader in the profession, can you please share any other involvement, whether that is volunteering mentoring?

Dr. Murphy: Over the years, I have mentored a number of chiropractors and future chiropractors as a research supervisor. Ensuring that the chiropractic profession has clinicians with strong backgrounds in critical thinking and interpreting research evidence is an important part of the profession "*coming of age*."

Question: Can you also share your involvement and experience with other parts of the of the broader health system?

Dr. Murphy: Over the years, in both Canada and New Zealand, I have taught students from chiropractic, medicine, nursing, physiology and kinesiology. What always strikes me is that, regardless of discipline, students struggle with the same concepts. I think that interprofessional education is an important part of breaking down stereotypes. I am privileged that my work is recognized globally; I am a recipient of the WFC best scientific paper award in 1995 and 2015. I was the New Zealand Chiropractor of the Year (2004); I received the 2010 OCA award for most significant contributions to research; I was honoured with the Earl Homewood CMCC Professorship in 2013 and 2014, and the UOIT Research Excellence Award in 2014 for excellence in research acknowledged as being of international calibre.

Dr. Paul Nolet (CMCC graduate and practices in Guelph)

Fast facts: Dr. Paul Nolet has provided chiropractic services in both Ontario and Harare, Zimbabwe for 36 years and is currently practicing in Guelph, Ontario. Dr. Nolet's practice emphasizes pain relief and functional restoration within an interprofessional setting in the Ontario ISAEC program and at Wellington Ortho and Rehab where he works with chiropractors, physiotherapists, massage therapists, orthopedic surgeons and a physical medicine specialist as the Director of Chiropractic Services.

Dr. Paul Nolet received a Master of Science in Sports Health Science from Life University, a Master of Public Health in Health Studies from Lakehead University, is a Fellow of the Royal College of Chiropractic Sports Sciences, an Internationally Certified Chiropractic Sports Practitioner, and a nonsurgical member of the Canadian Spine Society. Dr. Nolet is completing his Ph.D. in Forensic Medicine from the Care and Public Research Institute at Maastricht University in the Netherlands. Dr. Nolet's research focuses on the risk factors of back and next pain from the view of musculoskeletal epidemiology. Dr. Paul Nolet has served on the Board of Directors of the Canadian Chiropractic Examining Board since 2013.

Question: Why are you joining the ***OCA Evidence-based Framework Advisory Council***?

Dr. Nolet: We've known for a while that many conditions like back pain, neck pain and headaches for instance, have a large burden of illness on the health system. With our profession's growing research and clinical guideline initiatives that show that many of the treatments chiropractors do to be effective for the treatment of many musculoskeletal conditions, it is time for the profession to move toward playing a more significant role in the province's health system. I would like to be involved in moving our profession in that direction.

Question: As a leader in the profession, can you please share any other involvement, whether that is volunteering for a sports team or mentoring others?

Dr. Nolet: Early in my chiropractic career, I practiced for almost five years in Harare, Zimbabwe. I practiced in one of the main medical centres and was able to spend time observing surgery with orthopaedic and neurosurgeons. I was also able to get involved in the local community. I understand cultural sensitivity and the complexity of what is in front of you. I joined another Canadian chiropractor and his family and we practiced together.

Question: Can you also share your involvement and experience with other parts of the broader health system, for example, teaching, establishing referral practices with other health professionals or new approaches to interprofessional practice?

Dr. Nolet: I volunteered for several years on a committee with the Waterloo Wellington Local Health Integration Network (LHIN). For the last few years, I chaired the Health Professions Advisory Committee and was able to get a glimpse of what the health system has to provide for Ontarians. I was involved in the Pan Am games 2015, supporting cyclists; I've also worked at the Pre-Pan American games at both the national and international levels.

I completed my Master of Public Health on neck injuries in car accidents. My thesis was completed at Toronto Western Hospital at the Centre for Research Expertise for Improved Disability Outcomes (CREIDO) that was funded by the WSIB.

When I am not practicing, I am working on my Ph.D. in Forensic Medicine through Maastricht University. I have been able to publish my research in journals such as Physical Medicine and Rehabilitation, European Spine Journal and The Spine Journal. I've published 15 articles and counting.

Dr. Antonio "Tony" Ottaviano (Life University graduate and practices in the Niagara area)

Fast facts: Dr. Antonio Ottaviano received his Doctor of Chiropractic from Life University and has been involved in the chiropractic profession in Ontario for much of his career. Dr. Ottaviano has contributed content for orienting new graduates to OCA materials, organized chiropractic seminars in the Niagara area, and is a former President of the Niagara Chiropractic Society. Dr. Ottaviano has practiced in both Alberta and Ontario and has been servicing the St. Catherine's region for the last 36 years, the last 10 of which he has been joined by his son. Dr. Antonio Ottaviano was actively involved with local soccer clubs and was the coach for a team for many years.

Question: Why are you joining the OCA Evidence based Framework Advisory Council?

Dr. Ottaviano: My personal motivation for volunteering for the Advisory Council is my concern about some of the disturbing trends being propagated by members of our own profession that are taking hold in our profession both outside Canada and most recently within Canada and our province.

Specifically:

1. The trend in Britain and Australia of prohibiting chiropractors from adjusting children and, closer to home, the recent moratorium by the British Columbia College of Chiropractors prohibiting the adjusting of children below the age of two.
2. The trend of disparaging and discouraging the use of x-ray in the overall assessment of a chiropractic patient
3. The trend toward the abandonment of the term subluxation and minimizing the essence of our care, the chiropractic adjustment and its effect on the nervous system.
4. The trend toward minimizing and disparaging the second and third pillars of the evidence-based practice framework which are clinical expertise and patient values and preferences over the first pillar, best available evidence.
5. The trend toward members of our profession disparaging fellow members in the press versus dealing the issue amongst ourselves.

I'm entering my 40th year in practice. Having practiced for that period of time and having seen changes in patients' health and wellbeing that could not always be backed up by a double-blind controlled study, I am concerned that a strictly evidence-based first-tier agenda to determine what chiropractors can and can't do undermines what I have witnessed firsthand in patients. Research should be directed towards understanding why we see the results we do and how we can improve on those outcomes further. I understand that making outlandish claims is damaging to the profession in the public's eye; but by the same token we cannot look to push for regulatory castration of our services because research may not have caught up with what I have seen improve in my patients with a regular program of chiropractic care, which has at its core the spinal adjustment.

My goal is that, with respectful discussion, we can forge a clear plan forward that incorporates the evidence- based framework to strengthen and empower our profession, not weaken it for the future generation of chiropractors in our province.

Question: As a leader in the profession, can you please share any other involvement , whether that is volunteering or mentoring?

Dr. Ottaviano: In the past, I served as president of the Niagara Chiropractic Society for two terms, at which time my focus was on bringing together the members in our district, regardless of their practice styles or philosophical leanings. My personal approach was, *"what can I do to help my fellow chiropractors become more successful in practice and provide better care for our patients?"* I organized diverse monthly speakers for our luncheon meeting, as well as quarterly evening seminars, bringing in high-profile speakers in our profession with the goal of empowering the members with speakers on science, philosophy and art, including practice management, technique, x-ray and motivation. Those seminars were attended by over 100 chiropractors and staff and were extremely well received.

I was involved with the James Carter Associates practice management program as a lecturer and also served in helping members in the assessment of their practices and the incorporation of practice management procedures and staff training. I was on the executive of a minor soccer association in our city and coached a competitive boys' team for 10 years, travelling across Canada the U.S. and Europe for competitive showcase tournaments.

Dr. Rod Overton (CMCC Graduate and practices in the London area)

Fast facts: Dr. Rod Overton has been serving the London area for 27 years with a wide variety of techniques and is actively involved with the community as a guest speaker with various groups, businesses, and schools. Dr. Overton has studied many chiropractic adjusting techniques over his career, including diversified, Talsky tonal technique, MC2, and has most recently been witnessing great changes with OTZ chiropractic technique. Dr. Overton's activities have been recognized by the Ontario Chiropractic Association for his work with the Professional Service Award in Public Relations in 2011.

Question: Why are you joining the ***OCA Evidence-based Framework Advisory Council***?

Dr. Overton: I had no idea what chiropractic was really about when I started chiropractic college. A good friend of ours was a chiropractor and he helped our family with some injuries. He was a kind and gentle man with a strong passion for what he was doing. When he suggested that I should become a chiropractor, I thought that it seemed like a good way to help people and make a living. I didn't know that it would change my life.

I was shocked when I began to learn how much your health could benefit through chiropractic care. During my teens, I suffered with a seemingly endless series of colds. Mononucleosis, strep throat and pneumonia were an unpleasant part of my university experience. When I started receiving regular chiropractic care, I stopped getting sick all the time. I still suffered the occasional cold but not nearly as often as before. Even more importantly, I began to realize that my new profession offered me a brand new perspective on health, and how the body works.

I hope that the work of the council will have a great effect on how the public, the government and industry, perceives the chiropractic profession. That makes it extremely important and I'm excited to be a part of that."

Question: As a leader in the profession, can you please share any other involvement, whether that is volunteering or mentoring others?

Dr. Overton: I organize chiropractic events and run a volunteer chiropractic clinic at the Salvation Army Centre of Hope that has operated for eight years. I've also given back to the chiropractic profession as the president of the London Chiropractic Society from 1994 to 1995, as well as from 2008 to 2012.

Question: Can you also share your involvement and experience with other parts of the of the broader health system?

Dr. Overton: I really enjoy being involved in organizing chiropractic events and bringing various speakers to London. I served as president of the London Chiropractic Society in 1994/1995 and from 2008 – 2012. I have inspired and educated many people through presentations on various health-related topics, at many schools, organizations and businesses. I've run a volunteer chiropractic clinic for people in need at the Salvation Army Centre of Hope since 2011. I'm proud that more than 20 chiropractors have been involved with the Salvation Army Centre of Hope clinic over the years.

From: Jo-Ann Willson
Sent: Tuesday, January 21, 2020 5:41 PM
To: Rose Bustria
Subject: Fwd: 2020-01-21 Weekly News: OCA EHC Working Group + Board Research + EBF Advisory Council Update + Webinars

Exec and Council.

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> **From:** OCA <OCA@chiropractic.on.ca>
> **Date:** January 21, 2020 at 5:03:24 PM EST
> **To:** Jo-Ann Willson <jpwillson@cco.on.ca>
> **Subject: 2020-01-21 Weekly News: OCA EHC Working Group + Board Research + EBF Advisory Council Update + Webinars**
> **Reply-To:** OCA <OCA@chiropractic.on.ca>

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Ontario Chiropractic Association

In this Issue:

OCA In the News

Extended call for expressions of interest for membership to the OCA Board Research Committee

OCA EHC Working Group

New Online Medical Invoice Form for Health Providers Completing ODSP Application Forms for Patients

OCA Aspire

Upcoming Webinars

OCA In the News

"Animal chiropractic becoming more commonplace with Canadian pet owners."

SUDBURY -- Sudbury chiropractor Dr. Sherrie Guillet has been treating spines in the City of Greater Sudbury for 15 years now and some of her best clients don't exactly walk on two feet.

"When I was in chiropractic college, there was an animal chiropractor that came in to do a presentation on what she does, and I was really fascinated by the stories that she told of the animals that she helped, and I thought I'd like to do that as well," said Guillet.

The Sudbury practitioner is one of only a handful in the country who has special certification. Click Here for the complete article and video.

For OCA's Public Statement, please follow this link.

Extended Call for expressions of interest for membership to the OCA Board Research Committee

The OCA Strategic Plan 2017-2022 includes a significant focus on the role of research in the advancement of our profession in Ontario. The Research Committee assists the OCA Board of Directors in fulfilling its oversight responsibilities regarding all research-related activities.

We are inviting three OCA members to participate in the work of the Board Research Committee.

Collaboration is a hallmark of our approach to advancing the profession on behalf of our members. The Research Committee will support the OCA to amplify the work of the Canadian Chiropractic Research Foundation (CCRF), the Canadian Chiropractic Guideline Initiative (CCGI) and others that have research as their core mission, ensuring that OCA investments in research are optimized to enhance care for patients in Ontario.

The Research Committee conveys its findings and recommendations to the Board of Directors for consideration, and where required, the decision by the Board of Directors.

Research Committee Composition

- Up to four OCA Board Directors
- Up to three OCA members who are engaged in research and who are not Board directors
- The OCA Chair (Ex-officio)
- Chief Executive Officer (Ex-officio)
- A non-OCA member with research expertise (NTD: Advisor - non-voting member of the Committee)

To support the activities associated with understanding the future needs for developing and supporting research capacity in Ontario, the following tasks will comprise the work plan of the Research Committee:

- Review OCA strategic initiatives
- Identify those elements within the strategic initiatives focused on research
- Identify how those elements within the strategic initiatives may impact the OCA strategic plan
- Review current and future research commitments
- Prioritize and make recommendations for funded research to present to the Board of Directors on a semi-annual basis
- Participate in planning to prioritize areas of investment for Ontario input into the national research agenda
- Identify priority research forums/conferences for OCA attendance

If you are interested in becoming part of the Board Research Committee, please send an email no later than **February 14** to dgibson@chiropractic.on.ca.

In your email, please outline:

1. Why you believe this work is important.

2. Contributions you can make through previous experience.

Thank you. We will connect by phone with each member who expresses interest.

Members of the Board Research Committee will be confirmed by end of February 2020.

Join the OCA Extended Health Care (EHC) Working Group and impact your future

OCA's 2019 Environics poll revealed four in five chiropractic patients surveyed have private health care coverage to pay for their chiropractic care, highlighting the significant importance of ensuring patients have access to chiropractic coverage in their EHC plans.

Join the new OCA EHC Working Group and assist the OCA in its development and execution of its long-term EHC strategy, as a complement to the CCA's long-term strategy for Canada. The OCA is looking for up to five OCA members in practice to play a key role by advising the OCA on ad-hoc Ontario chiropractic and EHC issues as they arise.

Given the time and complexity of developing and implementing an Ontario EHC strategy, **all working group members must commit to, at minimum, a two-year term**. Terms may be renewable for an additional year at the discretion of the OCA.

Meetings will be held on a monthly basis in two-hour increments, with the exception of the months of December and July. Our initial in-person meeting will be held on April 1, 2020, at our OCA office. After this, members will have the choice of joining future meetings either by teleconference or in-person at the OCA's office. The OCA will provide reimbursements for travel expenses and your time.

Are you ready to join the OCA EHC Working Group?

491

We welcome your application to become a member of the OCA EHC Working Group if you are:

- A registered chiropractor in Ontario in good standing
- Experienced with making EHC claims

If you have any questions about the application or selection process, please email esully@chiropractic.on.ca.

Submission Deadline – Tuesday, February 11, 2020

Learn More and Apply Now.

New Online Medical Invoice Form for Health Providers Completing ODSP Application Forms for Patients

For health providers who complete the Ontario Disability Support Program (ODSP) application forms for their patients, the Ministry of Children, Community and Social Services has established a new standardized online invoice form. This new online invoice form contains all the required information that is fast, easy and secure to bill all in one place using Form 3261, in the Ontario Central Forms Repository. Please note that having the latest version of Adobe Acrobat Reader is required to access this form.

Full details can be found in the memo released by the Ministry and any questions about the online invoice can be directed to Ola Kolodij, Senior

Manager, DUA, Social Assistant Central Services Branch at 416-212-6752 or at ola.kolodij@ontario.ca.

The Benefits of Security

Last week we shared how ***OCA Aspire*** integrates practice management tools and electronic health records. This week, we dive deeper into how you can leverage our new solution to elevate your patient care and practice while maintaining the highest level of patient privacy.

OCA Aspire uses cloud-based servers that host your data with the kind of encryption that you'd expect from your online banking.

These servers are located in a secure Canadian data centre that meets all regulatory and industry standards, including all privacy and security requirements outlined by PHIPA. That means your patient data is protected the event of physical damage or loss, such as flooding or theft at your practice.

OCA Aspire 2.0 is coming soon – have you booked your demo?

Sign Up To Learn More

Upcoming Webinars

HOW TO AVOID AND RESOLVE DISPUTES BEFORE THEY COST YOU MONEY (REBROADCAST)

Wed. Jan. 22, 12 p.m. - 1 p.m.
David P. Lees, Mills & Mills LLP

A legal overview of the types of disputes a chiropractor may be involved in with, landlord, employee, partner, patient and the cost of litigation.

Register Now

UPDATES UNDER THE EMPLOYMENT STANDARDS ACT

Wed. Jan. 29, 12 p.m. - 1 p.m.
Zachary Silverberg and Reshma Kishnani, Mills and Mills LLP

There have been several recent changes (and reversals of changes) under the Employment Standards Act. Mills & Mills LLP will provide an update for employers and employees on current rights and obligations.

Register Now

Visit our **Webinars On Demand** web page to access our collection of previously broadcast sessions.

Webinars on Demand

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From: Jo-Ann Willson
Sent: Wednesday, February 19, 2020 4:11 AM
To: Rose Bustria
Subject: Fwd: 2020-02-18 OCA Weekly News: Advocacy Day 2020 + Webinars

Council.

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> **Date:** February 18, 2020 at 4:06:17 PM EST
> **To:** Jo-Ann Willson <jpwillson@cco.on.ca>
> **Subject: 2020-02-18 OCA Weekly News: Advocacy Day 2020 + Webinars**
> **Reply-To:** OCA <OCA@chiropractic.on.ca>

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Ontario Chiropractic Association

In this Issue:

Advocacy Day 2020

Upcoming Webinars

Advocacy Day 2020

Enhancing the Scope of Chiropractic Care in Ontario

OCA will be hosting Advocacy Day at Queen's Park tomorrow. During the lunch reception and in one-on-one meetings with Members of Provincial Parliament (MPPs), we will be advocating the call-to-action from our Red Tape Campaign. We will be sharing with MPPs and political staff how reducing unnecessary physician visits by giving chiropractors authority to order diagnostic tests, can improve patient care while saving Ontario's health system between **$15.1 and $23.7 million a year.**

Speaking at the OCA's Advocacy Day lunch reception will be (Progressive Conservative) MPP Robin Martin, Eglington Lawrence and Parliamentary Assistant to the Minister of Health, (NDP) MPP France Gélinas, Nickle-Belt and Health Critic and (Liberal) MPP John Fraser, Ottawa South, Interim Leader of the Liberal Party.

Dr. Ken Brough, Board Chair and Caroline Brereton, OCA CEO will be hosting

the event.

Look for a wrap-up of this important event in a future bulletin.

Upcoming Webinars

WHEN TO INCORPORATE A PRACTICE: CONVERTING A SOLE PROPRIETORSHIP TO A CORPORATION (REBROADCAST)

Wed. Feb. 19, 12 p.m. - 1 p.m.
Shayan Rashid, CPA, CA, SRJ Chartered Accountants

Find out how to convert a sole proprietorship into a corporation in Canada. Limited Liability Protection and Lower Corporate Tax Rate are explained thoroughly in this webinar.

Register Now

HOW THE WSIB IS TRANSFORMING PREMIUM RATE SETTING FOR ONTARIO BUSINESSES

Wed. Feb. 26, 12 p.m. - 1 p.m.
Janine Dyck, Vice President of Employer Services, WSIB Ontario

On January 1, 2020, the WSIB ushered in a new era of enhanced transparency and clarity in premium rate setting for almost 300,000 businesses across Ontario. Our new premium rate-setting model introduces new classifications for businesses, provides greater foresight into future rate changes and more insight around how your premium rate is set and adjusted. To

ensure a smooth transition to the new model, all premium rate changes will be staggered over three years.

497

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Rose Bustria

498

From: Jo-Ann Willson
Sent: Tuesday, February 11, 2020 9:17 PM
To: Rose Bustria
Subject: Fwd: 2020-02-11 OCA Weekly News: Advocacy Day 2020 + Practice Opportunity 2020 + OCA Aspire + Webinars + Coronavirus 2019 Update

Council.

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

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Begin forwarded message:

> **From:** OCA <OCA@chiropractic.on.ca>
> **Date:** February 12, 2020 at 12:43:56 AM GMT+2
> **To:** Jo-Ann Willson <jpwillson@cco.on.ca>
> **Subject: 2020-02-11 OCA Weekly News: Advocacy Day 2020 + Practice Opportunity 2020 + OCA Aspire + Webinars + Coronavirus 2019 Update**
> **Reply-To:** OCA <OCA@chiropractic.on.ca>

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Ontario Chiropractic Association

In this Issue:

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Practice Opportunity 2020

OCA Aspire

Upcoming Webinars

2019 Coronavirus Update

Advocacy Day 2020

Enhancing the Scope of Chiropractic Care in Ontario

OCA will be hosting Advocacy Day on Wednesday, February 19, at Queen's Park. During the lunch reception and in one-on-one meetings with Members of Provincial Parliament (MPPs), we will be advocating the call-to-action from our Red Tape Campaign. We will be sharing with MPPs and political staff how reducing unnecessary physician visits by giving chiropractors authority to order diagnostic tests, can improve patient care while saving Ontario's health system between **$15 and $23.7 million a year.**

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to the Minister of Health, (NDP) MPP France Gélinas, Nickle-Belt, Health Critic and MPP John Fraser, Ottawa South, Interim Leader of the Liberal Party.

Board Chair, Dr. Ken Brough and OCA CEO, Caroline Brereton will be hosting the event.

We will report back to you on this important event.

The annual Practice Opportunity event is back at the CMCC campus on **Wednesday, Feb. 12, 2020**.

OCA remains the event`s "Title Sponsor" by inviting leading chiropractors to be part of our popular Practice Realities Panel and following speed-mentoring session. Discussions will help new graduates navigate real-life career path challenges and accomplishments. The speed-mentoring session will offer students the experience and power of mentorship by connecting with established chiropractors.

Stay tuned for complete event highlights in an upcoming issue.

This year's mentors are left to right: **Dr. Alena Russo, Dr. Dwight Chapin, Dr. Evelyn Lock, Dr. Moez Rajwani (Moderator)**

Students will visit our booth where they can spend time with OCA team members to learn about membership benefits and our new ***OCA** Aspire* business solution.

501

Exclusive *OCA Aspire* News!

In our last bulletin, we shared with you how ***OCA Aspire*** can help you save on practice management costs. This week, we're excited to share with you the first of two new features for ***OCA Aspire 2.0—Kinduct***.

With ***Kinduct***, you will be able to upload either your own or over 5000 validated physical therapy exercise videos to your practice.

With ***Kinduct***, detailed 3D animation models are available to help you easily explain injuries to your patients.

With ***Kinduct***, a connection is provided to your patient's fitness tracker that will enable you to send surveys and journals to their text or email accounts for their review.

Videos, 3D animation models and fitness tracking data can be uploaded

remotely by you with the level of security that you expect from ***OCA Aspire***.

Remember, *OCA Aspire* 2.0 is coming soon – have you booked your demo?

Sign Up to Learn More

502

Upcoming Webinars

TEAMING UP: CRITICAL CONSIDERATIONS FOR ASSOCIATE AGREEMENTS (REBROADCAST)

Wed. Feb. 12, 12 p.m. - 1 p.m.
Heather Keachie, Mills & Mills LLP

Joining an established practice can be a great way to launch your career. Everyone starts these relationships intending to be respectful and prosperous. However, as in any business relationship, it is prudent to put the terms of the association down on paper. Not only does a written agreement ensure that all parties understand the terms, but this negotiation helps everyone

WHEN TO INCORPORATE A PRACTICE: CONVERTING A SOLE PROPRIETORSHIP TO A CORPORATION (REBROADCAST)

Wed. Feb. 19, 12 p.m. - 1 p.m.
Shayan Rashid, CPA, CA, SRJ Chartered Accountants

Find out how to convert a sole proprietorship into a corporation in Canada. Limited Liability Protection and Lower Corporate Tax Rate are explained thoroughly in this webinar.

Register Now

discuss details, issues, and future eventualities that you might not have otherwise considered. Heather Keachie will review the basic structure of an associate agreement, critical considerations to bear in mind when negotiating, and a few practical suggestions for common issues that arise.

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Novel Coronavirus 2019 Update

As of today, the novel coronavirus 2019 has surpassed 1,000 deaths in China. Locally, Ontario has tested 259 Ontarians with 8 remaining under investigation and 3 confirmed positive.

As you continue to monitor on behalf of your patients, it's important to be reminded, the symptoms of the novel coronavirus 2019, which can include fever and cough, are like other respiratory infections -- including influenza. As a result, individuals who may simply have the flu are being tested out of an abundance of caution and in line with Ontario's vigorous detection protocols. This means that most individuals who are tested are unlikely to be infected with the novel coronavirus 2019.

For more information on the novel coronavirus 2019 and the health care worker guidance document click on the button below,

Ministry of Health Link Here

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From: Jo-Ann Willson
Sent: Thursday, January 2, 2020 12:32 PM
To: Rose Bustria
Subject: FW: Happy New Year!

Exec and Council.

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*Note Address Change
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From: allianceforchiropractic.activehosted.com@s3.csa1.acemsd5.com <allianceforchiropractic.activehosted.com@s3.csa1.acemsd5.com> **On Behalf Of** Alliance For Chiropractic
Sent: Thursday, January 2, 2020 12:29 PM
To: Jo-Ann Willson <jpwillson@cco.on.ca>
Subject: Happy New Year!

ALLIANCE FOR CHIROPRACTIC

INTEGRITY - ACCOUNTABILITY - LEADERSHIP

Jo-Ann,

New Year's Greetings to you!

We at the Alliance For Chiropractic wish you and yours all the very best in the year to come!

As we look forward to 2020, the 125th anniversary year of chiropractic, we ask you as a colleague to reflect on where we have been the past twelve months and look beyond.

In our opinion, the public image of chiropractic profession may have been tarnished by our lack of resolve and lack of professionalism by some in managing ourselves as colleagues both in the public forum and privately within our profession.

In the interests of the public, we ask for continued demonstration of maturity and respect for the diversity that Canada bases and prides itself on. If you observe bullying, marginalization or intolerance towards colleagues we ask you to document and report the behaviour. Do not engage.

It is our sincere hope that in 2020 we can all put aside our collective differences and find common ground.

Whether you manage and treat MSK, care in a NMSK, salutogenic, crisis models or combination thereof in an evidence-informed framework, we believe that our common ground is that we can all agree that:

A properly functioning spine and nervous system is essential to optimal human health and performance regardless of age or condition.

Within the scientific literature, we have ample understanding of the basic sciences to support the above statement.

Our clinical sciences are developing as a profession from within and externally. Both the MSK science is developing as we learn about the role of chiropractic in back pain and the opioid crisis, and in the non-MSK arena as we learn about how the adjustment improves and changes cortical function. We are building our understanding and confirming what many predecessors thought was possible but didn't have the technology at the time to prove.

The AFC believes that this is a very exciting time with abundant possibilities for the profession.

At this time, we have many choices. We can recognize the strengths and the assets we have as a profession. Alternately, we can allow inside and outside detractors to purposefully marginalize to contain and divide chiropractic to minimize or worse, eliminate our growth. We believe it is in the patient centric model for the public of Ontario to have continued unencumbered and unobstructed access to chiropractic care maximized within our scope of practice.

Here are our wishes for 2020:

1. Immediately cease interactions with the media. We have observed a biased agenda of a few designed to decrease public opinion and trust. Communicating and colluding with the media to "eradicate" a certain type of Chiropractor or style of practice only sullies the voice of Chiropractic. Many who have chosen to do so, do not seem to have the foresight to see that these particular media detractors want to see the entire profession cut at the knees, not just a certain type of practitioner. It will only be a matter of time before they come for them too. Report being approached. There is an agenda and it is designed to obfuscate, marginalize and distort what we do and why we do it. It is not in the public interest nor in the interest of fair and accurate journalism. It serves the interests of their agenda.

2. Be professional and include ALL researchers at summits and gatherings of the scientific minds. The principles of science demand objectivity. The exclusion of the collective body of research reeks of a directive that ties in with Wish #1. There is a mass of us who resonate and collectively support the proposition statement above. Research should focus on science not politics or opinion pieces as we move forward.

3. In the study of ethics, it behooves one to support contradictory values. We suggest it is time to stop supporting the people and organizations that are working to limit the profession. Whether by the research they conduct or support, the direction they wish to see the profession move, the position statements they choose to make, or how they support you as a practitioner in your practice. Your support, financially or otherwise, only promotes their directives. Let them know why you choose to stop supporting them too. They need to hear from you too.

And support those you fundamentally agree with. Like our patients in evidence- informed care, engage with and support those who have similar values, wishes and ideals.

4. Get involved. Share your voice and solutions. Write letters to support or provide constructive feedback on what would make things even better. Speak and connect with your colleagues. Perhaps get involved and run for positions on boards. Be an active participant in your profession and your practicing future.

5. We ask you to reflect on your ability to change a person's life with your two hands and your education. It is exceptional. Don't be made to feel any other way.

6. Connect with your community in greater ways this year. Want to see Chiropractic flourish? Expand your reach into your community and let them know more about what you do. See Wish #5.

7. Take a different perspective when communicating through your outreach media be it website, social media or other. Can you connect with others and be even more accurate and helpful? Perhaps use references, cite sources. Perhaps the best advise at times might be to disengage in some conversations. We ask you to pause, reflect and consider before communicating.

The Alliance For Chiropractic stands for the growth of Chiropractic as a profession that is:

- Inclusive
- Non discriminatory
- Pro freedom of choice over a patient's self-autonomy of their body

- Pro Informed consent for ALL healthcare decisions
- Evidence Informed
- Patient-Centred Care
- Supportive of the above proposition statement
- Respectful of the inherent differences among us
- Professional

To our best,

Craig Hazel - Chairman

Alliance For Chiropractic
17A-218 Silvercreek Pwy N, Suite 126
Guelph, ON N1H 8E8

Toll free: 1-877-997-9927
allianceforchiropractic.com

Sent to: jpwillson@cco.on.ca

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From: Jo-Ann Willson
Sent: Wednesday, January 22, 2020 6:41 PM
To: Rose Bustria
Subject: Fwd: CCPA Communiqué

Exec and Council.

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Registrar & General Counsel

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From: CCPA <admin@ccpaonline.ca>
Date: January 22, 2020 at 2:02:00 PM EST
To: drmizel@stcatharineschiropractic.com
Subject: CCPA Communiqué
Reply-To: admin@ccpaonline.ca

CANADIAN
CHIROPRACTIC
PROTECTIVE
ASSOCIATION

CCPA Communiqué

January 2020

A message from the new CEO

Dr. Dean J. Wright

Change is a certainty in life. It's as true for companies as is it for individuals. CCPA has undergone some significant changes; we've said goodbye to a valued leader and a new corporate executive team is in place. Though the positions have changed, the faces are the same and our commitment to you and the profession is as strong as ever. We want you to know that we are here for you at all times, so you can focus on providing top-quality care to your patients. Because while that's *your* calling, ours is providing protection and support for you and our profession.

The growth and evolution of chiropractic is dependent on the good work of chiropractors and our partners – from caring for patients and educating a new generation of practitioners, to undertaking important research and advocating for and guiding the profession. We all have our work to do, and it will require our collective effort to continue the advancement of a profession we are proud to be part of.

The devil is in the details

A new year is a great time for a healthy dose of self-reflection. Why not reflect on your practice while you're at it?

It's called practice for a reason. As a trained and accomplished DC, you are an expert – but you're also learning with each new patient case because humans are complex. When you approach patient care, you bring with you your scientific training, manual skills, experience as a doctor and general life experience. You apply all this to the issue in front of you – it's a pretty awesome feat when you really think about it. As you go about your clinic hours this year, be sure to keep the following considerations top of mind to continue learning and protecting yourself and your patients.

- **Listen to your patient.** Did they mention some recent or historical trauma? Did they say they have some tingling in their toes? These things need to be evaluated. Your education and training have shown you the fine line between efficiency and a missed diagnosis.
- **Don't rush exams.** You are looking for patterns while also keeping an eye out for outlying symptoms and red flags. To make an optimal decision about treatment (or to recognize when not to treat), you need information. So be thorough when you examine patients and don't make assumptions.

- **Avoid the temptation to cut corners.** Rule in and rule out your considerations for a diagnosis. Be aware of any valid and reliable testing and note all your findings in your file.

And as we always say, if you're ever in doubt about a patient situation, call us. We're here to help at 1-800-668-2076.

New on the CCPA member portal

Want to know more about what our claims team does? Have you heard of our LicenseAssist program but wondered what it entails? Meet our claims team through video as they explain our core offerings on a new "Your Protection" page on the CCPA member portal. Click here to check it out.

Our records indicate you prefer receiving correspondence in English. To update your communication preferences please contact us at admin@ccpaonline.ca.

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ITEM 4.2

Submitted, February 19, 2020

College of Chiropractors of Ontario
Advertising Committee Report to Council
Wednesday, February 26, 2020

Members: Dr. Brian Budgell, *Chair*
Dr. Paul Groulx
Mr. Rob MacKay
Dr. Janine Taylor, *non-Council member*

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

Meetings

Since the last meeting of Council, the Advertising Committee has met once in person on January 10, 2020.

Recommendations

The committee has no recommendations to present to Council at this time, but has provided a draft handbook on advertising to the Executive Committee for its consideration.

Committee Work

The Advertising Committee has developed a handbook to explain to members the do's and don't's for advertising that are consistent with the standard and guideline. The handbook is based on a review of advertising previously submitted to the committee, taking into account those practices which were most often felt to contravene the standard or guideline. The handbook includes criteria according to which a practitioner may claim to treat particular diseases, and this is based on levels of evidence for effectiveness, rather than a proscriptive list of diseases. This work has been submitted to the Executive Committee for its consideration.

The committee has previously presented to Council the suggestion of creating an advertising workshop, akin to the record keeping workshop, and amending the advertising review protocol to shift some of the workload to the member.

A previous initiative to introduce evidence-based standards for advertising has encountered headwinds and is not now being pursued by the Advertising Committee.

Acknowledgements

I would like to thank professional members Dr. Paul Groulx and Dr. Janine Taylor, public member Mr. Rob MacKay, and support staff Mr. Joel Friedman and Ms Andrea Szametz for their valuable contributions to the work of the advertising committee.

Respectfully submitted,

Dr. Brian Budgell
Chair, Advertising Committee

Submitted February 18, 2020

College of Chiropractors of Ontario
Patient Relations Committee Report to Council
February 26, 2020

Members: Ms Karoline Bourdeau, *Chair*
Dr. Steven Lester
Ms John Papadakis
Dr. Angela Barrow, *non-Council member*
Dr. Nicole Thornicroft, *non-Council member*

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

I. Introduction and Recommendations

The Patient Relations Committee met once on January 22, 2020 since the last meeting of Council.

Recommendation 1

That Council approve development of a short video produced by Mr. Rolph Scharwz and Millennium Media for a cost of approximately $5000 to provide an introduction to CCO and the Partnership of Care.

The Patient Relations Committee has been working on developing video content to accompany a future distribution of the Partnership of Care. The Committee reviewed several samples and proposals from various vendors and concluded that the submission from Mr. Rolph Schwarz has the most professional look, is consistent with CCO's mission, vision, values and strategic objectives and is cost-effective. A 40 second sample will be available for viewing at the February 26th Council meeting. The Committee's objective is to develop this video for initial viewing at the June AGM. The Committee also sees this as an opportunity to possibly develop future videos in other CCO areas.

The Committee thanks CCO Public Member Ms Sheryn Posen for putting CCO in touch with Mr. Schwarz.

II. Ongoing Business

The Patient Relations Committee continues to work on a number of priorities for 2020, including:

- Developing scenarios for an upcoming newsletter on privacy issues.
- Updating the "Members of the Public" section of CCO's website, including the inclusion of more photos of members of the public and including more links on the homepage.
- Attending a meeting of the Citizen's Advisory Group and collecting further information about the costs and benefits of possibly joining this group.
- Monitoring and approving funding for therapy and counselling.

561

III. Acknowledgements

Many thanks are extended to the members of this committee Mr. John Papadakis, Dr. Steven Lester, Dr. Angela Barrow, and Dr. Nicole Thornicroft.

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

Sincerely,
Ms Karoline Bourdeau
Chair, Patient Relations

ITEM 7.1

581

LIFE CHIROPRACTIC
COLLEGE WEST

Express your potential

Perspective on chiropractic research in Canada

December 17, 2019 *by Guest Writer* *Comments are off*

By Austin Bergquist, PhD

It is a wonderful time to be a chiropractor in Canada. The profession has witnessed a gradual increase in utilization since the 1980s, women and diverse populations represent a greater proportion of the profession than ever before, and research activity designed to understand how chiropractic works and how to make it better has never been more productive.

However, low trust from the public and allied medical professions remains a major barrier to widespread chiropractic consumption. To address this issue, among other concerns, the Canadian Chiropractic Association now strongly encourages chiropractors to adopt an evidence-based practice model in their patient care.

Dr. Austin Bergquist

From its inception in the early 1990s, the phrase "evidence-based practice" has meant that clinical decision-making should be guided ultimately by a balance between the implicit knowledge that accumulates through clinical experience, the personalized preferences of the patient, and knowledge gleaned from outcomes of high-quality scientific research studies. However, in Canada, the balance has shifted in recent years. A disproportionate emphasis has been placed on the importance of high-quality scientific research evidence.

Specifically, if a clinical decision lacks demonstrated value in the form of a randomized controlled trial, the gold standard in scientific research design, then that clinical decision is considered unsupported and falls outside the boundaries of evidence-based practice, regardless of the "lesser quality by design" literature base that may exist, as well as the personalized clinical reasoning or patient preferences that may have informed the decision.

The move toward such a research-focused practice is done with the best of intentions. The scientific research process is viewed as our most reliable method of generating knowledge unencumbered by confounding variables, such as the many forms of bias that can systematically hijack the truth. However, the problem with relying so heavily on research evidence when guiding clinical decision-making is that most research evidence lacks the ultimate objectivity it is designed to provide and carries a number of limitations often overlooked by its advocates.

THE MAGAZINE OF LIFE CHIROPRACTIC COLLEGE WEST

Recent News & Updates

- Does biohacking technology have a place in the chiropractic industry?
- Perspective on chiropractic research in Canada
- Experience at India service trip transforms student's approach
- Life West chiropractic clinic in India flourishes
- Life West research prioritizes Vitalism, objective biomarkers that give insight to optimization of health

Categories

- Academics
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582

Replicating results

Let us consider a limitation generalizable to all research. An important step in the scientific research process involves the confirmation or "replication" of research findings by others within the scientific community. Until the research finding is replicated, it is unclear whether the finding represents the truth, or whether it is a result of something unique to the scientists who conducted the experiments. Unfortunately, replication is rarely undertaken because it is not incentivized within the current research climate. Funding agencies, journals that publish research, and university or college faculties that determine which scientists are hired and which receive tenure, are only interested in who made the initial research "discovery," not in who reproduced it.

However, when replication studies are undertaken, more often than any scientist would like to admit, published research findings are unsupported or even refuted by subsequent research evidence. The pressure to find something in academia is immense, and whether done intentionally or unintentionally, research outcomes are often subjected to the needs and desires of the scientists conducting the experiments. This widespread phenomenon, known as the replication crisis, describes how only a fraction of published literature can be reproduced, calling into question the utility of research findings in clinical practice. When replication studies become incentivized and integrated more deeply into research culture, scientists will be held more accountable for their findings, and subsequently, the reliability of their findings will carry more utility in clinical decision-making.

Research funding in Canada

Let us now consider a more nuanced limitation specific to chiropractic research in Canada, a portion of provincial licensing fees collected from every chiropractor is directed to the Canadian Chiropractic Association's research foundation, the Canadian Chiropractic Research Foundation. The mission statement of the Foundation is to "fund research to improve the lives of people living with musculoskeletal pain and disability." Accordingly, much of the high-quality chiropractic research coming out of Canada has taken a musculoskeletal pain-based approach. It is thanks to this work that chiropractors in Canada are becoming known to the public as back pain, neck pain and headache "experts."

Arguably, the effects of chiropractic are broader in scope than the musculoskeletal pain-based mission of the Canadian Chiropractic Research Foundation. Patients regularly report relief of non-musculoskeletal pain, and even seek preventive chiropractic care to stay healthy. However, the burden of proof falls on the vitalistic chiropractor to generate research evidence. Unfortunately, research proposals investigating such vitalistic-based health outcomes are unlikely to be funded by the Canadian Chiropractic Research Foundation, a funding body that receives funding from both mechanistic and vitalistic chiropractors.

A Catch-22 for Vitalism

The vitalistic chiropractor is caught in a Catch-22. Their association pushes for them to align with evidence-based practice that relies heavily on research evidence but tends not to fund research that represents their full experience in practice. The kicker is that the vitalistic chiropractor has no say how their licensing money is used and is beholden to support the mechanistic agenda of the Canadian Chiropractic Research Foundation; the epitome of circular logic.

The problem is compounded further by the association acknowledging only research evidence generated by randomized controlled trials in the development of their clinical practice guidelines. Since there has been little research funding directed toward vitalistic-based health outcomes, there are very few randomized controlled trials investigating these outcomes. Importantly, we should remain aware that a properly conducted and

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583

objective research study of "lesser quality by design" is far more valuable than a compromised "gold standard." At present, there is considerable opportunity to improve upon research in this area and to expand the chiropractic evidence-based scope of practice. We must remain cognizant that research funds are limited and that we owe it to our patients to be responsible shepherds of the funds available.

Informing the 'gold standard'

Evidence-based practice has not solved what it has intended, in large part due to the disproportionate emphasis that has been placed on the importance of only "gold standard" research evidence. Rather than do away with evidence-based practice, I support the growing movement to re-adjust the balance placed on the original tenants of evidence-based practice.

In its ideal form, evidence-based practice is an iterative process, whereby clinical experience and patient preferences inform research inquiry while research outcomes inform clinical reasoning, and so on. If done compassionately with our patient's best interests at heart, research evidence can be a valuable addition to clinical decision-making.

About Austin Bergquist

Austin Bergquist, PhD, earned his doctorate degree in Neuroscience at the University of Alberta (funded by Alberta Paraplegic Foundation). He has completed a post-doctoral fellowship at the Toronto Rehabilitation Institute (funded by the Canadian Institutes of Health Research). He has researched novel methods of generating fatigue-resistant muscle contractions through spinal reflex pathways in people who experience paralysis due to spinal cord injury, and he is currently studying at Life Chiropractic College West to become a fourth-generation chiropractor.

About the Author

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From: Jo-Ann Willson
Sent: Friday, January 24, 2020 10:12 AM
To: Rose Bustria
Subject: FW: Nov 2011 Chiropractic Report "After the Storm-What Have We Learned" - Dr Richard Brown

Exec and Council.

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From: Jo-Ann Willson
Sent: Friday, January 24, 2020 10:12 AM
To: 'Harald Simon' <hfsimon@amtelecom.net>
Cc: 'Kristina Peterson' <kristyp@tbaytel.net>; Dennis Mizel (drmizel@stcatharineschiropractic.com) <drmizel@stcatharineschiropractic.com>
Subject: RE: Nov 2011 Chiropractic Report "After the Storm-What Have We Learned" - Dr Richard Brown

Thank you for your further communication. In general, if information is to be included in the Council information package, there should be a direct relationship to CCO's public interest mandate. For example, this article is relevant to the CCO's public interest protection in the following ways: ... The Council information package will not be prepared until closer to the meeting, and the materials will be published in the ordinary course. Information concerning the tender for software will be reported to everyone at the same time and in the same way. I know the Quality Assurance Committee is working on this, and I expect they will have recommendations for Council's consideration.

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From: Harald Simon <hfsimon@amtelecom.net>
Sent: Friday, January 17, 2020 2:11 PM
To: Jo-Ann Willson <jpwillson@cco.on.ca>
Subject: RE: Nov 2011 Chiropractic Report "After the Storm-What Have We Learned" - Dr Richard Brown

Thanks for your prompt reply and forwarding of Dr Brown's landmark speech for consideration in the FYI of the Feb 26/20 Public Council Package. Your use of "but" implies the president, in his wisdom, will reject it. That would be unfortunate at a time when the Ontario chiropractic brand is in decline in part due to CCO advertising regulation being reactive rather than proactive. I can attest that Dr Brown is a significant international chiropractic leader from meeting him at a ECU conference in Zurich. Please let me know what the president's decision is.

I would also appreciate an answer to the query in my Jan 14/20 email as to the status of the CCO tender for software to monitor registrants' websites for keywords.

Dr Harald Simon

From: Jo-Ann Willson [mailto:jpwillson@cco.on.ca]
Sent: Thursday, January 16, 2020 12:57 PM
To: Harald Simon
Cc: Caroline Brereton; shawn@rrseducation.com
Subject: RE: Nov 2011 Chiropractic Report "After the Storm-What Have We Learned" - Dr Richard Brown

Thank you for forwarding this. The agenda for Council meetings is set by the President, but I will forward it for consideration of inclusion in the FYI of the Council information package.

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From: Harald Simon <hfsimon@amtelecom.net>
Sent: Tuesday, January 14, 2020 6:40 PM
To: Jo-Ann Willson <jpwillson@cco.on.ca>
Cc: Caroline Brereton <cbrereton@chiropractic.on.ca>; shawn@rrseducation.com
Subject: Nov 2011 Chiropractic Report "After the Storm-What Have We Learned" - Dr Richard Brown

Dear Ms Willson,

While sorting out some files, I came across this eminently germane speech by Dr Richard Brown. I would suggest it be included in the February 26/20 Public Council Package as a classic piece of advice that behooves everyone in the chiropractic regulatory business to be reminded of. Perhaps it would serve to enlighten those long standing elected Council members, whose inappropriate tenure abetted by bad

bylaws, from over staying their usefulness after losing sight of a realistic chiropractic horizon and stymieing new ideas. For example on page 2, software packages to search for key words in chiropractors' websites were already in use 10 years ago. At what stage is this initiative that CCO was looking to tender out last year?

587

Please let me know what you think.

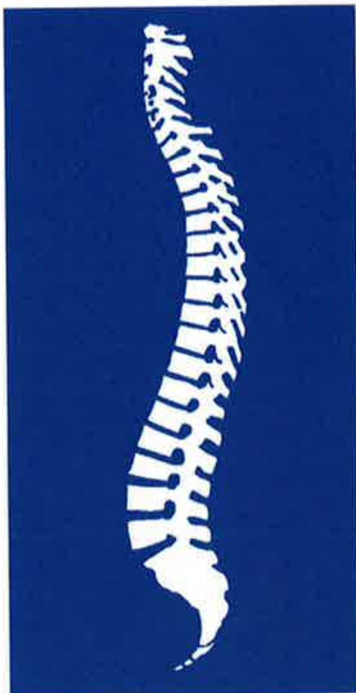
Thanks for your kind attention to this matter.

Sincerely,

Dr Harald Simon

The Chiropractic Report

www.chiropracticreport.com Editor: David Chapman-Smith LL.B. (Hons.) November 2011 Vol. 25 No. 6



After the Storm – What Have We Learnt?

Dr Richard Brown, both a chiropractor and lawyer with a Doctor of Chiropractic degree from the Anglo-European Chiropractic College and a Master of Laws from the University of Cardiff, is a practising chiropractor in Stroud, Gloucestershire, in the United Kingdom.

He has been President of the British Chiropractic Association (BCA) since 2009, at which time the BCA was in the midst of a prolonged libel court case with Simon Singh, a well-known UK author and scientist.

At the same time the chiropractic profession in the UK was being subjected to an orchestrated attack from sceptics that led to unprecedented media criticism and 718 complaints of professional misconduct against many BCA members and others. It was these two matters, the hard fought legal battle and the unprecedented media and regulatory attacks, that comprised the Storm referred to in the title above.

In 2011 Dr Brown was elected to the Executive Council of the European Chiropractors' Union (ECU).

The following speech, then titled After the Storm: Strategic Objectives in Europe, was given by him last month at the 2011 Conference of the Chiropractic and Osteopathic College of Australasia in Melbourne, Australia.

In it he reflects upon the Storm and lessons learnt, and speaks candidly and eloquently about the shortcomings he sees in the profession and what must be done about them. His direct experience is in Europe, but his words are of relevance to chiropractors everywhere.

The last issue of this Report focused on the importance of the philosophy of chiropractic. This issue brings you a chiropractic leader warning against inappropriate exploitation of that philosophy, and delivering an earnest call for more consistent ethics and maturity in the profession.

THERE HAVE BEEN SEVERAL defining moments in chiropractic throughout its 116 year history. Its turbulent journey from obscurity to becoming a recognised healthcare profession has been characterised by infighting, conflicting ideologies and external persecution. Yet in 2009, events in the UK took a turn which was to consume the British Chiropractic Association (BCA) for two years and force the wider profession to confront key issues that for decades had kept it distanced from its medical counterparts and attracting ridicule from its critics.

Chiropractic in the UK had long faced criticism from its nemesis, Edzard Ernst. The world's first professor of complementary medicine, now retired from the University of Exeter, became the foremost critic of chiropractic, challenging its track record on safety, effectiveness and the making of outlandish claims. Throughout his career, Ernst pursued a damning condemnation of many forms of complementary and alternative medicine, but for reasons that still elude us, reserved his most poisonous venom for the chiropractic profession.

Richard Brown DC, LL.M, FEAC

Professional Notes

Mechanisms of Action of Manipulation in LBP Patients

A study just published in *Spine* is the first to investigate the specific mechanisms of action of spinal manipulation in patients with back pain, and at the same time to show the correlation between those and clinical improvement. Previously many mechanisms of action have been demonstrated, usually in asymptomatic subjects. However the matter of how spinal manipulation works has not been directly linked to clinical improvement and subjected to reliable measurement.

The study is from Julie Fritz, PT PhD, Shane Koppenhaver, PT PhD, Greg Kawchuk DC PhD, Jeffery Hebert DC, PhD et al., an interdisciplinary team of prominent physical therapy and chiropractic researchers in the US and Canada. It concludes that the following two effects or underlying mechanisms of action of spinal manipulation measured in the trial correlate with and may explain improved clinical results:

a. Immediate decrease in global stiffness

continued on page 4

Yet the figure whose words were to spark controversy and ignite a firestorm of antipathy against the chiropractic profession was not Ernst, but a young scientist, documentary-maker and author whose brand of pop science had made him a successful and well-connected figure. Simon Singh was someone who had not previously featured on the chiropractic radar, yet his encounter with the profession left an indelible print on the profession not only in the UK, but around the globe.

Co-author with Ernst of *Trick or Treatment; Alternative Medicine on Trial*, Singh promoted his book by writing a piece in the UK's *Guardian* newspaper in which he was critical of a patient information leaflet produced by the BCA called *Happy Families*, which made claims of effectiveness for chiropractic treatment of a number of childhood disorders, including colic, asthma and bedwetting.

Singh claimed that the BCA 'happily promotes bogus treatments' even though there was 'not a jot of evidence'. The BCA was faced with a dilemma. Did it sit by and permit an assault on its reputation and good name, or did it stand up for its members and challenge the criticism? For years, chiropractic had been castigated in a succession of critical articles, but here was a published article which had explicitly named a chiropractic association and had made defamatory comments about it.

The BCA took advice from a leading specialist London libel lawyer, and was told that it had a cast-iron case. A number of meetings took place and the BCA also sought advice from other sources, including leading academics. Faced with a decision to either meet the criticism with silence or confront the issues head on, the BCA wrote to Simon Singh and demanded an apology and a retraction. He refused.

In a move largely unexpected by many, rather than sue the newspaper, the BCA sued Simon Singh personally for libel. In doing so, the BCA began one of the darkest periods in its history; one that was ultimately to cost it financially, reputationally and politically. *(In a preliminary hearing, the UK's leading libel judge, Mr Justice Eady, ruled in favour of the British Chiropractic Association but following an appeal in the Court of Appeal, the decision was overturned, forcing the BCA's withdrawal from the case and leaving it responsible for its and Dr Singh's legal costs.* Ed.*)*

The action galvanised the UK and world media. Never before had the media focused its attention so much on the profession, nor had been given the opportunity to subject it to so much vitriol.

With what they saw as one of their own being hauled over the legal coals amidst claims of an assault on free speech, an army of scientists, sceptics and comedians was mobilised to disgrace, degrade and demolish the chiropractic profession. Cabinet ministers, BBC journalists and erstwhile Members of Parliament also joined the fray, determined to pitch in and use the case to reform what they claimed were Britain's draconian libel laws.

In using the case as a powerful vehicle to promote his Sense About Science campaign, Singh's crusade mobilised a dark force of UK sceptics who suddenly found their raison d'être, shifting their attention from the fairy tales of homeopathy to the cure-all claims of chiropractors. Following a call to action, an army of PC pilots and laptop lizards began a war which was to lead to one in three UK chiropractors facing formal disciplinary proceedings from its regulator, the General Chiropractic Council.

Using a software package to highlight key words in chiropractors' websites, claims were uncovered relating to everything from haemorrhoids to hair loss, chlamydia to cancer. A total of 718 complaints were made to the General Chiropractic Council (GCC), alleging that chiropractors were misleading the public and exploiting their lack of knowledge over health matters. The GCC faced fitness to practice hearings on a scale previously unknown in the healthcare regulatory world.

Chiropractors were under assault. As the process rumbled on, and Singh crowed from the rooftops following a favourable judgment in the Court of Appeal, one in three chiropractors was facing the misery of prolonged formal regulatory proceedings.

The GCC itself was in an unprecedented situation. Faced with a 1500% rise in complaints, Investigating Committees were assembled to determine whether there was a case to answer. Temporary staff were drafted in to deal with the workload and the solicitors appointed by the GCC to prosecute the complaints found that all their Christmases had come at once. To the surprise of many, seemingly fuelled by the actions of regulatory staff and buoyed by the commissioned report of Dr Gert Bronfort, the Investigating Committee referred most complaints to the Professional Conduct Committee and a mass of hearings were scheduled. As a recipient of three separate allegations I can attest to what was for many a deeply stressful and miserable period for UK chiropractors.

Following a robust legal defence mounted by the BCA on behalf of its members, over 91% of the allegations against chiropractors were dismissed as being not proven. For the first time in two long years, BCA chiropractors could sleep a little easier and move on.

However, the genie was out of the bottle. Once again, questions surfaced as to whether chiropractors were serious,

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science-based, evidence-informed healthcare professionals or, as the media portrayed, simply profiteering, pseudomedical quacks? For the BCA and the chiropractic profession, it was time to reflect, learn lessons and define strategic objectives.

The UK experience highlighted a longstanding schism in the wider chiropractic profession between those who seek to deliver evidence-based care and pursue a research driven agenda, and those who seek to uphold and promote the chiropractic of yesteryear; those who cling to an unwavering principle that the vertebral subluxation complex is the cause of illness and disease; and those who decry integrating with mainstream healthcare on the misguided assumption that it will sound the death knell of chiropractic as a 'separate and distinct' profession.

Some may say that we owe Simon Singh a debt of gratitude. His newspaper article, his confrontational stance and his defiance in standing up to UK libel law has all made us, at long last, recognise what, to be fair, many chiropractic researchers have been telling us for years. If we are ever going to get anywhere near being accepted by the wider healthcare community – and, let's face it, for us to move forward as a respected profession we need that acceptance – we need to know who we are, know what we do and know why it works. It is no longer good enough in 2011 for us to expect chiropractic to survive on outdated dogma.

The scrutiny that chiropractic now enjoys as part of the regulated framework in many countries must be matched by a public distancing of historical theories that have long since lost support in any scientific forum and should now be consigned to the annals of history. It is right that we should not forget the past, but not right that we should live in it.

To move the profession forward in Europe, the European Chiropractors' Union (ECU) has embarked on a new strategic project called Vision 2020. Vision 2020 is about looking at where we are today and seeing where we want to be in 2020. It is unashamedly aspirational. Through engaging with the 20 national association member countries of the ECU, we are working to identify what we consider to be our strengths and our weaknesses, seeing what opportunities exist and being alive to the threats to the stability and success of the profession.

Vision 2020 is about European chiropractors being honest with themselves and taking a reality check. What is clear at present is that while some European nations have it all in terms of legislation, credibility, integration and publicly funded university-based education, others have nothing. There are stark contrasts between the haves and the have-nots. To understand these contrasts is to understand attitudes and beliefs, deeply ingrained prejudices and political motivations, both within and outside of the profession.

Yet as was seen in Switzerland throughout the evolution of the chiropractic profession during the twentieth century, the vision and tenacity of even a small number of individuals can influence the direction of travel in the chiropractic profession. The status of Swiss chiropractic as a mainstream medical profession, revered by the public, reimbursed by the state and respected by medical colleagues, is testament to an uncompromising commitment to quality standards of education and practise. Norway and Denmark share similar stories, the latter now considered the world's most striking chiropractic success story with quality education, public access to care and an unrivalled commitment to research.

What has become immediately evident during the early stages of Vision 2020 is that there is a need for a far clearer identity for the European chiropractic profession. What do we stand for?

Chiropractic, when compared to medicine and dentistry, remains in a period of teenage angst. It demands to be listened to, yet at times struggles to articulate itself in a way that mainstream healthcare will tolerate. It speaks in its own language, yet often fails to realise that others in healthcare may not comprehend. It insists on acceptance, yet sometimes displays an inflexibility that seemingly shuns the notion of true integration.

There is currently a blurred image of the profession and an unclear scope of practice that results in inconsistent perceptions and mixed messages. The images of chiropractic from one European country to another could not be more different. Scientists and subluxationists have carved up the continent and the great divide is reflected in pockets of great success and pockets of abject failure. While some countries have embraced the need to focus on achieving credibility through research and integration, the stability of others is being jeopardised by groups wishing to stay distanced from the concept of evidence-based care and lifelong learning.

The events of the past two years have exposed a blind adherence to outdated principles amongst a small but significant minority of the profession. Mindful of the adage that it's the squeaky wheel that gets the grease, the vocalism of this group has ensured that chiropractic is characterised by its critics as unscientific, unsafe and slightly wacky. Claims that the vertebral subluxation complex is the cause of illness and disease have persisted despite the three UK educational establishments advising the GCC that no evidence of acceptable quality exists to support such claims.

So why do we find graduates of the Anglo-European College of Chiropractic (AECC) and Welsh Institutes of Chiropractic (WIOC) manning Subluxation Stations in supermarkets and shopping malls and advising their unwitting patients that spinal decay is the deadly consequence of uncorrected subluxation? Why is it that the graduates of some of the Europe's most established chiropractic programmes decide that surface electromyography and similar electrical gadgetry is the default diagnostic technique and the preferred method of securing the compliance of vulnerable patients? Why is there a surge in practice building seminars promising financial reward and a utopian work-life balance?

Sadly, with the stark realisation that the cake is being sliced ever more thinly, combined with student debt and escalating living costs, it is unsurprising that new (and not-so-new) graduates are seeking innovative ways of making a living. Inevitably, however, innovation for some means sailing closer to the wind than ethics and professionalism permit. Cue one sceptic feeding frenzy and a panoply of Ernst-fuelled editorials.

The idea that somehow achieving a subluxation-free world will be the panacea for all ills has to be publicly debunked. Moreover, cheap public denouncements of standard medical care whilst at the same time lauding the near-magical effects of the spinal adjustment must stop.

continued on page 7

The Chiropractic World

Mechanisms of Action of Manipulation in LBP Patients
continued from page 1

of the lumbar spine, objectively measured at the L3 spinous process by a mechanised instrument and a protocol developed by Dr. Greg Kawchuck a chiropractic scientist at the University of Alberta in Edmonton, Alberta, Canada. The probe of the instrument applied an increasing force from preload 5 Newtons to a final load of 60 Newtons to the patent lying prone.

Measurements recorded were global stiffness (slope of the force displacement curve between 5 N and 60 N) and terminal stiffness (the ratio between the applied maximal force and resultant maximal displacement). Patients with greater immediate decrease in global stiffness after thrust manipulation had better clinical results.

b. Improved recruitment of the lumbar multifidus (LM) muscle, with change in muscle function measured by ultrasound.

The authors describe these as preliminary results, which need confirmation and expansion in further research, but that their study "provides important advances in understanding the hypothesized relationship between SMT and spinal stiffness." Summary points are:

a. **Patients.** This study involved 48 adult patients with low-back pain, with or without leg pain, but no red flags and not treated with spinal manipulative therapy (SMT) within the past four weeks. They received two SMT treatment sessions 3-4 days apart. At these there was pre- and post- SMT spinal stiffness and lumbar multifidus (LM) recruitment assessment. At a third visit after another 3-4 days there was no treatment but further assessments. SMT technique involved posterior-inferior thrusts applied by a DC or PT to each side of the patient's pelvis during each session.

b. **Improvement in LBP.** The major outcome measured was improvement on the Oswestry Disability Index (ODI)

c. **Measurements of spinal stiffness and LM recruitment.** Spinal stiffness was assessed at the L3 level "because motion at the L3/L4 segment is less likely to be painful and does not differ from L4/L5 motion, the level from which the LM measures were taken." Load was applied three times at each assessment, with values averaged.

With respect to LM recruitment, "Thickness of the LM at L4/5 on the patient's more symptomatic side was quantified during submaximal contraction using an ultrasound imaging protocol with documented reliability. Contraction was elicited by the prone patient holding a 1 to 2 kg weight and lifting the contralateral arm approximately 5 cm, resulting in approximately 30% maximal voluntary LM contraction. Image acquisition was performed three times. Measures were averaged to reduce variability."

d. **Results.** There were significant improvements in ODI scores following each treatment session. Stiffness and LM recruitment measurements and analysis suggested:

- "The effects of SMT may be mediated by both immediate global stiffness (GS) changes and enhancement of LM recruitment".
- Level of initial terminal stiffness (TS) influences the ability to improve the LM recruitment with SMT. So does the matter of whether or not the patient falls within a clinical prediction rule (CPR) developed by Fritz et al. and described in the paper.

A further interesting observation by Fritz, Koppenhaver, Kawchuck et al. is that manipulation may be superior to mobilization in reducing spinal stiffness. Previous studies using mobilization "failed to identify an immediate effect of non-thrust mobilization on stiffness". Here the authors found immediate stiffness reduction after manipulation and "a significant relationship between immediate post-SMT stiffness decrease and clinical outcome. This finding may suggest a relationship between stiffness change and outcome for thrust SMT that is not present if nonthrust mobilization techniques are employed."

(Fritz JM, Kopperhaven SL, Kawchuk GN, et al. (2011) *Preliminary Investigation of Mechanisms Underlying the Effects of Manipulation*, Spine 36: 1772-1781)

Other Research

1. Australia. LBP – A New and Better Classification of Sub-Groups

Authors in the paper discussed above include Julie Fritz, PT, PhD, of the University of Utah and Jeffery Hebert, DC, PhD, formerly of the University of Utah but now at the School of Chiropractic and Sports Science at Murdoch University, Perth, Australia. Hebert has been a leader in an important new research undertaking – development of a treatment-based classification of patients with back pain.

This replaces traditional pathology-based classifications. It categorizes patients into 1 of 4 sub-groups – those who should primarily receive either spinal manipulation, stabilization exercise, end-range loading exercise or traction. There are now controlled trials showing much better results when patients are treated according to these subgroups.

Hebert and colleagues, including Bruce Walker, DC, MPH, DrPH also of Murdoch University and Editor for the online journal Chiropractic and Manual Therapies, have just summarized this new approach to classification and the evidence in support. This is in a paper titled *Sub- grouping Patients with Low-Back Pain: A Treatment-Based Approach to Classification* published on August 23 in the online version of Sports Health: A Multidisciplinary Approach, the official journal of the American Orthopaedic Society for Sports Medicine.

It can be found at http://sph.sagepub.com/content/early/2011/08/20/1941738111415044 This is clear and concise with excellent opening details on the prevalence and cost of LBP in Australia, the UK and the USA. Note these challenging points:

a. The authors suggest that "the application of spinal manipulation based solely on a paradigm of biomechanical faults and/or spinal misalignments is inappropriate" now that subgroup criteria have been established for patients best suited to each of manipulation, stabilization, end-range loading exercise, and traction.

b. "Manipulation is more effective than mobilization." However "the identification of the proper patient subgroup is more important to a successful outcome than choosing the right manipulative technique".

c. In one recent trial from the University of Utah group, in which clinical success was defined as a 50% improvement in Oswestry Disability Index score, less than half the back pain patients experienced clinical success with spinal manipulation – but success rate increased to 95% in patients meeting at least 4 of the 5 criteria for the manipulation subgroup gained from history and physical examination.

d. These results have been supported by a further trial from the University of Utah group, which also shows that the clinical benefit of receiving matched treatment according to subgroup classification remained at 6 months follow-up.

The January 2011 issue of The Chiropractic Report featured the successful new spine care program developed by Dr Ian Paskowski and colleagues at the Jordan Hospital in Plymouth, Massachusetts. An important aspect of that program is adaptation and use of the classifications and clinical decision rule of Hebert et al. as in Figure 1.

(Hebert JJ, Koppenhaver SL, and Walker BF (2011) *Sub-grouping Patients with Low-Back Pain: A Treatment-Based Approach to Classification,* Sports Health: A Multi-Disciplinary Approach. Published online August 23, 2011 as doi: 10.1177/1941738111415044.)

2. US and Canada. LBP- Comparative Effectiveness of Exercise, Acupuncture and Spinal Manipulation

In July 2011 *The Chiropractic Report* reviewed a new Cochrane systematic review of the evidence for SMT for chronic LBP by Dutch chiropractor Sydney Rubinstein, DC PhD and co-authors. Here now is a new systematic review of the evidence of comparative effectiveness of three common non-surgical approaches to management of patients with chronic LBP – exercise, acupuncture and spinal manipulation.

Authors include Christopher Standaert, MD, from the Departments of Rehabilitation Medicine, Orthopaedic Surgery and Neurological Surgery, University of Washington, Seattle and Mark Erwin DC PhD, from the Division of Orthopaedic Surgery, Toronto Western Hospital, University of Toronto, Canada.

This study, published prominently in *Spine*, makes clearly the point that many of the trials included in reviews of spinal manipulation not only involve very different skill levels but also mobilizations and other manual treatments that are not spinal manipulation at all. Points are:

a. There is continuing chaos in the management of patients with chronic LBP and "a critical need to identify which treatment options optimize clinical utility and cost-effectiveness for specific patients".

b. For each of three commonly used treatments, namely exercise, SMT and acupuncture, "there are significant variations in how they are defined, applied or practiced as well as in the skill level and training of providers".

c. Overall there is no strong evidence favouring any specific non-operative treatment approach for patients with chronic LBP – as to effectiveness or cost effectiveness.

d. There is more evidence for SMT and structured exercise than acupuncture. Both "appear to offer equivalent benefits in terms of pain and functional improvement for those with chronic LBP with clinical benefits evident within 8 weeks of care. However, the level of evidence is low".

e. The lack of evidence of clearly superior benefit of SMT may be a reflection of the many different approaches and skill levels used in the trials as well as the mixture of many different sub-groups of patients – rather than limitation in the effectiveness of skilled manipulation for appropriate patient populations. Good quotes on the first problem include:

- In the trials and the reviews "what is referred to as SMT may include high-velocity thrust techniques, manual mobilization, or other specific techniques or even broad treatment approaches such as osteopathy, which cloud the actual treatment effect of specific manipulative techniques".
- "...many studies of SMT use variable approaches that are termed "manipulation," often delivered with co-interventions or within the framework of a specific method of practice. In a more defined sense, SMT is a highly specific manoeuvre that requires considerable training and experience."

(Standaerd CJ, Friedly J, Erwin MW et al. (2011) *Comparative Effectiveness of Exercise, Acupuncture, and Spinal Manipulation for Low Back Pain,* Spine 36: S120-S130.)

3. United States. SMT for the Elderly with COPD

Here is a new study from Dr. Paul Dougherty, of New York Chiropractic College and the University of Rochester School of Medicine and Dentistry, and colleagues offering preliminary evidence that chiropractic SMT has the potential to improve lung function in elderly patients with chronic obstructive pulmonary disease (COPD). This study is a case series involving 6 residents of a long-term care facility, the Monroe Community Hospital, and was performed with the assistance of staff at the respiratory therapy department.

The patents, all over age 65 and with an average age of 79.1 years, had a course of 12 SMT sessions over a four week period with lung function measurements recorded by a respiratory

Figure 1. A Clinical Prediction Rule and Treatment Classification System. Adapted from Hebert et al

Flexion Bias	*Extension Bias*	*Manipulation*	*Stabilization*	*Traction*
• Older age (>50 y) • Directional preference for flexion • Imaging evidence of lumbar spine stenosis	• Symptoms distal to the buttock • Symptoms centralize with lumbar extension • Symptoms peripheralize with lumbar flexion • Directional preference for extension	• No symptoms distal to knee • Duration of symptoms <16 d • Lumbar hypomobility • Fear-Avoidance Beliefs Questionnaire for Work <19 • Hip internal rotation range of motion >35	• Younger age (<40 y) • Average straight-leg raise (>90°) • Aberrant movement present • Positive prone-instability test	• Symptoms extend distal to the buttock(s) • Signs of nerve root compression • Peripheralization with extension movement; or positive contra-lateral straight leg raise test

continued on page 8

Advances in Research in Canada

The Canadian Chiropractic Association (CCA), led by Dr. Allan Gotlib, Director, Research Programs, has been building impressive chiropractic research capacity in Canada during the past decade. This is in partnership with the Canadian Institutes of Health Research (CIHR), the federal government's funding agency which provides almost $1 billion in funding annually.

Canada now has more than 20 DC PhDs at leading universities and educational institutions across the country, including its two chiropractic colleges the Canadian Memorial Chiropractic College (CMCC) in Toronto and the Université du Québec à Trois-Rivières (UQTR) in Quebec. Another 15 chiropractic PhD students are set to graduate soon.

To direct this growth in research, the CCA and the CIHR have formed and funded a Canadian Chiropractic Research Consortium which brings chiropractic and other researchers and their institutions together. The Consortium's 2011 Symposium was held at the University of Toronto September 23-24,2011 titled *Advancing the Canadian Chiropractic Research Agenda* with a theme of "a transdisciplinary approach to neuromusculoskeletal health, injury and disease: collaborative engagement in chiropractic research."

Opening keynote speakers were Dr. David Naylor, former Dean of Medicine and now President, University of Toronto and Dr. Patrick Loisel, Professor, Dalla Lana School of Public Health, University of Toronto who has Dr. David Cassidy and Dr. Pierre Cote among the five DC PhDs at his institution and also serves as a professor at CMCC.

Dr. David Cassidy, a leading Canadian chiropractic researcher currently living in Denmark but maintaining research affiliations and projects in both countries, led the final open session devoted to conclusions drawn from the two days of the workshop. One central conclusion was that there were two vital criteria of growing importance to gaining large government and foundation grants for research in an increasingly competitive environment.

The first is that research is of practical importance, that it is seen to relate to improved healthcare delivery for patients and improved economic and other performance of the healthcare system. Areas discussed included reducing surgeries and wait time for surgeries, and reducing crowding and wait times in hospital emergency departments.

As a good example of this Dr. Deborah Kopansky-Giles, who leads the Chiropractic Department at St. Michael's Hospital at the University of Toronto, is part of an interdisciplinary team that has just received a large government grant to assess the impact of having chiropractic services introduced in the Emergency Department at St. Michael's Hospital. This is to assist with the large volume of patients with acute back pain and other musculoskeletal disorders.

The second criterion is that funded research projects must increasingly be collaborative and interdisciplinary. Greg Kawchuk DC PhD, Canada Research Chair in Spinal Function, Department of Physical Therapy, University of Alberta, described an excellent example of this. He is one of five principal investigators who have just received a $2.5 million grant from the CIHR and partner foundations for a new project titled SafetyNet. This comprises interdisciplinary research aimed at "building a culture of safety for spinal manipulation." This will include building an adverse events reporting system.

Very interestingly, this not only brings together a large network of researchers from different professional groups such as biomechanics, chiropractic, law, neurology, orthopaedics, pediatrics, and physical therapy, but is also supported by the regulatory bodies for the four professions that deliver spinal manipulation in the Province of Alberta – chiropractic, medicine, osteopathy and physiotherapy. Dr. Kawchuk identified this high level of collaboration, together with evidence of past successful collaborations, as being of key importance in gaining this large research grant in competition with many others.

As was apparent to the international chiropractic community at the WFC's Congress in Montreal in 2009, and as this symposium confirmed, strong integration and partnerships with major universities is bringing an impressive quality and quantity to chiropractic and chiropractic-related research in Canada.

(From left) *Canadian chiropractic researchers Jeffrey Quon DC, PhD, University of British Columbia, Pierre Cote DC, PhD, University of Toronto, Greg Kawchuk DC, PhD, University of Alberta, David Cassidy DC, PhD, University of Toronto, and Patrick Loisel MD, Orthopedic Surgeon, Professor at the Dalla Lana School of Public Health, University of Toronto and Canadian Memorial Chiropractic College.*

Bernadette Murphy DC, PhD, Director, Human Neurophysiology and Rehabilitation Laboratory, University of Ontario Institute of Technology, with keynote speaker Phillip Gardiner PhD, Scientific Director, Institute of Musculoskeletal Health and Arthritis, Canadian Institutes of Health Research.

Main Article *continued from page 3*

As we stand, the chiropractic profession continues in some high-profile quarters to shoot itself in the foot. For example, minority-group guidelines which advocate high-intensity, prolonged courses of care for simple mechanical back pain. Practice-building seminars which guarantee immense wealth to their delegates through the utilisation of rehearsed high-pressure scripts, and warnings, even by national chiropractic associations, of the devastating effects of uncorrected vertebral subluxation. Practice methods which sacrifice patient dignity and privacy in favour of an open plan approach to patient care. And, perhaps saddest of all, is the promulgated view that those who take a differing approach to care are somehow lesser chiropractors, who are 'non-philosophical', 'unprincipled' and who are pain-based rather than 'wellness' based.

The time is here to engage the silent majority. For most chiropractors, professional practice means keeping your head down and doing a good job, caring for patients and going home to our families each evening hoping that we've made the world a better place. The very thought of becoming involved in political activity is an understandable anathema to most chiropractors.

Much as we like to comfort ourselves that such a silent majority exists, and supports us – silently – we have no evidence that we have that support. Silence could be perceived as a tacit contentment with what is being done by our political leaders but conversely it may convey a sense of hopelessness, a feeling that the direction of the profession has shifted so far away from the science-based programmes promoted at their respective alma maters that they would rather keep themselves distanced from the current goings-on and stay focused on their day-to-day lives.

I am saddened when I speak to chiropractors who find themselves constantly having to defend their profession in the face of the media's far-too-easy discovery of embarrassing revelations about their colleagues. My heart sinks when I see patient leaflets that describe subluxation as 'the silent killer'. Young colleagues who tell me that at practice-building seminars they are given scripts that tell them how to shake their heads, adopt a solemn expression and sigh, "It's bad news Mrs Jones; you have subluxation."

Is this really what we want chiropractic to be reduced to? Intelligent young graduates, full of knowledge, skill, hope and expectation being seduced by those who style themselves as 'principled chiropractors'? What does that make the rest of us? And are we any better if we stand by and fail to react?

Through the catalyst that was the Singh case comes the realisation that we must focus on the evidence, we must pursue research and we must be supportive of the concept of lifelong learning through the facilitation of graduate education and continuing professional development (CPD).

We must also support quality undergraduate chiropractic institutions, particularly those affiliated with public universities; in Europe we have a growing number of such programmes: the Swiss at the University of Zurich, the Danes at the University of Southern Denmark, AECC in Bournemouth and the Welsh Institute of Chiropractic at the University of Glamorgan. France and Spain also have established chiropractic programmes which have attracted much interest in their respective countries.

The ECU has set up an Education Task Force to expand the number of countries offering chiropractic education and has recently met with university leaders in Istanbul with a view to setting up a programme in Turkey. Chiropractic education is the source of ongoing heated debate, yet through links with publicly funded higher educational institutions, it is gaining legitimacy and stepping up to the plate.

Accountability requires that faculty deliver high-quality programmes and reject unproven theories of the past. Sharing faculty members with other healthcare programmes further enhances the credibility of the courses and brings chiropractic students into contact with their medical and dental counterparts. Contrary to the gloomy predictions of those prophesising the imminent demise of the chiropractic profession should they even breathe near a medical practitioner, many of today's chiropractors seek integration and express a strong desire to be part of the accepted medical community.

The ECU recognises that cultural acceptance of the chiropractic profession will be driven by a clear identity, underpinned by sound research. It is committed to positioning chiropractors as the spinal healthcare specialists of choice, but knows that research will ultimately be the currency of the profession. If we fail to invest properly in research we will fail in our quest for credibility and with it we will lose a momentum that has been pioneered by European researchers.

Put simply, if we ignore the need for research and partnership with others in mainstream healthcare, and fail to challenge the charismatic evangelists among us who are often heard to be the voice of the profession, chiropractic will remain on the periphery and will be considered but a fringe player in the musculoskeletal healthcare community.

In the UK, the BCA has just invested in a Research and Development Department based at AECC. It will specifically focus on the key question of the moment – cost effectiveness. It is no longer acceptable to merely show that chiropractic care is clinically effective; for chiropractors to be even on the horizon when it comes to National Health Service commissioning the profession must show that it can deliver cost-effective healthcare. Through the use of patient-reported outcome measures it may produce data seen to be of increasing relevance.

The ECU ringfences part of its subscription for research. A dedicated Research Council distributes funds for research. But it's not good enough just to fund research; as political leaders we have a duty to shout our chiropractic researchers' achievements from the rooftops and celebrate their successes.

Through a 2010 agreement with the Chiropractic and Osteopathic College of Australasia (COCA), the European Academy of Chiropractic (the academic arm of the ECU) co-funds the Chiropractic and Manual Therapies online journal. It is extremely proud to do so. The agreement demonstrates a commitment to drive the profession forward on an evidence-based footing and encourage chiropractors to participate in authoring high-quality papers. Through the vision of its leaders and its editorial board, chiropractic now has a second powerful journal which has set the bar far higher than any other previous journal in Australasia or Europe. (*The profession's other leading peer-reviewed, indexed journal is of course the* Journal of Physiological and Manipulative Therapeutics, *the official scientific journal of the American Chiropractic Association and the National University of Health Sciences, Chicago, Illinois, and published by Elsevier Inc.* Ed.)

We must support this initiative and awareness of this open

access journal should be promoted not just by those conducting research, but by all of us in chiropractic.

We cannot stop evolution, nor should be endeavour to do so. The enhanced profile of chiropractic in Europe has inevitably led to a greater degree of scrutiny. We must be answerable to enquiries made of us and we must continue to enquire of ourselves. Challenging our beliefs and adapting to evidence are marks of maturity that the chiropractic profession must embrace to move forward. Having strategic objectives in Europe will hopefully enable the chiropractic profession to unite behind common issues but whatever happens, a discerning society will continue to support good practice and condemn the bad.

I'm reminded of the words of Charles Darwin, whose words perfectly articulate the position in which we find ourselves:

"*In the long history of humankind (and animal kind too) those who have learned to collaborate and improvise most effectively have prevailed*".

Some may say that the BCA was foolhardy to pursue a journalist over comments made in a national newspaper. Others supported its stance and congratulated the BCA on standing up to what it felt was unfair criticism. Things didn't go the way it had hoped or planned and it was left somewhat licking its wounds.

Someone once said, "The one thing you get, when you don't get what you want, is experience." The BCA gained much experience in those two years. There has been much to reflect on, and in a strange way the chiropractic profession may one day look back and thank Simon Singh for making the chiropractic profession recognise its weaknesses and evolve from teenage angst into adult maturity. We have been indecently exposed and we must now seek to clothe ourselves in the respectability that modern healthcare demands of us.

Our challenge lies with ensuring that chiropractic commits itself to practising evidence-based, research-driven healthcare. Anything less will sell ourselves down the river and perpetuate the feeding frenzy of criticism witnessed in the UK.

Richard Brown DC, LL.M, FEAC

President, British Chiropractic Association
Secretary, European Chiropractors' Union
Secretary-General, European Academy of Chiropractic

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continued from page 5

therapist at baseline and at 2 and 4 weeks. To quote Dougherty et al:

"Thoracic SMT increases the functional mobility of the chest wall by increasing the mobility of the thoracic spinal joints and their associated rib articulations. Because improving the functional mobility of the chest wall has been shown to benefit lung function in the elderly, applying the intervention to elderly patients with COPD carries with it at least the potential to improve lung function, as this case series suggests."

There was a clinically significant increase in forced expiratory volume immediately after SMT in 4 of 6 patients that was sustained at 2 weeks. This was sustained in only 1 patient at 4 weeks – but this was the only ambulatory patient with a full set of outcome measures at that time. Two of the others were wheel chair dependant.

There were no adverse events from the 216 thoracic spinal manipulations delivered. The authors note that more sustained improvement may be achieved where there are higher patient activity levels.

(Dougherty PE, Engel RM et al. (2011) *Spinal Manipulative Therapy for Elderly Patients with Chronic Obstructive Pulmonary Diseas:* A Case Series. (J Manipulative Physiol Ther 34; 413-417)

4. United States. Chiropractic Management of Postsurgical LBP

There is little published evidence concerning chiropractic spinal manipulation for postsurgical patients, whether as to effectiveness or safety. JMPT has just published a good case series from Ralph Kruse, DC, in private practice in Chicago, and Jerrilyn Cambron, DC PhD, a research scientist at the National University of Health Sciences in Chicago, which reports good results with 32 consecutive patients. Points are:

a. This was a retrospective review of 32 patients with postsurgical low back pain who received Cox flexion distraction manipulation (together with adjunctive procedures) for at least 2 weeks and had a record of pre-treatment and post-treatment pain scores on the Numeric Pain Scale (NPS).

b. On an average number of treatments of 14 (range 6-31) the mean or average reduction in NPS pain scores was from 6.4-2.3, a reduction of 4.1 out of 10.

No adverse events were reported for any of these postsurgical patients. In summary, good results with difficult patients.

(Kruse RA, Cambron J, (2011). *Chiropractic Management of Postsurgical Lumbar Spine Pain:* A Retrospective Study of 32 Cases, J Manipulative Physiol Ther 34; 408-412)

From: Jo-Ann Willson
Sent: Friday, January 3, 2020 1:36 PM
To: Rose Bustria
Subject: FW: CMRTO is now the College of Medical Radiation and Imaging Technologists of Ontario!
Attachments: nr-cmrito-01-01-20.pdf

Exec and Council.

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From: CMRTO Communications <communications@cmrito.org>
Sent: Friday, January 3, 2020 1:26 PM
Subject: FW: CMRTO is now the College of Medical Radiation and Imaging Technologists of Ontario!

The College of Medical Radiation Technologists of Ontario (CMRTO) is pleased to announce that it is now the College of Medical Radiation **and Imaging** Technologists of Ontario (CMRITO).

The *Medical Radiation and Imaging Technology Act* (MRIT Act) came into force on January 1, 2020, replacing the *Medical Radiation Technology Act* (MRT Act). The MRIT Act changes the name of the College and changes the name of the profession to medical radiation and imaging technology to encompass the regulation of diagnostic medical sonographers by the College, which began in 2018. CMRITO thanks the Minister of Health, and the Ministry managers and policy analysts at the Health Workforce Regulatory Oversight Branch, for working to modernize the regulation of medical radiation and imaging technologists to protect the public of Ontario. A full report on the implementation of the MRIT Act will be provided at the end of March 2020.

For additional information about the changes at CMRITO, please read the attached news release, watch our short video, and visit www.cmrito.org.

Thank you,

*Please note that the Communications email address has changed to communications@cmrito.org. We will still receive emails sent to our old address for the next few months. Please be sure to update your address book and add this new email address to your safe sender list.

CMRITO Communications

CMRITO
Regulator of medical radiation and imaging technologists in Ontario

597

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NEWS RELEASE JANUARY 1, 2020

CMRITO
Regulator of medical radiation and imaging technologists in Ontario

CMRTO is now the College of Medical Radiation and Imaging Technologists of Ontario

Toronto, January 1, 2020 - The College of Medical Radiation Technologists of Ontario (CMRTO) is pleased to announce that it is now the College of Medical Radiation and Imaging Technologists of Ontario (CMRITO).

The *Medical Radiation and Imaging Technology Act* (MRIT Act) came into force on January 1, 2020, replacing the *Medical Radiation Technology Act* (MRT Act). The MRIT Act changes the name of the College and changes the name of the profession to medical radiation and imaging technology to encompass the regulation of diagnostic medical sonographers by the College, which began in 2018.

"We are excited to continue our work in regulating over 11,000 medical radiation and imaging technologists as the College of Medical Radiation and Imaging Technologists of Ontario," notes Linda Gough, CMRITO Registrar & CEO. "Thank you to the government of Ontario for enhancing public protection and ensuring the regulatory framework is consistent for all areas of medical radiation and imaging technology through the *Medical Radiation and Imaging Technology Act*."

"The coming into force of the *Medical Radiation and Imaging Technology Act* and the evolution of the CMRTO into the College of Medical Radiation and Imaging Technologists of Ontario is a seminal moment in the regulation of medical radiation and imaging technologists (MRITs) in the province," notes CMRITO President Wendy Rabbie. "Now the public can be assured that MRITs in all five specialties – radiography, radiation therapy, nuclear medicine, magnetic resonance, and diagnostic medical sonography – are qualified to practise and are providing safe, effective, and ethical care to Ontario residents."

To reflect this change in name, the College has developed a new visual identity that provides additional clarity and transparency to the public and our members. This new logo includes an updated symbol, the acronym CMRITO, and a descriptor that explains our role as the regulator of medical radiation and imaging technologists in the province.

Our transformation into the CMRITO marks the end of a long journey to bring diagnostic medical sonographers into the same public protection framework as the other four specialties of medical radiation and imaging technology. The College's Council members and staff have worked tirelessly to ensure that the College's logo, website, and key publications like our Standards of Practice, Code of Ethics, and Quality Assurance Program reflect this important change. Further updates to other publications and resources will continue in the coming months.

To watch a short video explaining the changes at CMRITO, please click here.

Please visit www.cmrito.org to learn more about CMRITO's transformation and to access additional information for the public, CMRITO members, applicants, and employers.

Have any questions about this? Please contact communications@cmrito.org, or call 416.975.4353 or 1.800.563.5847.

CMRITO
Regulator of medical radiation and imaging technologists in Ontario

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From: Jo-Ann Willson
Sent: Wednesday, December 11, 2019 12:51 PM
To: Rose Bustria
Subject: FW: FW for OCP: Governance
Attachments: Eligibilities- Bylaw No. 6 .pdf; Competencies - Bylaw No. 6.pdf; 13.1 Briefing Note - Executive Committee - Governance Renewal.pdf

Exec and Council.

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From: bakenny@regulatedhealthprofessions.on.ca <bakenny@regulatedhealthprofessions.on.ca>
Sent: Wednesday, December 11, 2019 12:47 PM
To: 'Beth Ann Kenny' <bakenny@regulatedhealthprofessions.on.ca>
Cc: 'Nancy Lum-Wilson' <nlumwilson@ocpinfo.com>
Subject: FW for OCP: Governance

The following is being forwarded on behalf of Nancy Lum-Wilson, C.E.O. and Registrar of the Ontario College of Pharmacists.

Dear All,

Further to our discussions regarding competence-based elections yesterday, I am sharing with you copies of the OCP Briefing Note on this subject which was passed in September; and our bylaws which were passed on Monday. I would be happy to connect with anyone who is considering moving in this direction.

Have a Happy Holiday season!

Nancy

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OCP By-Law No. 6

Eligibility for Election

A Registrant who holds a valid Certificate of Registration as a pharmacist or as a pharmacy technician is eligible to seek to be a candidate for election to the Board if he or she meets the following requirements:

(a) the Registrant is not in default of payment of any fees prescribed in the By-Laws;

(b) the Registrant is not the subject of any disciplinary or incapacity proceeding;

(c) the Registrant has not been found to have committed an act of professional misconduct or to be incompetent by a panel of the Discipline Committee.

(d) the Registrant is not a registered pharmacy student or intern;

(e) the Registrant's Certificate of Registration is not subject to a term, condition or limitation other than one prescribed by regulation;

(f) the Registrant is not, and has not within the three (3) years immediately preceding the election been, an employee, officer or director of a Professional Advocacy Association. For greater certainty, nothing in this clause will prevent a Registrant who serves on an association or organization to which he or she has been appointed by the Board as a representative of the College, from running for election to be an Elected Director;

(g) the Registrant has not been disqualified from serving on the Board or a Committee within the six (6) years immediately preceding the election;

(h) where the Registrant was formerly a Director, but is not as of the date of the election a Director, it has been at least three (3) years since he or she was a Director;

(i) the Registrant is not an adverse party in litigation against the College, the Board, a Committee or any of the College's officers, employees or agents;

(j) the Registrant commits to devoting sufficient time in his or her schedule to participating in all required Board and Committee activities;

(k) the Registrant has not, in the opinion of the Screening Committee, engaged in conduct unbecoming a Director; and

(l) the Registrant is not the Owner or Designated Manager of a pharmacy that, within the six (6) years immediately preceding the election, has undergone a re-inspection, as a result of deficiencies noted in an initial inspection, for a third time or more after the initial inspection.

Director Competencies.

The Board shall at all times comprise Elected Directors who collectively serve, or have experience working with, the following diverse patient populations:

(a) patients served by rural community pharmacies;

(b) patients served by urban community pharmacies;

(c) patients treated at teaching hospitals;

(d) patients treated at community hospitals;

(e) patients located in northern/remote areas;

(f) patients who identify as Indigenous;

(g) patients with mental health and addictions needs; and

(h) patients in long-term care.

The Board shall in addition at all times comprise Directors who collectively have the following knowledge, skills and experience:

(i) experience in and understanding of the principles of protecting, and acting in, the public interest;

(j) experience working with diverse populations, marginalized groups and people with disabilities;

(k) experience serving on boards in an oversight capacity;

(l) experience in managing risk, including reputational risk;

(m) experience in senior leadership roles in business;

(n) experience as a human resource professional including in occupational health and safety, organizational structures and human resources oversight and compensation, recruiting and succession planning;

(o) financial and/or accounting expertise, including experience preparing, auditing, analyzing or evaluating financial statements and an understanding of generally accepted accounting principles;

(p) ability to navigate electronic systems to access Board and Committee materials;

(q) legal experience or familiarity with regulated professions, including overseeing regulations and setting standards for certification; and

(r) experience participating in, or leading, an organization in planning for its future, such as: conducting S.W.O.T. (strengths, weaknesses, opportunities, and threats) analysis, environmental scans, strategy design, planning, implementation and evaluation.

COUNCIL BRIEFING NOTE
MEETING DATE: SEPTEMBER 2019

FOR DECISION	X	FOR INFORMATION

INITIATED BY: Executive Committee

TOPIC: Governance Renewal

ISSUE: Direction from Council on additional elements of the governance renewal framework

PUBLIC INTEREST RATIONALE: Governance best practice supports a small governing Board comprised of an equal number of public and professional members, with members collectively possessing a range of governance competencies. The proposed governance renewal framework is intended to move toward best practice with the goal of strengthening the ability of the Council (Board) to provide oversight that is transparently aligned with the mandate of the College to serve and protect the public interest.

BACKGROUND: At the December 2018 Council meeting, a governance renewal framework was approved that reflects best practice with respect to governance in professional regulation with a view to strengthening the ability of governing boards to align with their public protection mandate and enhancing public trust in regulatory institutions and their processes.

- The four elements of the framework approved by Council in December 2018 are as follows:
    1. Reduction in Council size
    2. Council composition
    3. Separation of Council and Statutory Committees
    4. Competency-based Council

In June 2019 the College undertook a facilitated discussion and made decisions on the next level intentions within each principle of the governance framework to enable the drafting of by-laws to operationalize the framework to commence at the beginning of the 2020/2021 Council (Board) year, barring any legislative changes being imposed on the sector.

ANALYSIS:

In order to further inform the drafting of bylaws Council is asked to consider and provide input into the following elements.

- Eligibility and competency based selection of Council (Board) members
- Honoraria for elected Board members and non-Council[1] committee members
- Lay Committee appointees including honorarium

[1] The term non-Council is used as to reflect the current nomenclature of the established roles of the committee members for ease of reference. Once the bylaws are formally changed the non-Council members will be referred to as professional committee appointees (PCAs).

Eligibility and Competency based selection of Council (Board) members

The RHPA sets out the authority for the College to establish by-laws respecting the qualification of candidates seeking election to Council (Board). While the current by-law (5.9) sets out eligibility criteria, it does not address competence. To conform with best practice, in addition to the changes agreed by Council in June relating to representation of patient populations as opposed to registrant geography, eligibility criteria will be expanded and desired competencies will be codified as follows.

For Consideration:

- **Additional Eligibility criteria**
  - Less than two Inquiries, Complaints and Reports Committee (ICRC) dispositions that invoke a posting to the public register (caution or specified continuing education or remediation program (SCERP)),dependent on the seriousness of the nature of the concern.
  - 3 year cooling off period since serving on the Board of Directors of the College to ensure continual renewal (6 consecutive year maximum approved in June 2019)
  - 3 year cooling off period since serving as an officer or director of a professional advocacy association.
  - Commitment to devote time to Board activity.

- **Knowledge, skills and experience** - The Board is to be comprised of a diverse mix of individuals with a complementary mixture of the knowledge, skills and experience noted below. Not all directors are expected to have experience in every area; applicants will be required to rate themselves on a sliding scale.

Public Interest/Patient Rights	Experience and understanding in the principles of protecting and acting in the public interest
Working with diverse populations	Experience working with diverse teams, marginalized groups, accommodating people of various abilities
Board Experience	Involvement in any sector; could include committee work; Board or committee chair experience
Governance/Fiduciary	Understanding of a Board member's role and good governance principles, including: • Risk Management, including reputational risk • Business Acumen • Human Resources • Financial Literacy
Computer Literacy	Able to navigate electronic systems efficiently and effectively
Regulatory / Legal Expertise	Legal experience or familiarity with regulated professions, and the ability to understand and/or oversee regulations and standards setting and certification
Strategic Thinking and Planning	Demonstrated ability to think strategically; experience participating in, or leading, an organization in planning for its future, such as: conducting S.W.O.T. analysis, environmental scans, strategy design, planning, implementation and evaluation

By continually assessing the level of knowledge, skills and experience of Board members, training and development plans can be customized to enhance the skills of existing members and recruitment for new members can be tailored to address identified gaps. (Election Framework – Attachment 1)

For consideration:

- ❖ **A transparent and independent selection process**
The competence of Registrants applying for a Board position will be assessed by an independent committee comprised of three members of the Board and two external representatives. This process, aimed at increasing public trust, reflects best practice as set out in the attached independent report prepared by Dundee Consulting - Attachment 2.

Honorarium for the elected members and non-council committee members

In June the Council agreed to review and amend the compensation model to address potential disincentives to participation on panels of the Discipline and ICRC.

A recent survey (Attachment 3) of Ontario Regulatory College bylaws indicates that, with the exception of OCP, all Ontario health regulatory colleges pay an honorarium plus expenses, similar to the model used by the Health Boards Secretariat for public appointees. Nine of the 25 health colleges pay an honorarium of $150/day, equal to the amount paid to public members; ten pay between $200 and $300/day; three between $301 and $400 and three above $400/day.

For Consideration

- ❖ Professional members of the Board and committees will receive a taxable honorarium for time spent on college work and be reimbursed for expenses incurred. Time will be paid on a full day or half day basis and expenses will be reimbursed in accordance with common practice followed by other health colleges and public appointments.
- ❖ The daily honorarium be set at :
    - o $260/day ($130 for <3 hours) which is midpoint of other provincial colleges.(financial impact approximately $250,000/year)

Maintaining the Public Voice on committees

As previously agreed by Council, due to the significant demand on the nine government appointed public members, they will only be appointed to committees per statute requirement. To ensure a public voice on all other committees, lay committee appointees will be selected by the Board of Directors.

For Consideration:

- ❖ Lay committee appointees will be selected using the same competency based recruitment and screening process as professional non-Council committee appointments.
- ❖ Lay committee members will receive the same honorarium as professional committee appointees

RECOMMENDATION:

That Council discuss and agree on the concepts presented to further inform the drafting of by-laws to operationalize the framework effective the start of the 2020/2021 Council year.

NEXT STEPS:

- Enabling by-law amendments to be drafted for consideration by Council in December 2019.
- The College will continue to liaise with AGRE Colleges and collaborate with the Ministry on governance changes, continuing to keep Council informed of any developments.

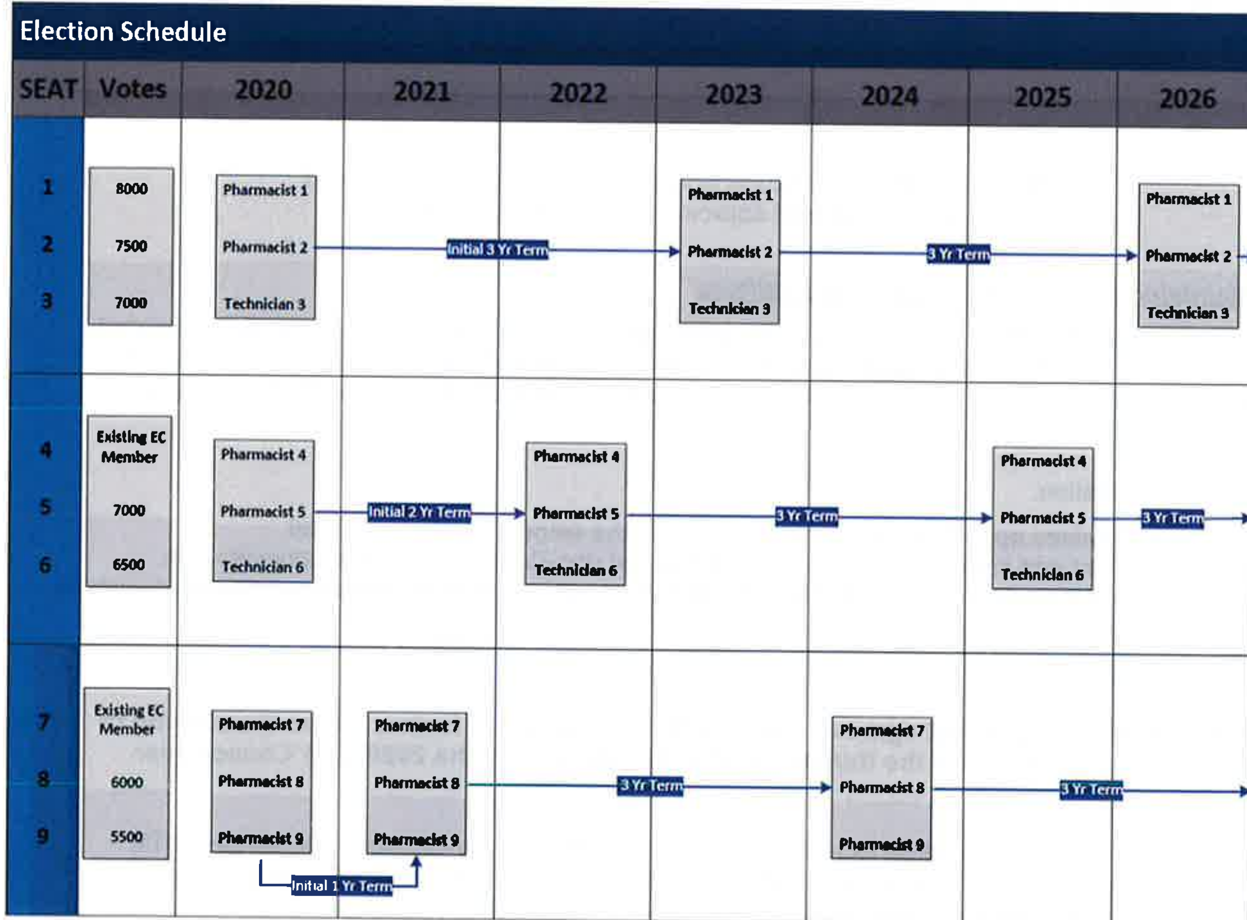
Attachment 1 – Election Framework

At the June meeting, council agreed to reduce the overall board to 20, comprised of nine (9) elected members, (9) nine public member and two (2) deans; the minimum required under the Pharmacy Act. Elected board members will be able to serve a maximum of six (6) consecutive years. To ensure continual renewal, one third of the elected board member seats will come up for election each year.

2020 will be a transition year in which all but two (2) existing council terms will cease and seven (7) eligible candidates will be elected from among a list of candidates pre-screened by the independent selection committee. As committed to council in June, to ensure some continuity between outgoing council and incoming board members, two of the nine seats will be reserved for current Executive Committee members. As election is no longer based on representation of geographic or practice areas of the profession but on the patient populations they serve the new model envisions all registrants voting for all seats each year.

The initial terms of the members elected in 2020 will be staggered to enable one third to come due for election each subsequent year. Terms will be determined by number of votes received with candidates receiving the most votes serving longer terms.

The following diagram illustrates the election cycle from 2020 onward.



COURT OF APPEAL FOR ONTARIO

CITATION: Ontario College of Teachers v. Bouragba, 2019 ONCA 1028
DATE: 20191231
DOCKET: C66080

Lauwers, Fairburn and Zarnett JJ.A.

2019 ONCA 1028 (CanLII)

BETWEEN

The Ontario College of Teachers

Plaintiff (Responding Party/Respondent)

and

Ahmed Bouragba

Defendant (Moving Party/Appellant)

Ahmed Bouragba, acting in person

Christine Lonsdale and Charlotte-Anne Malischewski, for the respondent

Heard: September 27, 2019

On appeal from the order of Justice Andra Pollak of the Superior Court of Justice, dated September 26, 2018, and from the costs decision, with reasons reported at 2018 ONSC 6481.

Lauwers J.A.:

I. OVERVIEW

[1] Mr. Bouragba brought a motion to dismiss the defamation lawsuit brought against him by the Ontario College of Teachers, under s. 137.1 of the *Courts of Justice Act*, R.S.O. 1990, c. C.43. This is a relatively new provision designed to

permit judicial scrutiny of lawsuits allegedly brought to silence or financially punish critics who have spoken out on matters of public interest, known as Strategic Lawsuits Against Public Participation, or SLAPP. The seminal case on s. 137.1 is *1704604 Ontario Ltd. v. Pointes Protection Association*, 2018 ONCA 685, 142 O.R. (3d) 161, leave to appeal granted and appeal heard and reserved November 12, 2019, [2018] S.C.C.A. No. 467. As Doherty J.A. observed in *Pointes*, at para. 3: "Defamation lawsuits, perhaps because of the relatively light burden the case law places on the plaintiff, have proved to be an ideal vehicle for SLAPPs." Section 137.1 is a carefully designed approach to discerning whether a lawsuit is improper as a SLAPP or is validly brought.

[2] The motion judge denied Mr. Bouragba's motion to dismiss the College's defamation action on the ground that it was a SLAPP, finding that he had not discharged his burden of proving that the defamation proceeding arose from an expression that relates to a matter of public interest. Mr. Bouragba appeals.

[3] The College is the self-governing regulatory body for teachers in Ontario. Mr. Bouragba is a member of the College and was a member of the College's Council from July 1, 2012 to October 2, 2014, when he resigned.

[4] Mr. Bouragba sent several communications to past and present members of the Council, the Attorney General of Ontario, and the Minister of Education. In

2019 ONCA 1028 (CanLII)

some of the communications he advocated for a public inquiry into a wide range of alleged misconduct on the part of the College and people affiliated with it.

2019 ONCA 1028 (CanLII)

[5] The College sued, alleging that the communications were defamatory, because they allege that the College, its Council and its leadership: are dishonest in the performance of their mandate; fabricate complaints; collude with their independent legal counsel and school boards; take action against members of the profession and Council for improper reasons; assemble biased panels; harass and discriminate against children, parents and elected Council members; and perform their duties in bad faith.

[6] There is a history between the appellant and the College that forms part of the context. First, the College processed a complaint about the appellant made by Diane Lamoureux, then the Principal of an Ottawa area school attended by Mr. Bouragba's son. The Investigation Committee declined to refer the complaint to the Discipline Committee but instead cautioned the appellant. Its decision was upheld by the Divisional Court: 2018 ONSC 6935.

[7] Second, the appellant made a complaint against three College members. The Investigation Committee declined to refer the complaint to the Discipline Committee, and its decision was upheld by the Divisional Court: 2018 ONSC 6940.

[8] Third, the appellant filed a complaint with the Human Rights Tribunal of Ontario. All but one allegation has been dismissed: 2017 HRTO 523. The hearing on the single outstanding issue was to be heard in June 2019.

[9] Fourth, the appellant sued the College and a number of parties including the College's Director of Corporate and Council Services, Richard Lewko, personally. The action has been stayed: 2016 ONSC 7798. The appellant has pursued motions to have the judge who ordered the stay recused for bias.

II. THE APPELLANT'S POSITION

[10] The appellant expressed frustration in his factum and in his oral argument with the motion judge's failure to engage with the arguments that he put forward. First, he argued that the College, as a public body, is not capable of initiating a defamation suit, relying on *Niagara Peninsula Conservation Authority v. Smith*, 2017 ONSC 6973, at paras. 11, 54.

[11] Second, the appellant noted that "the motion judge failed entirely to mention any content or a subject of my three impugned communications … [and] also failed to mention my position as a defendant." He questioned whether the motion judge had even read the impugned communications. His position, as expressed in his factum before the motion judge was this:

> It is beyond question that the expressions in question relate to a matter of public interest, to wit: the governance of the College, it is a body created by the government of Ontario. Its action or inaction in its

2019 ONCA 1028 (CanLII)

> sphere of responsibility does affect the public welfare (students safety and well being).

[12] Third, the appellant pointed out that the motion judge "adopted the plaintiff's speculation by copying it and pasting it directly into her decision with no adequate analysis." This led the appellant to suggest that the motion judge was not impartial.

III. THE GOVERNING PRINCIPLES CONCERNING SLAPP LITIGATION

[13] This court addressed s. 137.1 of the *Courts of Justice Act* in a group of linked decisions, the heart of which is *1704604 Ontario Ltd. v. Pointes Protection Association*. The associated decisions were *Fortress Real Developments Inc. v. Rabidoux*, 2018 ONCA 686, 426 D.L.R. (4th) 1; *Platnick v. Bent*, 2018 ONCA 687, 426 D.L.R. (4th) 60, leave to appeal granted and appeal heard and reserved November 12, 2019, [2018] S.C.C.A. No. 466; *Veneruzzo v. Storey*, 2018 ONCA 688, 23 C.P.C. (8th) 352; *Armstrong v. Corus Entertainment Inc.*, 2018 ONCA 689, 143 O.R. (3d) 54; and *Able Translations Ltd. v. Express International Translations Inc.*, 2018 ONCA 690, 428 D.L.R. (4th) 568.

[14] In *Pointes*, Doherty J.A. noted that the scheme in s. 137.1 of the *Courts of Justice Act* has three features or steps. The first is that for the section to be engaged, the expression must relate to a matter of public interest under s. 137.1(3), which provides:

2019 ONCA 1028 (CanLII)

> (3) [A] judge shall, subject to subsection 4, dismiss the proceeding against the person if the person satisfies the judge that the proceeding arises from an expression made by the person that relates to a matter of public interest.

[15] The second feature is the "merits-based hurdle." It is set out in s. 137.1(4)(a), which provides:

> (4) A judge shall not dismiss a proceeding under subsection (3) if the responding party satisfies the judge that,
>
> (a) there are grounds to believe that,
>
> (i) the proceeding has substantial merit, and
>
> (ii) the moving party has no valid defence in the proceeding; and

[16] The third feature is the "public interest hurdle." It is found in s. 137.1(4)(b), which provides:

> (4) A judge shall not dismiss a proceeding under subsection (3) if the responding party satisfies the judge that,
>
> (b) the harm likely to be or have been suffered by the responding party as a result of the moving party's expression is sufficiently serious that the public interest in permitting the proceeding to continue outweighs the public interest in protecting that expression.

[17] The first step in the required analysis is to identify the relevant "public interest," if any. This requirement is intended to be based on a "broad reading" of the meaning of "public interest" so that public discourse on matters of public interest is not unduly discouraged: *Pointes*, at para. 57. Doherty J.A. did not identity an exhaustive list of topics that fall under the rubric of public interest but

2019 ONCA 1028 (CanLII)

noted that *Grant v. Torstar Corp.*, 2009 SCC 61, [2009] 3 S.C.R. 640 provided considerable assistance.

2019 ONCA 1028 (CanLII)

[18] Of significance to this case, Doherty J.A. noted, at para. 47, that s. 137.1 "does not fix on the plaintiff's purpose or motive in bringing the claim as the determining factor". Regarding the concept of public interest, he noted, at para. 65:

> In summary, the concept of "public interest" as it is used in s. 137.1(3) is a broad one that does not take into account the merits or manner of the expression, nor the motive of the author. The determination of whether an expression relates to a matter of public interest must be made objectively, having regard to the context in which the expression was made and the entirety of the relevant communication. An expression may relate to more than one matter. If one of those matters is a "matter of public interest", the defendant will have met its onus under s. 137.1(3). [Emphasis added.]

[19] Doherty J.A. returned to the issue of motive at para. 94, when he contrasted the assessment of the public interest in s. 137.1(3) with the "public interest hurdle" in s. 137.1(4)(b), which is the third step in the analysis. He said, at para. 94: "Unlike the 'public interest' inquiry in s. 137.1(3), in which the quality of the expression or the motivation of the speaker are irrelevant ..., both play an important role in measuring the extent to which there is a public interest in protecting that expression." He added, at para. 95:

> In addition to the quality of the expression and the defendant's motivation for making the expression, the

> consequences of the plaintiff's claim will figure into the weight to be given to the public interest in protecting that expression. Evidence of actual "libel chill" generated by the plaintiff's claim can be an important factor in the public interest evaluation required under s. 137.1(4)(b): *Able Translations Ltd.*, at para. 102. [Emphasis added.]

[20] Doherty J.A. noted, at para. 96, in relation to the third or balancing step: "Because the balancing of the competing public interests will often be determinative of the outcome of the s. 137.1 motion, and because the analysis contains an element of subjectivity, it is crucial that motion judges provide full reasons for their s. 137.1(4)(b) evaluations."

IV. THE MOTION JUDGE'S REASONS

[21] The motion judge's reasons were sparse, not full. She noted, at paras. 23, 25:

> The College's position is that Mr. Bouragba's communications are related to his personal grievances with the College. They were personal attacks on individuals within the College.
>
> ...
>
> The College submits that although it has a public interest mandate, not all comments made about the College are matters of public interest. Mr. Bouragba's emails are solely related to:
>
> (a) "his dissatisfaction with a decision of the Investigation Committee which cautioned him.

2019 ONCA 1028 (CanLII)

(b) his dissatisfaction with three decisions of the Investigation Committee which declined to refer three of his complaints against members of the College involved in his son's education.

(c) his personal belief that the College conspired with Paul Marshall to cause teachers and members of the Board to take steps to remove his son from school in Ottawa.

(d) his personal belief that the College fabricates complaints in order to retaliate against him and other former members of the College council;

(e) his personal belief that staff lied because they were mistaken about the date on which Paul Marshall first commenced providing legal services as independent legal counsel to panels."

[22] The motion judge concluded, at para. 28:

> Applying the test in *Grant v. Torstar Corp.*, 2009 SCC 61 (S.C.C.), I find that Mr. Bouragba's private disputes with the College are not matters inviting public attention, affecting the welfare of citizens, or which are the subject of any controversy other than with Mr. Bouragba. I agree with the submissions of the College that the communications relate to private grievances. I find that Mr. Bouragba has not satisfied his burden under s. 137.1(3). It is therefore not necessary for the Court to consider the other criteria set out in s. 137.1 of the *CJA*.

[23] The motion judge's costs endorsement was very brief and did not describe the "detailed submissions" she considered. Nor did she refer to s. 137.1(8), which provides:

> (8) If a judge does not dismiss a proceeding under this section, the responding party is not entitled to costs on the motion, unless the

2019 ONCA 1028 (CanLII)

> judge determines that such an award is appropriate in the circumstances.

V. THE PRINCIPLES APPLIED

2019 ONCA 1028 (CanLII)

[24] It is surely right, as the motion judge paraphrased the College saying: "The College submits that although it has a public interest mandate, not all comments made about the College are matters of public interest." The difficulty is with her adoption of the College's argument that the appellant's emails are "solely related" to his "personal grievances" with the College. They were not.

[25] The College's statement of claim refers to three communications in particular. The first is an email to Michael Salvatori, Registrar of the College, copied to past and present members of the Council on June 4, 2015. The statement of claim does <u>not</u> quote the first sentence of the communication, which states: "Please find attached some documents and a request for a public inquiry to investigate the College's conduct and faith."

[26] In the email the appellant cited his own personal experience to explain his loss of confidence in the College. He went on to cite other situations in which the College misbehaved, in his opinion, which did not involve him.

[27] The second communication was a letter sent by the appellant and a colleague to the Attorney General dated June 5, 2016. The letter states:

> We address this letter to you as the new Attorney General of Ontario in a request to review the

> investigation and discipline processes and decisions at the Ontario College of Teachers.
>
> Despite the Report and Recommendations of the Chief Justice Patrick Lasage [sic] in 2012, there continues to be lack of transparency and accountability in the manner the College investigates complaints.

[28] The writers state:

> A Public Inquiry is requested to explore the influence exercised by school boards over the investigation and discipline process and decisions made by the Investigation and Discipline Committees of the College over the last five years, as a systemic issue for which the College is not under any scrutiny, since it enjoys immunity from any oversight in Ontario.

[29] This letter to the Attorney General must be set in context, since the appellant and his colleague (whom the College did not sue) sent a follow up letter on June 30, 2016, to which they attached a brief entitled: "Reasons for a Public Inquiry into the Ontario College of Teachers". The brief was detailed and made a number of complaints. It called for a public inquiry to "examine and investigate the following issues in protecting the Public Interest," and then listed: the manner in which public appointments to the Public Interest Committee of the College and to College Council are made; the preferential treatment of school board employer complaints over complaints by the public or members of the College; and conflict of interest and other concerns, because there is no whistleblower policy. The brief ended with a list of "[l]egislative issues requiring review of the OCT Act, 1996 and its Bylaws".

2019 ONCA 1028 (CanLII)

[30] The third communication was an email dated July 18, 2016 inviting council members to witness a discipline hearing. The email complained that the "College falsified the teacher's complain [sic] against his vice-principal" and invited Council members to attend the hearing so that they could see how the hearing unfolded, in order to enhance "transparency according to College's mission".

[31] Although the motion judge adverted to the requirement to view the communications objectively, she did not properly apply the test. Viewed objectively, and divorced from any consideration of the merits or manner of expression and the motive of the speaker, the communications could not be reasonably said to relate solely to "private grievances". The motion judge's finding to this effect was a palpable and overriding error.

[32] The finding also appears to have been impermissibly tainted by a consideration of the appellant's motive. As noted at the outset, at the first threshold step of the analysis, in assessing whether the expression is a matter of public interest under s. 137.1(3) of the *Courts of Justice Act*, the court is not to consider the motivations of the allegedly defamatory speaker. Motivations do play a role in the third step relating to the "public interest hurdle". However, in this case the motion judge appears to have taken the appellant's motivations into account in concluding, at step one, that the appellant was expressing "private grievances," so that the public interest element had not been satisfied. The

2019 ONCA 1028 (CanLII)

motion judge made the same error criticized by this court in *Levant v. Day*, 2019 ONCA 244, 145 O.R. (3d) 442, at paras. 11-12.

2019 ONCA 1028 (CanLII)

[33] Moreover, the test is meant to set a low bar, as Doherty J.A. noted in *Pointes*, at para. 65: "An expression may relate to more than one matter." Even so, he added: "If one of those matters is a 'matter of public interest', the defendant will have met its onus under s. 137.1(3)." In my view, the motion judge misapprehended the test under s. 137.1 as explicated in *Pointes*. The appellant's communications are mixed, but many elements manifestly engage the public interest. Whether those elements are sufficient to attract the protection of s. 137.1 must be assessed further at the second step, the "merits-based hurdle," and at the third step, the "public interest hurdle."

[34] However, the motion judge stopped her analysis at the first step, concluding that Mr. Bouragba did not satisfy his burden to establish that the communications relate to a matter of public interest. The motion judge did not proceed to the second and third steps of the *Pointes* analysis. I would be reluctant to carry forward the reasoning process required by s. 137.1 on appeal without full argument on the "merits-based hurdle" and the "public interest hurdle," and in the absence of careful analysis by a motion judge.

[35] The appellant's criticisms of the adequacy of the motion judge's reasons are understandable. Most importantly, the reasons glossed over the appellant's

arguments. In *R. v. Walker*, [2008] 2 S.C.R. 245, 2008 SCC 34, Binnie J. stated, at para 20: "Reasons are sufficient if they are responsive to the case's live issues and the parties' key arguments." He noted that: "Their sufficiency should be measured not in the abstract, but as they respond to the substance of what was in issue."

[36] As McLachlin C.J. stated in *R. v. R.E.M.*, [2008] 3 S.C.R. 3 at para. 64, "a trial judge is not obliged to discuss all of the evidence on any given point, provided the reasons show that he or she grappled with the substance of the live issues on the trial." The purposes for good reasons were set out by L'Heureux-Dubé J. in *Baker v. Canada (Minister of Citizenship and Immigration),* [1999] 2 S.C.R. 817, at para. 39:

> Reasons… foster better decision making by ensuring that issues and reasoning are well articulated and, therefore, more carefully thought out. The process of writing reasons for decision by itself may be a guarantee of a better decision. Reasons also allow parties to see that the applicable issues have been carefully considered, and are invaluable if a decision is to be appealed, questioned, or considered on judicial review: …Those affected may be more likely to feel they were treated fairly and appropriately if reasons are given (internal citations omitted).

See generally *R. v. Sheppard*, 2002 SCC 26, [2002] 1 S.C.R. 869, per Binnie J., at para. 55; and *Vancouver International Airport Authority v. Public Service Alliance of Canada*, 2010 F.C.A. 158, [2011] 4 F.C.R. 425, per Stratas J.A., at

2019 ONCA 1028 (CanLII)

para. 16. See also *Clifford v. Ontario Municipal Employees Retirement System*, 2009 ONCA 670; 98 O.R. (3d) 210.

[37] Although the motion judge's reasons inadequately addressed the appellant's arguments, there is no basis for the appellant's suggestion that the motion judge showed bias. An allegation of bias is serious and is not to be made lightly. As Robertson J.A. observed in *Murray v. New Brunswick Police Commission*, 389 N.B.R. (2d) 372, at para. 10, unfortunately, self-represented litigants sometimes operate, like Mr. Bouragba, "on the mistaken assumption that if he or she is unsuccessful on any ruling it is because of bias on the part of the decision-maker." This was an unwarranted allegation.

VI. DISPOSITION

[38] I would allow the appeal, set aside the judgment and the order for costs, and remit the appellant's motion to the Superior Court to be heard by a different judge.

Released: "P.L." December 31, 2019

"P. Lauwers J.A."
"I agree. Fairburn J.A."
"I agree. B. Zarnett J.A."

2019 ONCA 1028 (CanLII)

Chapter 3

Reports on Value-for-Money Audits

Our value-for-money (VFM) audits examine how well government ministries, organizations in the broader public sector, agencies of the Crown and Crown-controlled corporations manage their programs and activities. These audits are conducted under subsection 12(2) of the *Auditor General Act*, which requires that the Auditor General, an independent officer of the Legislative Assembly of Ontario, report on any cases where we have found money spent without due regard for economy and efficiency, or where appropriate procedures were not in place to measure and report on the effectiveness of service delivery. Where relevant, such audits also include compliance issues. In essence, VFM audits delve into the underlying operations of the ministry program or organization being audited to assess both their cost-effectiveness and the level of service they deliver to the public. This chapter contains the conclusions, observations and recommendations for the VFM audits conducted in the past audit year.

The ministry programs and activities and the organizations in the broader public sector audited this year were selected by the Office's senior management on the basis of selection criteria including the financial impact of a program or organization, its significance to the Legislative Assembly, related issues of public sensitivity and safety, and the results of past audits and related follow-up work.

We conducted our work and reported on the results of our examination in accordance with the Canadian Standard on Assurance Engagements—Direct Engagements issued by the Auditing and Assurance Standards Board of the Chartered Professional Accountants of Canada. These standards involve conducting the tests and other procedures that we consider necessary, including obtaining advice from external experts when appropriate to obtain a reasonable level of assurance.

Our Office applies Canadian Standards on Quality Control and, as a result, maintains a comprehensive quality control system that includes documented policies and procedures with respect to compliance with the code of professional conduct, professional standards and applicable legal and regulatory requirements. We have complied with the independence and other ethical requirements of the Code of Professional Conduct issued by the Chartered Professional Accountants of Ontario, which are founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour.

Before beginning an audit, our staff conduct in-depth research into the area to be audited and meet with representatives of the auditee to discuss the focus of the audit, including our audit objectives and criteria. During the audit, staff maintain an ongoing dialogue with the auditee to review the progress of the audit and ensure open communications. At the conclusion of the audit fieldwork, significant issues are discussed with the auditee and a draft audit report is prepared. Senior audit staff then meet with senior management from the auditee to discuss the draft report and the management responses to our

recommendations. In the case of organizations in the broader public sector, discussions are also held with senior management of the funding ministry.

Once the content and responses for each VFM audit report are finalized, the VFM audit reports are incorporated as sections of this chapter of the Annual Report.

Acute-Care Hospital Patient Safety and Drug Administration

1.0 Summary

Although patients visit hospitals in order to address health concerns and receive health-care services, there are some instances where patients can be unintentionally harmed as a result of the care provided during their visit.

Patient safety refers to reducing the risk of patient harm through policies and procedures that hospitals design, implement and follow. Patient safety incidents—such as hospital-acquired infections and medication errors—can be caused by poorly designed systems and processes and unsafe human acts in the delivery of hospital care.

As of April 1, 2019, there were 141 public hospitals in Ontario, operating on a total of 224 sites. These include 123 acute-care hospitals, where patients primarily receive active short-term treatment; eight chronic-care and rehabilitation hospitals for patients with long-term needs; four specialty psychiatric hospitals; and six hospitals that provide a variety of out-patient and rehabilitation services. In this report we focused on patient safety in acute-care hospitals, and we use the word "hospitals" to refer only to acute-care hospitals.

Under the *Public Hospitals Act, 1990*, hospitals are required to investigate patient safety incidents and to take steps to prevent similar incidents from occurring in the future. Non-governmental organizations, such as Accreditation Canada, also inspect and accredit hospitals to assess whether they comply with standards that focus on patient safety.

Public hospitals in Ontario are corporations accountable to their own boards and directly responsible for their own day-to-day management. Hospitals are required by law to monitor and report on various patient safety indicators, and to comply with relevant standards and legislation.

Hospital data collected by the Canadian Institute for Health Information shows that each year, among the more than 1 million patient discharges from Ontario acute-care hospitals, on average approximately 67,000 patients were harmed during the hospital stay. Between 2014/15 and 2017/18, nearly six of every 100 patients experienced harm while in hospital. This is the second-highest rate of hospital patient harm in Canada, after Nova Scotia.

Public concern with the safety of health care has increased in recent years due to growing research on the impact that medical errors and hospital-acquired infections have on patients and on the health-care system.

While the vast majority of patients in Ontario receive safe care in hospital, and the acute-care hospitals we visited are committed to patient safety, our audit found that more can be done to improve patient safety. Current laws and practices in Ontario make it difficult for hospitals to address concerns with the safety of care provided by some nurses and doctors. Staff survey results at Ontario

hospitals varied significantly, rating Ontario hospital patient safety practices from excellent to poor and failing, and many hospitals did not fully comply with required patient safety practices.

Among our significant findings:

- **Current practices in Ontario put confidentiality about nurses' poor performance ahead of patient safety.** Non-disclosure arrangements negotiated by unions with hospitals can result in potential new employers not being made aware of a nurses' poor past performance. Because of concerns about potential civil legal actions, during an employment reference check hospitals may not freely share with potential employers a nurse's complete and truthful employment and performance history. We found that such practices can mislead hiring hospitals and pose an increased risk to patient safety. For instance, on October 16, 2018, one hospital fired a nurse for a very serious breach of mandatory patient care standards resulting in a patient's death. The hospital reported the termination a few days later to the College of Nurses of Ontario. However, as of July 31, 2019, the College had not yet completed its investigation. The termination was treated as a resignation and the nurse currently works for another hospital. Some jurisdictions in the United States have specific legislation in place that protects hospitals from liability associated with any civil legal action for disclosing a complete and truthful record about a current or former nurse to a prospective employer.
- **Nurses who hospitals have found lack competence and who have been terminated or banned continue to pose a risk to patient safety.** We reviewed a sample of nurses who were terminated for lack of competence and/or inappropriate conduct, and agency nurses that were banned, in the past seven years in nine of the 13 hospitals we visited. (Agency nurses who are found incompetent may be banned by a hospital.) After their first termination or banning, 15 of the nurses subsequently worked at another hospital or for another agency. We noted that four of them were either subsequently terminated or banned again for lack of competence. For example, one nurse who currently works as an agency nurse was, between May 2016 and March 2019, terminated from two hospitals and also banned from a third hospital for lack of competence.
- **Information about nurses available to prospective employers limits the employers' ability to assess past performance issues.** The *Regulated Health Professions Act* limits the information the College of Nurses of Ontario is able to share with hospitals and with any other member of the public with respect to reports received about nurses terminated by other hospitals. Hospitals have also informed us that if they contact the College to obtain information about a prospective nurse employee, they are usually referred to the nurse's public profile, which does not have information on ongoing investigations and may have incomplete information. Therefore, when hospitals or agencies hire these nurses they do not have access to a complete record of their past employment history and performance issues.
- **As noted in our 2016 audit of Large Community Hospital Operations, hospitals are not able to quickly and cost-effectively terminate physicians who hospitals have found lack competence.** In our 2016 audit, we recommended that the Ministry evaluate this problem. However, in our current audit, we found that this problem still persists. For instance, the disciplining of one physician who a hospital found to have practice issues took about four years and cost the hospital over $560,000. An ongoing disciplinary process against this same physician at a second and third hospital,

where the physician currently works, has so far cost the two hospitals over $1 million. In defending themselves, physicians mostly do not personally incur legal fees; rather, their legal costs are indirectly paid by taxpayers through the liability insurance reimbursement program through which the Ministry reimburses physicians for enrolling in the Canadian Medical Protective Association that provides lawyers to represent physicians. We noted that in 2016/17, the Ministry of Health reimbursed physicians $256 million for costs of the Medical Liability Protection Reimbursement Program. In 2017/18, the amount was $326.4 million, an increase of $70.4 million, or 27.5%.

- **Patient safety culture at different hospitals varies significantly, from excellent to poor and failing.** We obtained the most recent staff survey results from all 123 acute-care hospitals in Ontario, completed between 2014 and 2019, and found that as many as nine in 10 staff at some hospitals graded their hospital as "very good" or "excellent" with respect to patient safety. However, at other hospitals, as many as one in three staff graded their hospital as "poor" or "failing."
- **Patient safety "never-events" have occurred at six of the hospitals we visited.** Health Quality Ontario and the Canadian Patient Safety Institute have identified 15 patient safety "never-events"—incidents that could cause serious patient harm or death and that are preventable using organizational checks and balances. According to these organizations, these events should never occur in hospitals. Yet we found that since 2015, 10 out of the 15 never-events have occurred a total of 214 times in six out of the 13 hospitals that we audited. However, we found that none of the six hospitals set any targets in their quality improvement plans to eliminate the occurrence of these events. One hospital we audited, Humber River Hospital, estimated that by reducing the occurrence of pressure ulcers—including serious pressure ulcers, one of the most common never-events—by about half, the hospital could save between $1.8 million to $3.7 million over two years. We also found that unlike hospitals in Saskatchewan and Nova Scotia, which are required to report never-events to their health ministries, Ontario hospitals are not required to track or report never-events to Health Quality Ontario, Local Health Integration Networks or the Ministry.
- **Between 2014 and 2019, over half of hospitals did not fully comply with required patient safety practices.** We obtained from 114 acute-care hospitals their most recent Accreditation Canada report between 2014 and 2019 and found that 18 hospitals did not comply with five or more required practices that are central to quality and patient safety. For example, Accreditation Canada found that some hospitals did not have strategies in place to help prevent patient falls and pressure injuries, while other hospitals did not meet the required communication practice to ensure that information is transferred when patients move between care units within the hospital. Washing and sterilization of reusable surgical tools and medical devices is an area where hospitals did not fully meet a significant number of high-priority criteria for infection prevention. If these practices are not complied with, a hospital is required to submit evidence of corrective actions to Accreditation Canada. Nevertheless, as Accreditation Canada conducts its visits every four years, it is unknown for how long prior to the visit hospitals did not have these required patient safety practices in place.
- **Hospital pharmacies do not fully comply with their own standards for the sterile preparation and mixing of hazardous chemotherapy and non-hazardous intravenous medications, but compliance is**

improving. In 2013, 1,202 hospital patients at four hospitals in Ontario—Windsor, London, Lakeridge and Peterborough—were infused with the wrong concentration of chemotherapy medication. In response to this incident, the College started annual inspections of hospital pharmacies in 2014 to assess their compliance with standards aimed at ensuring patient safety. Yet in 2018, hospital pharmacies on average fully met less than half of the 50 standards, which relate to the sterile preparation and mixing of intravenous medications. In response to the College's requirement for improvement, early inspection results from 2019 shared with us by the College showed that pharmacies' compliance has improved. However, on our visits to five hospitals, we found that some hospitals are not properly cleaning and disinfecting their sterile-rooms and the equipment used in the preparation and mixing of intravenous medications.

- **Hospitals do not always follow best practices for medication administration.** From 2012 to 2018, hospitals in Ontario reported to the Canadian Institute for Health Information 154 critical patient safety incidents involving administration of medications. Thirty-nine of these incidents resulted in a patient's death. We found that three of the hospitals we visited did not always comply with best practices for the administration of high-risk medications, such as using an independent double-check to verify medication and dosage, witnessing patients taking and swallowing medications, or confirming the identities of patients. Our expert told us that not following these best practices increases the likelihood of patient harm and/or death.
- **Hospitals do not always follow best practices for nursing shift changes that could reduce the risk of medication errors.** We found that six out of the 13 hospitals we visited did not always follow patient safety best practices for nursing shift changes, which recommends, if possible, conducting shift changes at the patient's bedside and involving the patient and the family (with the consent of the patient) in the process. In this way, the patient and/or family can identify any missing information or miscommunication between the nurses during shift change that could, for example, lead to medication administration errors causing patient harm.
- **Hospital staff may not be washing their hands as frequently as reported.** Although in 2018/19, hand-washing compliance before patient contact and after patient contact reported by hospitals was about 90% and 93%, respectively, we found that these results may be inflated due to the way they are observed and recorded. One hospital study found that hospital staff washed their hands 2.5 times more often when they saw an auditor observing and recording their hand-washing rate than when an auditor was not identifiable. Another study found that while the hand-washing compliance rate as observed by the auditor was 84%, the rate as observed by covert observation auditors was actually 50%. Hospital-acquired infections such as *C. difficile* are commonly spread via the hands of health-care workers. One hospital estimated that patients who acquired *C. difficile* while in its hospital required additional treatment costing an average of $9,000 per patient, or $1.6 million overall. In the past five years, 12,208 hospital-acquired *C. difficile* infections were reported in Ontario, an average of about 2,440 people each year. This suggests the additional treatment costs to the provincial health-care system as a result of these infections are substantial.

This report contains 22 recommendations, with 38 action items, to address our audit findings. **Appendix 8** lists our recommendations, and shows the stakeholders they are addressed to.

Overall Conclusion

Our audit concluded that the hospitals we visited have effective processes in place to investigate and learn from patient safety incidents. However, the Ministry and hospitals are not doing all that could be done to improve patient safety. Nurses that hospitals have found lack competence and who have been terminated or banned are rehired at other hospitals and/or agencies and continue to pose a risk to patient safety, because confidentiality about nurses' poor performance is put ahead of patient safety. Hospitals are not able to quickly and cost-effectively deal with physicians who hospitals find lack competence and harm patients. Hospitals do not always comply with some required patient safety practices and standards. For example, staff do not wash their hands as frequently as required, which contributes to the spread of hospital-acquired infections among patients, and best practices are not always followed when medications are administered to patients and during nurse shift changes, which contributes to medication administration errors. Hospital pharmacies also do not fully comply with their own standards for the sterile preparation and mixing of hazardous chemotherapy and non-hazardous intravenous medications.

OVERALL RESPONSE FROM OHA

The Ontario Hospital Association (OHA) appreciates the Auditor General's work to enhance patient safety. Patient safety remains the most important priority for Ontario hospitals, and every effort is made to ensure that patients and clients receive the highest-quality care possible.

Over the past decade, Ontario hospitals have been seeking to embed a culture of safety and quality within their organizations. Hospitals have worked closely with Accreditation Canada and others to implement best practices on quality and safety. This includes making required changes to high-priority areas like organizational culture, incident disclosure and management, medication reconciliation, surgery checklists, infection control and risk assessment.

Hospitals are also required to create and share an annual Quality Improvement Plan that provides measurable targets and have a Quality Committee at the board level, making a strong statement about the permanence of quality as an organizational strategy. Most importantly, hospitals routinely undertake comprehensive reviews of patient safety and critical incidents, which is an important part of quality improvement efforts in hospitals. While significant foundational progress has been made, Ontario hospitals recognize that there is still more to do.

The recommendations included in the Auditor General's 2019 report provide an opportunity for hospital leadership to reflect on what's needed within their organizations to further improve patient safety. In addition to existing work, the OHA will continue to share best practices, support hospital boards as they work to identify areas of improvement within their organizations, and work closely with the Ministry of Health and other patient safety stakeholder organizations as changes are made to improve safety and quality system-wide.

OVERALL MINISTRY RESPONSE

The Ministry of Health (Ministry) appreciates the comprehensive audit conducted by the Auditor General and welcomes the recommendations in the report. The safety of Ontario's patients is of utmost concern to the Ministry, and it is committed to a safe and reliable publicly funded hospital system.

The safety of Ontario's patients is a responsibility shared by providers, organizations, health system associations and the Ministry. Although the Ministry recognizes that there continues to be a need for improvements, steps have been taken to strengthen patient safety in health-care institutions across the province.

632

Ontario Health has a clear mandate to provide leadership on patient safety, through the public reporting of patient safety data and the development of clinical and quality standards for patient care and safety.

Key investments in quality improvement have also led to the delivery of safer, more reliable care in hospitals across the province. For instance, the Ministry has supported the implementation of the National Surgical Quality Improvement Program—Ontario.

Ontario hospitals that participated in the program reported better outcomes, shorter patient hospital stays and fewer surgical complications. As of March 2019, the province saw a 27% reduction in post-surgical infections among participating hospitals. This program also led to a 51% reduction in the rate of post-surgical urinary tract infections.

Performance on key patient safety indicators has also improved. According to 2017/18 data published by the Canadian Institute for Health Information, Ontario performs as well or better than the Canadian average on obstetric trauma, worsened pressure ulcers in long-term care, falls in the last 30 days in long-term care, and potentially inappropriate medication prescribed to seniors.

The Ministry will continue to identify opportunities for improvement in partnership with front-line providers and support institutions across the province as they work to deliver safe and reliable to care.

2.0 Background

2.1. Overview of Hospital Patient Safety

Patient safety practices are the set of policies and procedures hospitals have in place to reduce the risk of patient harm. Incidents of patient harm can be organized into the four types listed in **Figure 1**.

2.1.1 Hospital Patient Harm Statistics

Canada

Conducted in 2004, the *Canadian Adverse Events Study* remains the most comprehensive study of patient safety in Canada to date. This foundational study of patient safety across 20 hospitals in Canada, four of which are located in Ontario, found that 7.5% (187,500) of all (2.5 million) hospital patients admitted annually to hospitals in Canada were unintentionally harmed by the care

Figure 1: Four Types of Patient Harm Incidents and Examples of Each

Source of data: Canadian Institute for Health Information and Canadian Patient Safety Institute

Type	Example
1. **Health-Care/Medication-Related Incidents** Harm related to general care provided and/or medication administered during a hospital stay.	A nurse administers the wrong medication to a patient.
2. **Hospital-Acquired Infections** Infections acquired during a hospital stay, including those related to or following a medical or surgical procedure.	A patient acquires a blood infection while receiving medication intravenously (directly into the vein).
3. **Patient Accidents** In-hospital injuries (e.g., fractures, dislocations, burns) due to an accident, not directly related to medical or surgical procedures.	An elderly patient slips and falls in the hallway, resulting in a hip fracture.
4. **Procedure-Related Incidents** Surgical and medical procedure errors and abnormal reactions to or complications from, surgical or medical procedures.	A sponge or instrument is mistakenly left inside the patient following a surgery.

Figure 2: Hospital Patient Harm Rate in International Jurisdictions and Canada
Prepared by the Office of the Auditor General of Ontario

Country	Patient Harm Rate (%)	Year Study Published
United States	7.7	2013
United States	13.5	2010
Spain	8.4	2006
Australia	8.3	2006
Canada	7.5	2004

they received in hospitals. The result for these patients was longer hospital stays and, in some cases, disability. The study also found that in one year, between 9,000 and 24,000 deaths caused by patient safety incidents could have been prevented. A more recent 2016 study, *Measuring Patient Harm in Canadian Hospitals*, found that on any given day, more than 1,600 hospital beds across Canada are occupied by a patient who suffered harm that extended their hospital stay. As seen in **Figure 2**, Canada's patient harm rate is similar to the rates reported in other international jurisdictions, such as the United States, Australia and Spain.

Ontario

Between April 2014 and March 2018, Ontario acute-care hospitals reported to the Canadian Institute for Health Information, a not-for-profit organization that provides essential information on Canada's health systems and the health of Canadians, almost 270,000 individual preventable patient harm incidents. One of the most common types of incidents is infections. In **Figures 3** and **4** we compare Ontario's results to the other provinces' and territories' results for the years 2014/15–2016/17. **Figure 3** compares the average number of hospital discharges per year with at least one occurrence of patient harm, and **Figure 4** shows the annual rate of occurrences of patient harm per 100 hospital discharges.

Ontario has the highest average number of discharges and the highest average number of discharges with at least one occurrence of harm in Canada. Comparatively, the province's 5.8% rate of hospital harm is the second-highest in Canada.

2.1.2 Hospital Patient Safety Governance Structure

Ontario hospitals are corporations accountable to their own boards and directly responsible for their own day-to-day management. Under the *Excellent Care for All Act, 2010* (Act), hospitals are required to:

- establish a service quality committee of the board, responsible for monitoring and reporting to the board on the overall quality of services and safety of care provided;
- develop annual quality improvement plans, which outline how a hospital will improve the quality of care it provides in the coming year;
- conduct regular surveys of patients and staff to assess patient safety and quality of care culture; and
- investigate all patient safety incidents and take steps to prevent similar incidents from occurring in the future.

Governance

Under the *Public Hospitals Act, 1990*, and the *Excellent Care for All Act, 2010*, hospitals must establish governance and reporting structures to monitor and address patient safety concerns. **Appendix 1** shows an example of the governance structure and required committees for Ontario hospitals, and describes their key responsibilities.

Depending on the hospital's size, the complexity of offered care services and the hospital's resources, hospitals could establish additional internal subcommittees and working groups to address patient safety issues.

Each hospital is required to enter into a Service Accountability Agreement with its Local Health Integration Network. This agreement outlines a hospital's accountability and performance expectations and includes measurement and

Figure 3: Provincial and Territorial Average Acute-Care Hospital Discharges per Year with at Least One Occurrence of Harm, 2014/15–2016/17

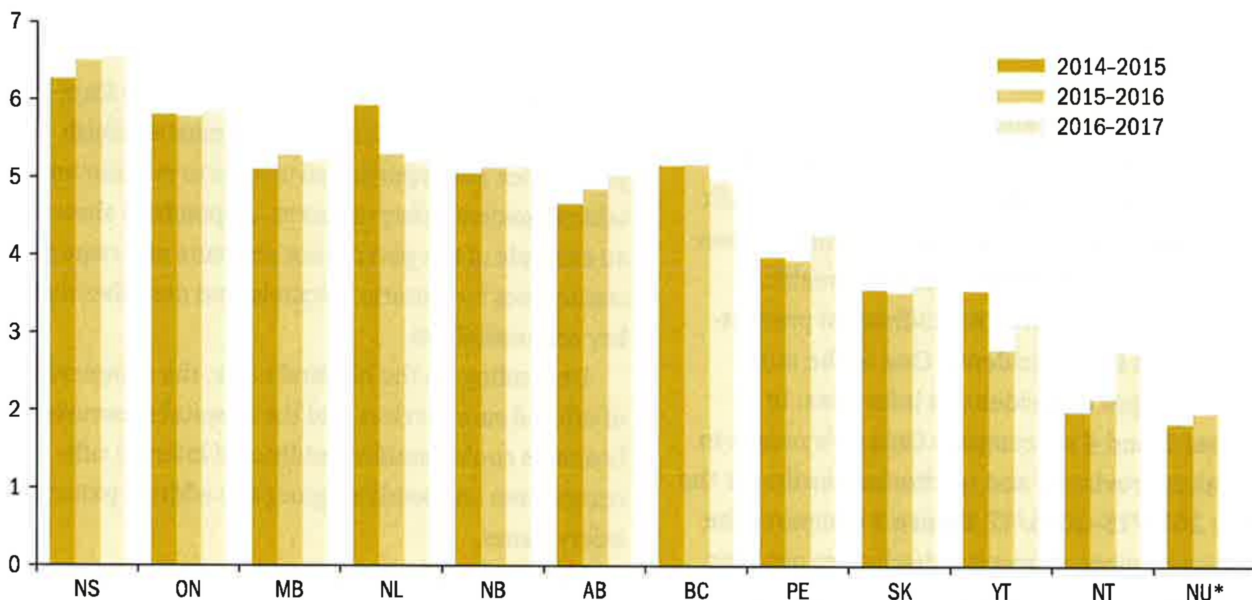
Source of data: Canadian Institute for Health Information

Province/Territory*	Average # of Discharges per Year	Average # of Discharges per Year with at Least 1 Occurrence of Harm	Rate of Discharges with Harm (%)
Nova Scotia	89,458	5,770	6.5
Ontario	**1,150,194**	**66,951**	**5.8**
Newfoundland and Labrador	52,165	2,861	5.5
Manitoba	125,868	6,554	5.2
British Columbia	412,049	21,033	5.1
New Brunswick	80,817	4,133	5.1
Alberta	384,487	18,666	4.9
Prince Edward Island	14,243	579	4.1
Saskatchewan	134,338	4,798	3.6
Yukon	3,170	100	3.2
Northwest Territories	4,804	111	2.3
Nunavut	1,754	34	1.9

* Data from Quebec is excluded due to methodological issues.

Figure 4: Provincial and Territorial Annual Rate of Occurrences of Harm per 100 Acute-Care Hospital Discharges, 2014/15–2016/17

Source of data: Canadian Institute for Health Information



* Patient harm data is not available for Nunavut for 2016/17.

evaluation requirements for the health services that it provides. On February 26, 2019, the Ontario Minister of Health announced the creation of a central agency called Ontario Health to oversee the province's health-care system. The 14 Local Health Integration Networks and six provincial health agencies, including Cancer Care Ontario and eHealth Ontario, will be integrated into Ontario Health. Transition to Ontario Health began in spring 2019 and will continue until full integration is reached. In this report, our recommendations are addressed to the Ministry of Health. Ontario Health may take on responsibility for implementation of these recommendations in the near future.

2.1.3 Patient Safety Standards and Best Practices

To support the overall objective of promoting patient safety and preventing patient harm, hospitals follow patient safety standards and best practices developed by several different federal, provincial and not-for-profit organizations. Some standards and best practices pertain to specific areas of care, such as surgery, or to specific departments within the hospital, such as the hospital pharmacy. Other risk areas pertain to the hospital as a whole, such as infection prevention and control. These risk-specific standards and best practices are shown in **Appendix 2**. Other legislated requirements apply to the hospital as a whole, such as establishing a quality committee to monitor the overall quality of services provided, and surveying staff and patients with respect to the quality of care. These organization-wide requirements are shown in **Appendix 3**.

One of the main organizations that promotes patient safety best practices is Accreditation Canada. Every four years, this non-governmental, not-for-profit organization visits and accredits all 141 (123 acute-care) hospitals in Ontario, as well as other health-care facilities, against national standards. The visits are conducted to assess hospitals' compliance with all applicable standards and the required practices in six patient safety areas. The required practices in these six patient safety areas are summarized in **Appendix 4**.

Depending on the size and complexity of the hospital, Accreditation Canada's on-site visit at an Ontario hospital may last from two to six days, with an average visit of four days. During the visit, surveyors use direct observation and interaction with patients, families and health-care providers to gather evidence about the quality and safety of care and services.

In **Appendix 5**, we list other key organizations involved in setting and promoting patient safety best practices and standards.

2.1.4 Reporting on Hospital Patient Harm

Hospitals report various patient safety statistics to different organizations, both government and not-for-profit. Some of the reporting is mandatory, whereas other information is reported voluntarily. **Figure 5** lists the mandatory reporting of patient safety information by hospitals. **Figure 6** lists the voluntary reporting of patient safety information by hospitals.

2.1.5 Nurses Deliver Most Hospital Patient Care

About 182,000 nurses provide care in Ontario, of whom about 89,000 work in hospitals (74,000 in acute-care hospitals). Nurses comprise the largest single component of hospital staff and provide hands-on care to patients at their bedside by administering medications, managing intravenous lines, observing and monitoring patients' conditions and behaviour, maintaining patient records and communicating with other members of the health-care team.

Most nurses are employees of the hospital. However, at times of nurse shortages, some hospitals recruit additional temporary nurses from external agencies. These nurses are not employees of the hospital, and the hospital pays the agencies for the

636

Figure 5: Mandatory Reporting of Patient Safety Information by Hospitals
Prepared by the Office of the Auditor General of Ontario

Reported To	Required By	Information Reported
Ministry of Health/Health Quality Ontario	*Public Hospitals Act, 1990* (Regulation 965)	**Publicly Reportable Patient Safety Indicators** • Hospital-acquired *Clostridium difficile* rate • Rate of ventilator-associated pneumonia • Central-line infection rate • Rate of hospital-acquired Methicillin-resistant *Staphylococcus aureus* bacteremia • Vancomycin-resistant *Enterococci* infection rate • Hospital Standardized Mortality Ratio: actual deaths compared to expected deaths • Surgical Site Infection Prevention for hip and knee joint replacement surgeries • Hand Hygiene Compliance • Surgical Checklist Compliance
Local Health Integration Network/ Ministry of Health	Hospital Service Accountability Agreement	**Contractual Performance Obligations** • Hospital-acquired *Clostridium difficile* rate • Hospital Standardized Mortality Ratio • Rate of ventilator-associated pneumonia • Central-line infection rate • Rate of hospital-acquired Methicillin-resistant *Staphylococcus aureus* bacteremia
Health Quality Ontario	*Excellent Care for All Act, 2010*	**Quality Improvement Plans (QIPs)** Annual plans include mandatory, recommended and other indicators, including: • workplace violence incidents • medication reconciliation at discharge • medication reconciliation at admission • physical restraints in mental health • antimicrobial-free days
Local Health Integration Network/ Ministry of Health	Hospital Service Accountability Agreement	**Quality-Based Procedures** • Cataract surgery complications • Mortality rate from chronic obstructive pulmonary disease • Mortality rate and hospital readmission associated with congestive heart failure • Post-hip fracture surgery re-fractures and mortality rate • Post-hip/knee replacement readmission and morality rate • Stroke patient rate of readmission
Public Health Ontario	*Health Protection and Promotion Act, 1990*	**Hospital Infections** Statistics on various infections
Health Canada	Bill C-17, Protecting Canadians from *Unsafe Drugs Act* (Vanessa's Law)	**Drug Reactions** Serious adverse drug reaction (e.g., allergies) that involves a therapeutic product, or a medical device incident that involves a therapeutic product
Canadian Institute for Health Information	Ministry of Health directive	**Critical Incident Reporting** Medication and intravenous errors that result in death or serious harm
Canadian Institute for Health Information	*Public Hospitals Act, 1990*	**Hospital Harm** Reported as part of Discharge Abstract Database. Number of occurrences of patient harm—31 types of harm (infections, bed sores, objects left inside patients, etc.)

Figure 6: Voluntary Reporting of Patient Safety Information by Hospitals

Prepared by the Office of the Auditor General of Ontario

Report To	Description (Current Reporting)
American College of Surgeons and Health Quality Ontario	**National Surgical Quality Improvement Program—Ontario*** Surgical safety: Statistics on surgical problems such as site infections, leaving items inside the patient, post-operative complications and death and other surgery-related incidents
Institute for Safe Medication Practices Canada	**Canadian Medication Incident Reporting and Prevention System** Medication incidents
Canadian Institute for Health Information	**National System for Incident Reporting** Medication and radiation treatment incidents
Healthcare Insurance Reciprocal of Canada	**Incidents Resulting in Litigation** As hospital's insurance provider, has access to incident cases. Develops and distributes risk mitigation strategy plans
Canadian Patient Safety Institute (CPSI)	**Patient Safety Incidents** Hospitals may share patient safety incident information with the CPSI so they can develop best practices and other documents

* The program is made up of 46 Ontario hospital sites representing up to 80% of all adult surgeries in the province.

hours worked by the agency nurses. Nursing agencies are unregulated, and many agencies operate in Ontario. In 2017 (the latest available information), they employed about 4,600 nurses.

Personal support workers also provide hands-on care to hospital patients; however, this care is restricted to assisting patients with activities of daily living such as feeding, changing, bathing and mobility assistance. Under specific conditions, personal support workers are allowed to administer medications, but the procedure must be delegated and overseen by a nurse and/or be a routine activity for the patient.

2.1.6 College of Nurses of Ontario

Nurses working in Ontario must be registered by the College of Nurses of Ontario. The College regulates the nursing profession in Ontario and is responsible for disciplining nurses who are found to have committed an act of professional misconduct. Between 2014 and 2018, the College revoked the licences of 37 nurses. The College maintains a publicly available database that contains disciplinary decisions posted by the College and information self-reported by nurses, such as their place of employment.

2.1.7 Physicians

There are about 37,000 physicians in Ontario. To practise medicine in Ontario, physicians must be members of the College of Physicians and Surgeons of Ontario, which regulates the practice of medicine to protect and serve the public interest. In a hospital, physicians are generally responsible for diagnosing diseases and health conditions, prescribing medication, performing medical procedures, including surgeries, and monitoring patients' health. Physicians report to the hospital's Chief of Staff. Hospitals consider physicians to be independent contractors, and grant them hospital privileges that give them the right to use hospital facilities and equipment to treat patients, without being hospital employees. A hospital's Board of Directors is responsible for appointing, disciplining and terminating physicians.

3.0 Audit Objective and Scope

The objective of our audit was to assess whether acute-care hospitals achieve patient safety by:

- ensuring that staff have processes in place that support the safe and appropriate use of equipment, procedures and medication in delivering medical care to patients;
- implementing effective processes and systems to identify and reduce the risk of patient harm; and
- identifying, reporting and responding to incidents of patient harm (including learning from past incidents and taking steps to prevent them from recurring).

In planning for our work, we identified the audit criteria (see **Appendix 6**) we would use to address our audit objective. These criteria were established based on a review of applicable legislation, policies and procedures, internal and external studies, and best practices. Senior management at the Ministry of Health and the hospitals we visited reviewed and agreed with the suitability of our objectives and associated criteria.

We conducted our audit between December 2018 and September 2019. We obtained written representation from the Ministry of Health (Ministry) and hospital management that, effective November 14, 2019, they had provided us with all the information they were aware of that could significantly affect the findings or the conclusions of this report.

Our audit work was conducted at hospitals of various sizes in regions across the province. See **Appendix 7** for a list of the hospitals we visited as part of the audit, and the areas of the hospitals we focused on during the visits.

To gain a fuller perspective of patient safety, we also consulted with many stakeholders, and reviewed relevant journals, reports and other related documentation. In addition to visiting the hospitals described above, our audit team:

- interviewed relevant stakeholder groups, including Public Health Ontario, Health Quality Ontario, the Canadian Patient Safety Institute, the Institute for Safe Medication Practices Canada, the Ontario Nurses Association, the Ontario Hospital Association, the Patient Ombudsman and Accreditation Canada;
- met with Dr. Ross Baker, lead researcher of the landmark 2004 *Canadian Adverse Events Study: the incidence of adverse events among hospital patients in Canada*;
- met with the Deputy Chief Coroner of Ontario, Dr. Reuven Jhirad, to discuss provincial perspectives and statistics on deaths resulting from patient harm incidents;
- performed multiple walkthroughs at one Toronto-area hospital and at two Peel-area hospitals to gain an understanding of relevant hospital departments and processes in advance of our fieldwork;
- reviewed many patient safety journal articles and research papers from several jurisdictions, including Canada, the United States and the United Kingdom;
- reviewed all publicly available statistics on patient harm in Ontario and co-ordinated a request through the Canadian Institute for Health Information for additional non-public statistics; and
- obtained and reviewed the most recent safety reports from all Ontario hospitals, including:
  - hospital accreditation (assessment against required patient safety practices);
  - patient safety staff survey (staff feedback on how safe the care is at their hospital);
  - risk assessment (high-risk areas based on liability claims against the hospital);
  - hospital pharmacy inspection (annual assessment against standards); and
  - other third-party assessments of hospital laboratories, medical testing facilities and medical equipment sterilization facilities.

During our hospitals visits, we reviewed patient files, medication documentation, hospital policies, incident investigation files, human resource files, and board and committee meeting minutes. Our audit work on nurses related to only the nine hospitals we visited with respect to human resources. We also engaged a consultant with expertise in the field of medication safety and nursing patient safety best practices to assist us on this audit.

4.0 Detailed Audit Observations

Our audit focused on five areas relating to patient safety, as shown in **Figure 7**. Our findings address these areas.

4.1 Focus on Patient Safety Not Consistent between Hospitals

As defined by the World Health Organization, "quality of care" is "the extent to which health-care services provided to individuals and patient populations improve desired health outcomes. In order to achieve this, health care must be safe, effective, timely, efficient, equitable and people-centred." Patient safety is therefore included as a dimension in quality of care.

We found that "patient safety" is not explicitly stated in the mission, vision and core values for most hospitals that we visited in a way that would foreground the phrase as the foundation for the organizational culture of these hospitals.

We expected that patient safety and quality of care would be one of the key priorities that would be clearly stated in each hospital's mission, vision and core values. However, when we reviewed the mission, vision and core values of the 13 hospitals we audited, we found that not all of them made a clear and direct reference to patient safety and quality of care. The other hospitals mention quality, excellence and compassion—but not specifically patient safety.

We also found that Ontario hospital survey results show that staff ratings on overall patient safety at hospitals vary significantly, from excellent to poor and failing.

4.1.1 Staff Survey Results Show Patient Safety Culture at Different Hospitals Varies from Excellent to Poor

According to the Canadian Patient Safety Institute, workplace culture influences patient safety both directly by determining accepted practice and indirectly by acting as a barrier or enabler to the adoption of behaviours that promote patient safety.

Under the *Excellent Care for All Act, 2010*, hospitals are required to survey staff and patients with respect to the quality and safety of care provided at the hospital. As part of their four-year accreditation cycle, hospitals use the mandatory patient safety culture survey provided by Accreditation Canada.

We obtained the most recent surveys results from all 123 acute-care hospitals in Ontario, completed between 2014 and 2019, and found that as many as nine in 10 staff at some hospitals graded their hospital as "very good" or "excellent" with respect to patient safety. However, at other hospitals, as many as one in three staff graded their hospital as "poor" or "failing."

Figure 8 lists the five hospitals where staff gave the best overall assessment of patient safety culture at their hospital and the five hospitals with the highest proportion of surveyed staff who graded their hospital as poor or failing with respect to patient safety. The five hospitals with the best overall patient safety culture were all smaller hospitals with less than 250 surveyed staff. **Figure 9** shows five large hospitals (those with 499 or more surveyed staff) with the best overall staff assessment of patient safety. In **Appendix 9**, we include the survey results for all 123 acute-care hospitals.

Figure 7: Five Patient Safety Areas of Audit Focus
Prepared by the Office of the Auditor General of Ontario

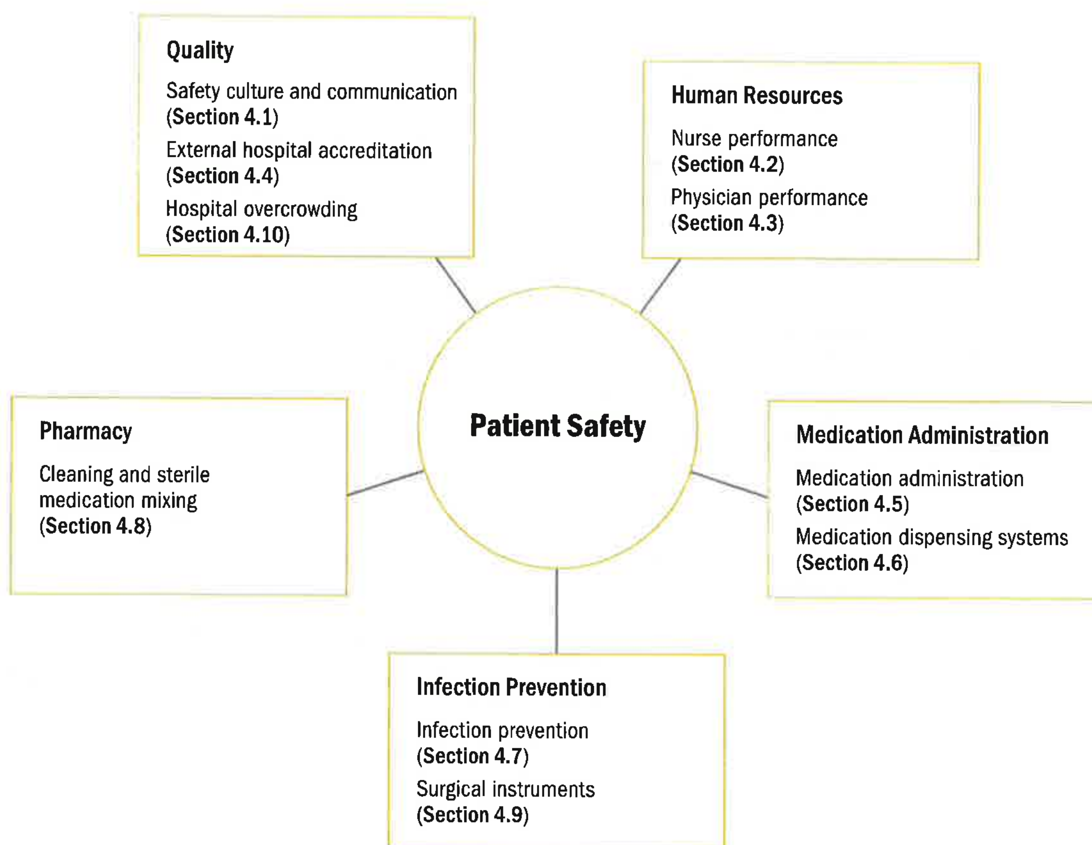


Figure 8: Five Acute-Care Hospitals with Best Overall and Worst Overall Patient Safety Culture Staff Survey Results, 2014–2019
Source of data: Ontario Hospitals

			Overall Grade on Patient Safety (%)			
Hospital	**Survey Year**	**# of Staff Surveyed**	**Excellent or Very Good**	**Acceptable**	**Poor or Failing**	**Total**
Best						
Services de Santé de Chapleau Health Services	2016	74	89	8	3	100
Hanover and District Hospital	2017	113	81	16	3	100
St. Francis Memorial Hospital	2016	82	84	14	2	100
Renfrew Victoria Hospital	2017	228	80	18	2	100
Hôpital Notre-Dame Hospital	2017	60	82	15	3	100
Worst						
Brant Community Healthcare System	2017	462	28	39	33	100
London Health Sciences Centre	2016	502	38	38	24	100
Southlake Regional Health Centre	2014	503	42	34	24	100
Joseph Brant Hospital	2018	530	36	42	22	100
Humber River Hospital	2016	995	41	38	21	100

Note: Survey results based on staff perceptions at a point in time.

Figure 9: Five Large Acute-Care Hospitals with Best Overall Patient Safety Culture Staff Survey Results, 2014–2019

Source of data: Ontario Hospitals

Hospital	Survey Year	#of Staff Surveyed	Overall Grade on Patient Safety (%)			
			Excellent or Very Good	Acceptable	Poor or Failing	Total
Woodstock Hospital	2016	499	70	26	4	**100**
The Hospital For Sick Children	2016	2,014	70	27	3	**100**
Sinai Health System	2015	751	68	29	3	**100**
University of Ottawa Heart Institute	2017	658	66	30	4	**100**
Sunnybrook Health Sciences Centre	2016	1,434	66	30	4	**100**

Note: Survey results based on staff perceptions at a point in time.

RECOMMENDATION 1

To further emphasize patient safety as a foundation for hospitals' organizational culture, we recommend that hospitals explicitly incorporate the words "patient safety" in their mission, vision, and/or as one of their core values, and communicate this to their staff, ensuring that related actions demonstrate this emphasis.

RESPONSE FROM OHA

Ontario hospitals are governed by independent hospital boards, which provide guidance on an organization's mission, vision and values. Ontario hospitals will review this recommendation at the board level to determine whether improvements are needed to elevate the culture of safety within their organization.

4.1.2 Patient Safety "Never-Events" Occurred at Six Hospitals We Visited

In 2015, Health Quality Ontario (HQO) and the Canadian Patient Safety Institute identified 15 patient safety "never-events," which are defined as patient safety incidents that result in serious patient harm or death and that are preventable using organizational checks and balances. Identifying and preventing these safety events was identified as a priority by a patient safety consortium of more than 50 Canadian health-care organizations in 2014. According to broad stakeholder consensus, "never events" are preventable and should never occur in hospitals. An organizational culture that minimizes or eliminates never-events could foster a reduction in other preventable patient harms.

Between the 2015/16 and 2018/19 fiscal years, 10 out of the 15 never-events occurred a total of 214 times in six of the 13 hospitals we visited that tracked these incidents. **Figure 10** describes the never-events and their overall frequency of occurrence at these six hospitals. Data was not available or never-events did not occur at the other seven hospitals we visited. **Figure 11** shows our compilation and summary of the number of never-events that occurred at each of the six hospitals we visited where never-events occurred between 2015/16 and 2018/19.

4.1.3 Patient Safety Never-Events Not Included in Quality Improvement Plans and Hospitals Have Not Set Targets to Eliminate Them

Preventing never-events has been identified by Health Quality Ontario and the Canadian Patient Safety Institute as a patient safety priority because these incidents are preventable and can have serious consequences for patients. For instance, at one

642

Figure 10: Never-Events and Their Frequency of Occurrence at Six Visited Acute-Care Hospitals, 2015/16–2018/19

Source of data: Ontario Hospitals

Patient Safety Never-Events		Frequency
1.	Serious pressure ulcer acquired after admission to hospital	111
2.	Patient under strict observation leaves a secured area without the knowledge of staff	26
3.	Unintended foreign object left in a patient following a procedure	26
4.	Wrong tissue, biological implant or blood product given to a patient	24
5.	Patient suicide, or attempted suicide that resulted in serious harm, while a patient was under suicide-prevention watch	11
6.	Surgery on the wrong body part or the wrong patient, or conducting the wrong surgical procedure	10
7.	Patient death or serious harm due to a failure to inquire whether a patient has a known allergy to medication, or due to administration of a medication where a patient's allergy was known	2
8.	Patient death or serious harm as a result of failure to identify and treat metabolic disturbances[1]	2
9.	Patient death or serious harm as a result of one of five pharmaceutical events[2]	1
10.	Patient death or serious harm as a result of transport of a frail patient, or patient with dementia, where patient was left in an unsafe environment	1
Total		**214**

Note: The hospitals visited did not report any of these five never-events:

- patient death or serious harm arising from the use of improperly sterilized instruments or equipment provided by the health care facility;
- patient death or serious harm due to the administration of the wrong inhalation or insufflation gas;
- patient death or serious harm due to uncontrolled movement of a ferromagnetic object in an MRI area;
- patient death or serious harm due to an accidental burn; or
- infant abducted, or discharged to the wrong person.

1. Metabolic disturbances are changes in the body's chemical processes that can cause serious life-threatening health problems.
2. The five pharmaceutical never-events:
   - wrong-route administration of chemotherapy agents;
   - intravenous administration of a concentrated potassium solution;
   - inadvertent injection of epinephrine intended for topical use;
   - overdose of hydromorphone by administration of a higher-concentration solution than intended; and
   - neuromuscular blockage without sedation, airway control and ventilation capability (this was the type of event which occurred at one of the hospitals we visited (Hamilton); the patient was given the wrong drug and needed to be resuscitated).

hospital, a surgery was performed on the wrong knee, and in another hospital, a sponge was left inside the patient after a surgery.

We found that none of the six hospitals set targets in their Quality Improvement Plans to minimize or eliminate the occurrence of these events. Two other hospitals we visited included one of the never-events—serious pressure ulcer acquired after admission to hospital—in their Quality Improvement Plans for 2018/19. No never-events were reported at these hospitals.

Figure 11: Occurrence of Never-Events at Six Visited Acute-Care Hospitals, 2015/16–2018/19

Source of data: Ontario Hospitals

Hospital	# of Never-Events
Hospital 1	71
Hospital 2	66
Hospital 3	37
Hospital 4	18
Hospital 5	17
Hospital 6	5
Total	**214**

4.1.4 Hospitals Not Required to Track and Report Patient Safety Never-Events

We found that hospitals are not required to track or report never-events to Health Quality Ontario or the Ministry of Health. Such information could be analyzed to determine the reasons for these events in Ontario, the cost that these events add to the health-care system and the systemic best practices to adopt to avoid these events. For instance, one hospital we audited (Humber River Hospital) estimated that by reducing the occurrence of pressure ulcers—including serious pressure ulcers, one of the most common never-events—by about half, the hospital could save between $1.8 million to $3.7 million over two years.

We noted that hospitals in Saskatchewan and Nova Scotia are required to track and report never-events to their respective health ministries.

RECOMMENDATION 2

To determine and reduce the impact of never-events on patient safety and the health-care system, we recommend that the Ministry of Health:

- work with internal and external partners to leverage an existing system that can accumulate and track hospital never-event data;
- upon implementation and rollout completion of this system, analyze the frequency of never-events occurring at Ontario hospitals, estimating their cost to the health-care system; and
- partner with hospitals and best practice organizations/stakeholder groups to develop a plan to prevent them from happening.

MINISTRY RESPONSE

The Ministry welcomes this recommendation as it supports patient safety across the health system. The Ministry will assess opportunities to leverage existing data collection tools to support the capture of hospital never-events and identify evidence-based approaches to address frequency of never events and assess the health-care system cost impacts.

RECOMMENDATION 3

To minimize the occurrence of serious preventable patient safety incidents, we recommend that hospitals:

- enhance patient safety practices to eliminate the occurrence of never-events;
- set a formal target to eliminate the occurrence of never-events and include this target in their Quality Improvement Plans; and
- track and report never-events to the Ministry of Health.

RESPONSE FROM OHA

Ontario hospitals are committed to enhancing patient safety practices and will work with their boards to determine whether never-events should be added to future Quality Improvement Plans.

4.1.5 Lessons Learned from Patient Safety Incidents Are Not Shared between Hospitals

Under the *Public Hospitals Act, 1990*, hospitals are required to investigate patient safety incidents and take steps to prevent similar incidents from occurring in the future. Overall, we found that the hospitals we visited were committed to the objective of learning from incidents occurring at their own sites and improving the safety and quality of patient care.

We noted that the Ontario Hospital Association provides patient safety resources and facilitates peer learning among its members, and that stakeholder groups, such as the Institute for Safe Medication Practices Canada, issue safety bulletins to flag new risk areas and identified best practices.

Currently, hospitals do not share lessons learned from investigating specific patient safety incidents. This increases the risk that a patient could experience an incident at Hospital A, and another patient could subsequently experience a similar incident

at a neighbouring Hospital B. Hospital A does not share lessons learned with Hospital B in order to help prevent the same type of incident.

RECOMMENDATION 4

To better enable hospitals to prevent similar patient safety incidents, including never-events from recurring at different hospitals, we recommend that the Ministry of Health work with the Ontario Hospital Association and applicable stakeholder groups to establish a forum where hospitals can share their knowledge and lessons learned from patient safety incident investigations.

MINISTRY RESPONSE

All health-care providers have a role in improving patient safety. The Ministry of Health supports this recommendation and will work with the Ontario Hospital Association and other health system partners like Ontario Health, the Canadian Patient Safety Institute, and the Canadian Medical Protective Association to examine the feasibility of having a shared knowledge platform for patient safety incident investigations.

4.2 Some Nurses Found by Hospitals to Lack Competence Pose an Ongoing Risk to Patient Safety

Nursing is a profession that requires a high level of trust. For most hospital patients, the nursing staff are the main providers of direct care. Although the vast majority of nurses provide safe care to their patients, there are rare exceptions that can impact patient safety. As nurses are the hospitals' front-line caregivers, with responsibility for vulnerable patients, including the old and the very young, a lack of competence in nurses can lead to serious harm. Yet the laws and regulations that protect nurses' professional status in these instances could limit hospitals' ability to know when they are hiring a nurse with a history of serious professional incompetence and/or misconduct. These limitations are discussed further in **Section 4.2.2**.

Recent events in Ontario demonstrate the risk to patient safety when a health-care facility hires a nurse without having access to their relevant work history. A former nurse who between 2007 and 2014 killed eight of her long-term care patients was terminated twice for poor performance, but long-term-care facilities and nursing agencies kept rehiring her. She was enabled to keep working and harming her patients because the current system, a combination of laws, institutional practices and employer-employee arrangements, protects the personal and professional interests of health-care professionals.

If a hospital finds that a nurse's lack of competence has caused a patient harm, as part of the progressive disciplinary process the nurse would first be provided with an opportunity to address the competence issues by completing and passing a learning plan. Only if the nurse fails to complete the plan would the hospital then consider termination. In some cases, the nurse would have more than one chance to successfully complete the learning plan. Hospitals and other organizations that employ nurses are required to report all terminated nurses to the College of Nurses of Ontario when the termination is for reasons of professional misconduct, incompetence or incapacity (for example, intoxication).

We noted that some nurses found to lack competence and who have been terminated by hospitals have been associated with repeated incidents impacting patient safety. Hospitals that rehire them are limited in the information regarding past poor performance that they can obtain from the College of Nurses of Ontario and from past employers.

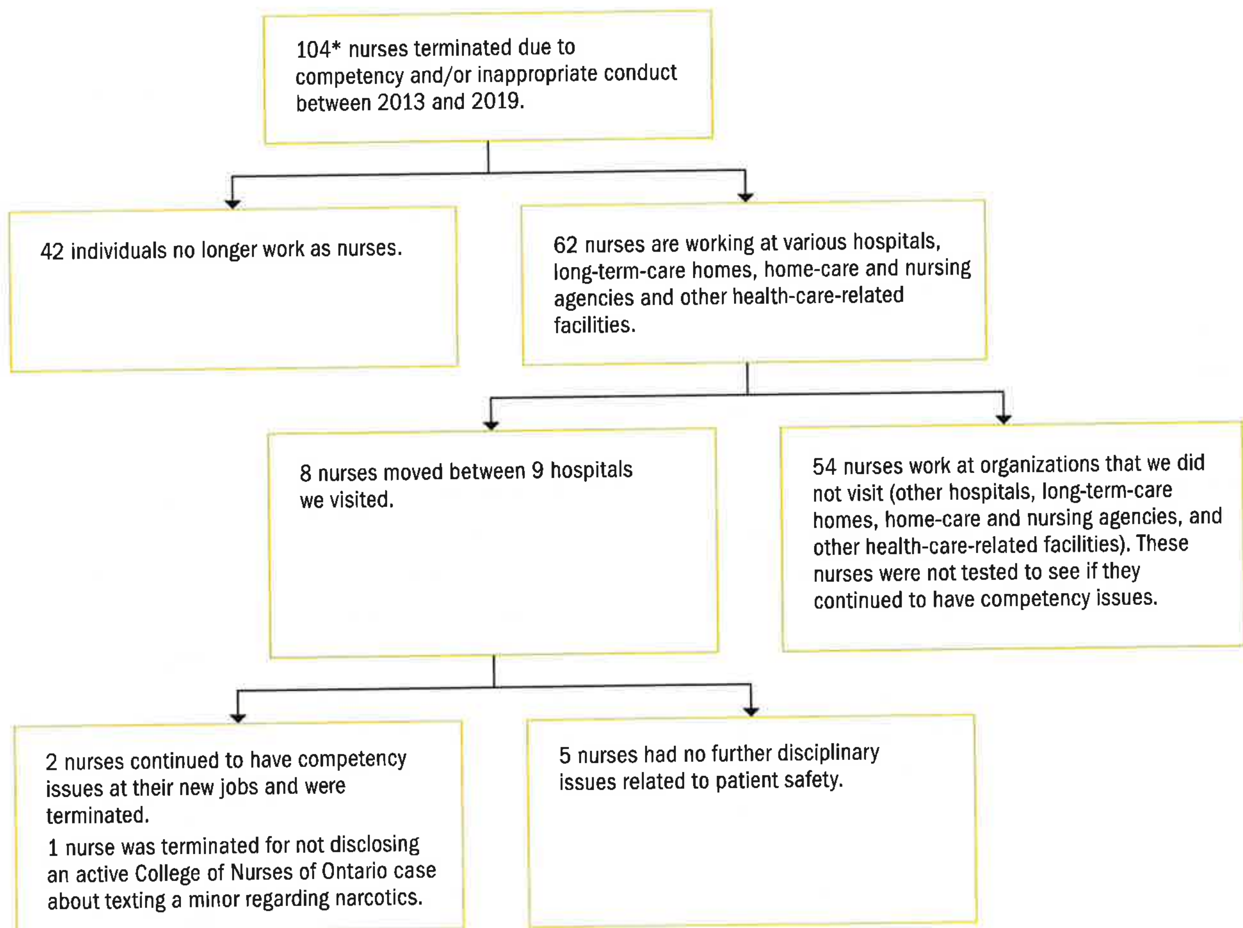
4.2.1 Hospitals We Visited Rehired Nurses Terminated Elsewhere Who Continued to Show Incompetence

Although the great majority of nurses at the hospitals that we visited have not faced any disciplinary actions, the hospitals have terminated some nurses for lack of competence and/or misconduct. As mentioned in **Section 2.1.5**, there are about 74,000 nurses working in acute-care hospitals in Ontario. Of more than 17,000 nurses employed at the nine hospitals where we conducted our work, we found that 104 nurses were terminated for lack of competence and/or inappropriate conduct over the past seven years. Of these 104 nurses, we found 62 who are still active and working (see **Figure 12**). The remaining 42 no longer practise as nurses, are not employed, have retired, work in another industry or have let their licences lapse. We also obtained from the three hospitals we visited that use agency nurses the names of 82 agency nurses who were banned from these hospitals.

We cross-referenced the names of the 62 terminated nurses between the hospitals that we visited. Eight of these nurses were subsequently rehired or worked through an agency at one of the hospitals we visited. The other 54 nurses continue to work as nurses elsewhere. We found that two of the eight nurses continued to harm patients and were again terminated or banned for lack of competence. For instance, one nurse made multiple errors, and a hospital terminated her after finding that she

Figure 12: Testing of Nurse Termination Cases Related to Competency and Practice Issues

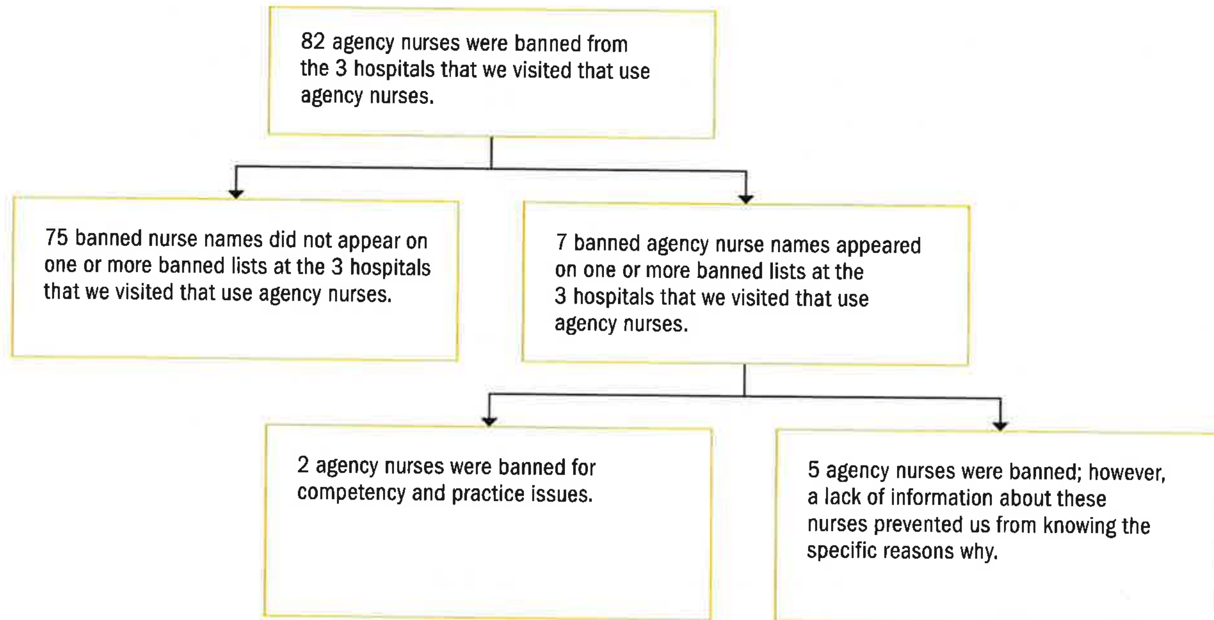
Prepared by the Office of the Auditor General of Ontario



* The number of cases may be incomplete due to lack of tracking of these cases—most hospitals rely on manual processes and store information in hard copies, some of which are archived.

646

Figure 13: Testing of Banned Agency Nurse Cases
Prepared by the Office of the Auditor General of Ontario



lacked basic nursing skills and knowledge, as well as critical thinking. This nurse then was hired by another hospital after not disclosing that she was terminated from the first hospital. The hospital then noted that this nurse lacked critical thinking skills, failed to recognize unsafe practices, failed to recognize or respond appropriately to a serious change in a patient's condition and lacked understanding of medication administration (including insulin). This nurse was then terminated by the second hospital. Currently, this nurse works as a nurse at a long-term-care home.

We also cross-referenced the names of the 82 banned agency nurses (see **Figure 13**) from the three hospitals that we visited that use agency nurses. We found that the names of seven banned agency nurses appeared on multiple lists or were terminated by the hospitals we visited. We found that two of the seven banned agency nurses were banned for lack of competence at multiple hospitals. This illustrates that when one hospital banned an agency nurse, this did not prevent the nurse from working at other hospitals, and this information was not shared by the agencies or the hospitals involved.

Figure 14 presents our observations on the work history of four nurses working at agencies or in a long-term-care home who have been terminated or banned by hospitals more than two times for lack of competence but continue to work.

4.2.2 Limited Information Available to Prospective Employers of Nurses Impacts Their Ability to be Aware of Past Performance Issues

We inquired why terminated nurses who continued to show incompetence were able to be rehired, either as employees or as agency nurses, by some of the hospitals we visited. The College of Nurses of Ontario informed us that the *Regulated Health Professions Act* limits the information it is able to share with hospitals and any member of the public with respect to nurses terminated and reported by other hospitals to the College. Hospitals also informed us that if they contact the College to obtain information about a prospective nurse employee, they are usually referred to the nurse's public profile, which does not have information on ongoing investigations

Figure 14: Work History Examples of Nurses Terminated or Banned by Acute-Care Hospitals for Lack of Competence Who Were Still Working in Hospitals

Prepared by the Office of the Auditor General of Ontario

Nurse (Current Employer)	Disciplinary Action (Employer)	Date	Cause for Termination/Banning
Nurse 1 (Agency)	Fired (Hospital)	May 2016	Medication administration and clinical decision-making errors. Over four months, failed to complete and pass a learning plan.
	Banned (Agency)	Dec 2018	Lack of critical thinking and knowledge gaps.
	Fired (Hospital)	Mar 2019	Medication administration errors. Lack of critical thinking and knowledge gaps. Over three months, failed to complete a learning plan.
Nurse 2 (Long-term-care home)	Fired (Hospital)	May 2016	Unsafe delivery of care and lack of basic nursing skills.
	Fired (Hospital)	Sep 2016	Unsafe delivery of care and lack of basic nursing skills.
Nurse 3* (Agency)	Banned (Agency)	Aug 2018	Medication administration errors.
	Banned (Agency)	Jan 2019	Medication administration errors.
Nurse 4* (Agency)	Banned (Agency)	Sep 2015	Medication administration errors.
	Banned (Agency)	Aug 2018	Practice issues (refused to help surgical patients resulting in understaffing of the surgical unit, which could lead to unsafe delivery of care for surgical patient).

Note: Agency nurses are not hospital employees, and therefore hospitals cannot discipline them. Instead, hospitals request that agencies not send them specific nurses. The names of these nurses are tracked on informal lists that hospitals refer to as "banned lists." Hospitals do not share these lists among themselves, and therefore a nurse banned in one hospital could work in other hospitals.

Hospitals store very limited information on agency nurses, as most of the information, including formal documents, is kept at the staffing agency. As a result, we reviewed only a list of agency nurses banned from the three hospitals that actively use agency nurses and the reasons for which these agency nurses were placed on the banned lists. We did not review agency records.

* These nurses were banned by two different hospitals.

and may have incomplete information. Therefore, when hospitals or agencies hire these nurses they do not have access to a complete record of their poor past employment history.

The College informed us that over the past five years, on average, organizations that employ nurses in Ontario have submitted to the College each year about 730 reports about nurses' professional misconduct, incompetence or incapacity (for example, intoxication). About 350 of the reports submitted each year (48%) pertain to nurses employed by hospitals. The other 52% have been submitted by other organizations that employ nurses, such as long-term-care homes.

Reports received by the College are individually screened for risk and are responded to in one or more ways, including meeting with the nurse, providing a written notice directing the nurse to take remedial action and, in some cases, initiating a formal investigation. From 2014 to 2018, between 26% and 47% of all reports received in the year resulted in a formal investigation. Depending on the nature and/or public risk of the reported issue, some investigations can take months or even years to resolve.

We found that the hospitals we visited reported all of the 62 terminated nurses in our sample to the College. As of July 31, 2019, there were no records publicly posted by the College relating to these nurses. There are several reasons why issues reported to the College do not appear on a nurse's public profile. For example, there may be an ongoing investigation, as was the case for Nurse 1 in **Figure 14**, or the College may take another corrective action, such as meeting with the nurse to arrange remedial steps, as occurred with Nurse 2.

In another example, one of the fired nurses failed on three separate occasions to complete and pass a learning plan; this nurse was found by the hospital to be unfit to practise and lacking the ability to perform a nurse's responsibilities, after the nurses was found to not know how to provide competent care during childbirth. This nurse currently works through an agency. The College of Nurses informed us that it is investigating this incident and assessing this nurse's competency gaps. However, none of this information is available online for prospective employers, and throughout the process, this nurse is able to continue working. We checked this individual's College profile, and it only indicated the timeline of their employment with no mention of termination or any performance issues.

RECOMMENDATION 5

To enable nurses' prospective employers to obtain a more complete record of nurses' employment history and performance and make well-informed hiring decisions, we recommend that the Ministry of Health have the Ontario Hospital Association work with the College of Nurses of Ontario and other regulatory stakeholders to:

- identify gaps in the current information available to prospective employers regarding past performance issues and terminations; and
- take steps to address gaps identified.

MINISTRY RESPONSE

The Ministry of Health is working with the health sector to address gaps in information-sharing between colleges and health system partners.

As part of continuing to improve transparency and increase information-sharing between employers and the health regulatory colleges, the College of Nurses of Ontario (College) and the Ministry have worked to add information about a nurse's employers from the past three years on the College's public register so that employers have a reliable way to obtain employment information about nurses.

The College has also worked to include all current employers on the public register. Since many nurses have more than one employer, this will provide a more accurate picture of a nurse's employment.

Work is currently under way to link information in better ways. The College has proactively partnered with nurse employers to establish an Employer Reference Group to identify areas to support employers' needs relating to nursing regulation.

4.2.3 Nurses' Self-Reported Employment History on the College of Nurses of Ontario Public Database Not Complete

Nurses can be licensed and can practise in multiple jurisdictions. However, we found that in Canada, there is currently no centralized system to which all provincial nursing regulatory bodies like the College of Nurses of Ontario can report their disciplinary actions. In the United States, regulatory bodies from each state are required to report all their disciplinary actions within 30 days to the National Practitioner Data Bank, a hospital-accessible database operated by the federal government. Hospitals in the United States can check whether nurses they hire are listed in this database for disciplinary actions. There is also a second public database operated by the National Council of State Boards of Nursing (NCSBN), which tracks disciplinary actions from every state (except Michigan) and also shows the jurisdictions where each nurse holds or has held a licence. Hospitals from around the world can check whether nurses they hire are listed in this database for disciplinary action.

In Ontario, nurses are required to self-report to the College of Nurses of Ontario any nursing licence they hold in any other jurisdiction, other professional designations they hold, their place(s) of employment, whether they have been investigated by a regulatory body for any misconduct in other

jurisdictions and whether they have been convicted of (or charged with) a crime.

We took a sample of 200 nurses from the 182,000 registered in Ontario and matched the information found in the College database with the US National Council of State Boards of Nursing database and the Michigan Board of Nursing. Five of the 200 nurses reported that Ontario was the only place where they held a licence; however, we found that these five nurses were also licensed in other jurisdictions, such as Michigan. Another four nurses reported that they held a licence in Ontario and one US state, but we found that these four nurses also held licences in at least one additional state. The College's public profile for these nurses therefore is incomplete.

For example, one Ontario hospital was unaware of the work history of one nurse who we found was involved in a number of errors relating to medication administration and delivery of patient care, and who, on April 2, 2019, resigned in the midst of disciplinary proceedings at the hospital. This nurse previously had a licence revoked in 2018 in Texas after the hospital filed a report to the nursing board that the nurse was "lacking fitness to practice nursing with reasonable skill and safety." This same nurse was arrested in 2015 in Texas and pleaded guilty to charges in January 2017. When the Ontario hospital hired this nurse, it was unaware of any of these things. Disclosure to the college of registration of disciplinary actions in other jurisdictions remains a self-reporting duty for nurses.

Hospital and agency hiring decisions are mostly based on information found in resumés. The Long-Term Care Homes Public Inquiry found that nurse Elizabeth Wettlaufer, who subsequently confessed and was convicted in the deaths of eight patients, did not include in her resumé her employment at Geraldton District Hospital in 1995, from which she was fired for stealing narcotics for herself. Her College of Nurses of Ontario public record was also clean when on April 21, 2014, another employer, a long-term-care home, conducted a search. This employer found her acceptable and hired her. In 2014, the College of Nurses would post only current employer information on the nurse's profile. So, even though the long-term-care home checked the profile for the employee it was considering, it could locate only the current employer: there was no employment history to be seen.

We have noted that the College tried to resolve this issue before the public inquiry into the safety of long-term-care residents in Ontario published its report on July 31, 2019. In March 2019, the College changed the nurse profile template to show not only a nurse's current employer, but a nurse's employment history as well. However, the College left it up to each individual nurse to update their own employment history. Despite these changes, we have noted that there are nurses in our sample whose self-reported employment history on their College profile omits hospitals where they were terminated for patient safety reasons.

RECOMMENDATION 6

In order for hospitals that hire nurses to have access to the complete record of nurses' past places of employment and disciplinary history, we recommend that hospitals:

- use the National Council of State Boards of Nursing public database to determine whether nurses they hire and employ have faced disciplinary actions in the United States; and
- if the hospital uses agency nurses, require nursing agencies to confirm these nurses have been screened through this database.

RESPONSE FROM OHA

Ontario hospitals will review this recommendation and are committed to working with the Ontario Hospital Association and the College of Nurses of Ontario to identify opportunities to enhance the information available to employers in making hiring decisions.

RECOMMENDATION 7

To help ensure that when hospitals hire nurses they have access to their full disciplinary record, we recommend that the Ministry of Health request that the Ontario Hospital Association and the College of Nurses of Ontario work together with their provincial and territorial counterparts to:

- explore a national system for provincial and territorial nursing regulatory bodies to report their disciplinary actions; and
- put in place an effective process that will ensure that all places of past employment and disciplinary records from other jurisdictions for each nurse are in its database, including records from US nursing databases.

MINISTRY RESPONSE

The *Regulated Health Professions Act, 1991*, requires every Ontario nurse to file a report in writing with the Executive Director of the College of Nurses of Ontario if there has been a finding of professional misconduct or incompetence made against the nurse by another body that governs a profession *inside or outside of Ontario* unless doing so would violate a publication ban. The report must be filed as soon as reasonably practical after the nurse receives notice of the finding made against her or him. The Ministry will work with the College of Nurses of Ontario to ensure that this requirement is communicated to nurses and will work with the College to explore best practices involving the sharing of information between provincial and territorial nursing regulators.

4.2.4 Nurses' Past Poor Performance Not Shared with Potential New Employers

We found that the potential risk of civil legal actions could prevent hospitals from disclosing a complete employment history record of a nurse to their potential new employer. As a result, during an employment reference check, hospitals may not freely share with potential employers a nurse's detailed work history record—for instance, that a nurse lacked competence and failed to complete a learning plan on several attempts. Only information about employment dates, hours worked and the role the employee held or holds in the hospital is usually shared with potential employers. Other important performance information remains confidential.

We found that jurisdictions in the United States, such as New Jersey, have specific legislation in place that protects hospitals and other health-care providers from liability associated with any civil legal action for disclosing a complete and truthful record about a current or former nurse to a prospective employer.

This legislation was enacted after these jurisdictions faced a similar situation to Elizabeth Wettlaufer's murders. After Charles Cullen was convicted of murdering at least 29 patients in multiple facilities, lack of transparency and information-sharing between health-care providers was identified as a weakness in the system. As a response, in 2005, New Jersey enacted this law to protect hospitals from liability for providing honest job evaluations and work histories to prospective employers.

Similar legislation does not exist in any Canadian jurisdiction. We have noted as well that other US states, such as Pennsylvania, North Carolina and Texas, have similar laws that extend legal protection to all employers and not just health-care providers.

RECOMMENDATION 8

To better inform employers in their hiring decisions and protect patients from the risk of harm, we recommend that the Ministry of Health assess for applicability in Ontario the actions taken by US states to protect hospitals and other health-care providers from liability associated with any civil action for disclosing a complete and truthful record about a current or former nurse to a prospective employer.

MINISTRY RESPONSE

The Ministry will assess the actions taken by US states and Canadian provinces to protect hospitals and other health-care providers from any civil action for disclosing a complete and truthful record about a current or former nurse to a prospective employer for applicability in Ontario.

4.2.5 Non-disclosure Arrangements Can Conceal Nurses' Poor Performance Records from Potential Employers

Almost all Ontario nurses are unionized, although agency nurses are not unionized. A nurse facing disciplinary action can approach his or her union for help. The union would then represent the nurse and try to negotiate with the hospital the most favourable disciplinary outcome for the nurse. For instance, the union could ask the hospital to treat the termination as a resignation or negotiate a non-disclosure arrangement; the nurse's disciplinary history would then be kept hidden in the confidential records of the hospital the nurse has departed from until the College of Nurses of Ontario completes its disciplinary investigation, if the College chooses to undertake one.

We found that this practice can prevent hospitals from knowing about a nurse's past performance to use in their hiring decisions in order to minimize potential harm to patients.

For instance, on October 16, 2018, one hospital fired a nurse for a very serious breach of mandatory patient care standards, which resulted in a patient death. The union negotiated that the firing be treated as a resignation, and this nurse currently works for another hospital. The hospital that fired this nurse reported the termination a few days later to the College. However, as of July 31, 2019, this nurse's College public record was clean. As explained in **Section 4.2.2**, there could be several reasons why a reported nurse may have a clean College public record.

In another case in October 2015, another hospital terminated a nurse for texting a young patient, treated by the nurse in the emergency department, about illegal substances, and reported the nurse to the College. The union, however, negotiated that the termination be treated as a resignation. In January 2017, after working for just over a year through a nursing agency, the nurse was hired by another hospital. Had the hospital that terminated the nurse provided a truthful reference, the second hospital, which hired the nurse, would have known that the nurse falsely stated on the job application that they had never been reported to the College and that there was not a pending College investigation. The second hospital terminated the nurse in December 2017, about 11 months later, when it found out that the College had suspended the nurse's licence for three months after completing its disciplinary process. This disciplinary process took just over two years while the nurse continued to work.

RECOMMENDATION 9

In the interest of patient safety and in order for hospitals and agencies to hire nurses fully aware of their past employment and performance history, we recommend that the Ministry of Health explore means to:

- enable hospitals and agencies to provide and receive truthful references and information to make informed nursing hiring decisions; and
- require these organizations to disclose such information when it is requested by a prospective employer.

MINISTRY RESPONSE

While the recommendation pertains to labour relations between the employer and unions, the *Regulated Health Professions Act, 1991*, may have a supportive role in enabling sharing of information between the College of Nurses of Ontario and employers. The Act provides a regulation that permits the government to prescribe purposes

for which disclosures can be made under clauses 36(1)(d.1) and (d.2) from the College of Nurses of Ontario to public hospitals or other named/described persons of certain information stemming from its investigations. The Ministry will examine this opportunity.

4.2.6 In Most Cases Hospitals Do Not Conduct Periodic Criminal Record Checks of Currently Employed Nurses

Our 2018 follow-up report found that only three hospitals that we audited as part of our 2016 Large Community Hospital Operations audit (Trillium Health Partners, Windsor Regional Hospital and Rouge Valley Health System) currently conduct, or will soon start conducting, periodic criminal record checks of their nurses. The other hospitals that we visited as part of this audit do not. Our 2016 audit of Large Community Hospital Operations found that some hospitals did not conduct initial and/or periodic background checks. We noted that the Ontario Hospital Association produced a document in July 2017 to guide hospitals when developing a criminal reference check program or enhancing an existing program.

RECOMMENDATION 10

So that hospitals can make optimally informed hiring and staffing decisions, we recommend that the Ministry of Health require all hospitals in Ontario to:

- perform criminal record checks before hiring nurses and other health-care employees; and
- periodically update checks for existing staff.

MINISTRY RESPONSE

Under the *Long-Term Care Homes Act* and its regulations, the Ministry outlines criminal record check requirements for long-term-care home employees. The Ministry will explore the possibility of similar requirements for hospital employees.

4.3 Disciplining Physicians Is Difficult and Costly—Legal Costs Are Indirectly Subsidized by Taxpayers

The *Public Hospitals Act, 1990* (Act) governs important elements of the physician-hospital relationship. In our 2016 audit of Large Community Hospital Operations, we reported that hospitals were not able to resolve human resources issues with physicians quickly because of the comprehensive legal process that the hospitals are required to follow under the Act. We recommended that the Ministry evaluate this problem. However, we found that hospitals still are not able to quickly and cost-effectively deal with physicians that hospitals find may have practice issues, lack competence and may pose patient safety concerns.

Once a competency and/or practice issue has been identified, hospitals must work through a lengthy process to determine whether the physician's privileges can be revoked, restricted or not renewed. While the disciplinary process is ongoing, physicians can continue to work, even at multiple hospitals, unless the hospital puts an emergency stop to a physician's work due to an immediate risk to patient safety. As part of our audit, we reviewed a sample of disciplinary proceedings to determine their duration and cost to the hospitals. We present our findings in **Figure 15**.

In defending themselves, physicians mostly do not personally incur legal fees; rather, their legal costs are indirectly paid by taxpayers through a liability insurance reimbursement program. Through this program, the Ministry reimburses physicians for enrolling either in the Canadian Medical Protective Association, a not-for-profit association that provides lawyers to represent physicians, or in any other organization they choose to purchase medical liability protection from. Disciplinary cases can take several years and cost hospitals hundreds of thousands of dollars in their own legal fees and other costs.

Figure 15: Costs Incurred by Hospitals to Discipline Physicians and Duration of Process

Prepared by the Office of the Auditor General of Ontario

Physician	Duration of Disciplinary Process (Years)	Cost Incurred by Hospital ($)	Outcome	Cause
Physician 1*	3.5	567,000	Privileges not renewed	Multiple complaints about patient treatment and misdiagnosis.
	3	901,000	Ongoing	Failed to disclose privileges not renewed at another hospital. Numerous staff and patient complaints about patient treatment including patients in critical condition within the emergency department.
	1	145,000	Ongoing	Between 2009 and 2019, numerous complaints about patient treatment including refusal to treat a patient; delayed diagnosis led to patient paralysis.
Physician 2	4	310,000	Privileges revoked	Interacted with patients in an inappropriate manner. Concerns due to prolonged absence from clinical work.
Physician 3	4.5	202,000	Privileges restricted	Hospital concerns that there were quality of care and patient safety issues related to physician performing complex surgical procedures. A review identified that the physician committed serious errors in judgment during three surgeries.

* One hospital did not renew Physician 1's privileges. Physician 1 is also involved in two separate ongoing disciplinary proceedings at two other hospitals.

We noted that in 2016/17, the Ministry of Health reimbursed physicians $256 million for costs of the Medical Liability Protection Reimbursement Program. In 2017/18, the amount was $326.4 million, an increase of $70.4 million, or 27.5%.

RECOMMENDATION 11

To enable hospitals to take timely action to improve patient safety, we recommend that the Ministry of Health explore means to make it easier and less costly for hospitals and ultimately the taxpayer to address physician human resources issues, especially in cases when doctors may have harmed patients.

MINISTRY RESPONSE

When harm to a patient occurs, hospitals, employers and health regulatory colleges have mechanisms in place to address concerns and to take action in a timely manner. Disciplinary action against health-care providers is but one way of preventing reoccurrence and is often an extreme measure that is linked to risk of harm. There are other less costly and more timely ways of addressing concerns, which may include mediation and alternative dispute mechanisms among others.

Following the release of the 2019 Arbitration Award regarding the dispute over physician compensation between the provincial government and the Ontario Medical Association (OMA), the Ministry is committed to investigating the recommendation from the Auditor General of Ontario's 2016 Large Community Hospital Operations audit to review the physician appointment and appeal processes for hospitals and physicians under the *Public Hospitals Act*.

As part of this review, the Ministry will also explore opportunities to make it easier and less costly for hospitals to address physician human resource issues, especially in cases when doctors may have harmed patients.

4.4 Hospital Accreditation Reports Highlight Gaps in Compliance

4.4.1 Eighteen Hospitals Did Not Fully Comply with Five or More Required Patient Safety Practices

We obtained the most recent Accreditation Canada report from 114 acute-care hospitals. Some of these reports include the inspection and accreditation results for more than one hospital. We found that, between 2014 and 2019, 18 hospitals did not comply with five or more required practices that are central to quality and patient safety. The required six practice areas against which Accreditation Canada assesses each hospital are listed in **Appendix 4**. As shown in **Figure 16**, 148 practices in the six practice areas deemed central to the quality and safety of care were not complied with at 18 out of 114 hospitals. For example, in the area of risk assessment, some hospitals did not have strategies in place to help prevent patient falls and pressure injuries, which increases the risk of these types of patient harm. Other hospitals did not meet the communication area required practice to ensure that information is transferred when patients move between care units within the hospital, increasing the risk of unsafe transitions of care. If these practices are not complied with, a hospital is required to submit evidence of corrective actions to Accreditation Canada. We noted that Accreditation Canada conducts its visits every four years, so it is unknown for how long prior to the visit hospitals did not have these required practices in place.

4.4.2 13 Hospitals Did Not Meet between 5% and 11% of High-Priority Patient Safety Criteria

We found that 13 out of the 114 hospitals did not meet between 5% and 11% of their high-priority patient safety criteria when assessed. Accreditation Canada assesses each hospital against a number of criteria that it uses to measure the hospital's compliance with standards that contribute to high-quality, safe and effectively managed care.

The number of applicable criteria varies according to the size of the hospital and the range and complexity of health services it provides. For instance, about 700 high-priority criteria in total could be used to assess a small rural hospital, whereas 1,200 or more could be used to assess a large hospital.

Figure 16: Unmet Required Practices in Six Patient Safety Areas at 18 Acute-Care Hospitals, 2014–2018

Source of data: Ontario Hospitals

Patient Safety Area	Examples of Required Practices	Instances of Required Practices Unmet
Safety Culture	• Patient safety incident management • Reporting and analysis of patient safety	4
Effective Communication	• Medication reconciliation as a strategic priority • Use of two identifiers to identify patients	78
Safe Use and Storage of Medication	• Infusion pumps training and safety • Monitoring and responsible usage of antibiotic medication	16
Safe Environment	• Management of patient flow to help prevent overcrowding in emergency department • Preventative maintenance program	5
Infection Prevention	• Hand hygiene compliance	3
Assessment of Patient Safety Risks	• Falls prevention strategy • Pressure ulcer prevention strategy	42
Total		**148**

High-priority criteria relate to safety, ethics, risk management and quality improvement, and have an impact on patient safety. These criteria weigh heavily in determining whether a hospital meets the accreditation standards.

Figure 17 shows the number of unmet criteria at each of the 13 hospitals, as well as some of the key patient safety concerns identified by Accreditation Canada. If high-priority criteria are not met, a hospital is required to submit evidence of corrective actions to Accreditation Canada.

4.4.3 Highest Rate of Patient Safety Concerns with Medication Management and Emergency Services

Accreditation Canada groups the various criteria into two main categories of patient safety standards against which it assesses hospitals' compliance:

- hospital-wide standards, which address patient safety throughout the hospital—these include governance, leadership, infection-prevention-and-control medication management; and
- service-specific standards, which apply to specific services provided, such as the emergency department and diagnostic imaging.

We found that as a group, the 114 hospitals did not meet 1,707 high-priority criteria relating to patient safety standards in the above two categories. **Figure 18** shows the instances when the 114 hospitals did not comply with the hospital-wide and service-specific standards that make up the high-priority criteria. Most of the instances when the 114 hospitals did not meet the criteria were in the areas of medication management, leadership, emergency department operations and reprocessing of reusable medical devices, which are also referred to in this report as "reusable surgical tools and medical devices."

4.4.4 Prevention of Falls an Ongoing Patient Safety Concern

We found that all of the 13 hospitals we visited had processes in place to assess patients who are admitted to hospital for their risk of falling. Assessing this risk is an important patient safety practice, since a patient fall could result in a hip fracture, a head injury, and in some cases, death.

Depending on a patient's identified risk of falling while in hospital, staff use additional measures to reduce this risk, such as bed exit alarms, which notify the nurse when a patient leaves the bed. Hospitals informed us that although these additional measures reduce the risk of patient falls, patient falls can still occur. For example, even when a hospital has a falls prevention process in place, a patient could still choose to leave their bed without notifying their nurse and be at increased risk of falling.

RECOMMENDATION 12

To improve patient safety, we recommend that the Ministry of Health:

- review the Accreditation Canada hospital reports and identify areas where hospitals may consistently not be meeting required patient safety practices and high-priority criteria; and
- follow up with hospitals in respect of problem areas to confirm that actions are taken to correct deficiencies.

MINISTRY RESPONSE

Patient safety is an important dimension of quality. Ontario Health's mandate includes holding health-care providers accountable for health system performance and quality. Moving forward, the Ministry will request that Ontario Health address this recommendation as part of its mandate.

656

Figure 17: Unmet High-Priority Accreditation Criteria at 13 Acute Ontario Hospitals
Source of data: Ontario Hospitals

Hospital	# of Unmet High-Priority Criteria	% of All High-Priority Criteria	Accreditation Date	Patient Safety Concerns
Hôpital Notre-Dame Hospital	76	11	Dec 10, 2015	• Medication storage and administration, including chemotherapy storage and preparation • Medical equipment stored in dirty areas
Haliburton Highlands Health Services	39	10	May 28, 2015	• No analysis or trends of patient safety incidents • No action plans to prevent/reduce patient safety incidents
Hornepayne Community Hospital	45	7	Nov 29, 2018	• No Quality Committee • Outdated safety plan • Private rooms not secure and unsafe
Kirkland and District Hospital	51	7	Jul 20, 2016	• Separation of similar-sounding medication names not consistently done
Lady Dunn Health Centre	41	6	Nov 30, 2017	• Pressure ulcers (bedsores) prevention not formalized and not tracked • Lessons learned from patient safety investigations not shared with front-line staff
St. Joseph's General Hospital Elliot Lake	60	6	Oct 23, 2017	• Lack of integrated Quality Improvement Plan
The Alexandra Hospital	35	5	Sep 30, 2015	• High risk of contamination of sterilized medical instruments: decontamination area not sufficiently isolated from clean storage area • No quality management program in place for cleaning and sterilization of medical and surgical tools
Riverside Health Care Facilities	41	5	Oct 23, 2015	• Chemotherapeutic intravenous medication storage and preparation concerns
North Shore Health Network	36	5	Jul 5, 2018	• No patient safety benchmarks and set goals to measure success toward targets
Englehart and District Hospital	26	5	Jun 26, 2015	• Unsafe storage of medical supplies
Campbellford Memorial Hospital	37	5	Dec 20, 2017	• Lack of proper area to clean medical equipment, dirty equipment is washed next to sterile and clean area • Quality Improvement Plan initiatives not communicated to front-line staff
North of Superior Healthcare Group	42	5	Oct 4, 2016	• No proactive approach to identify risks to patient safety in emergency department • No falls prevention strategy in place
MICs Group of Health Services	41	5	Mar 16, 2018	• Quality Improvement Plan initiatives not communicated to front-line staff • No monitoring of patients who are receiving a new dosage of narcotics or sedatives

Figure 18: Total Instances of Unmet High-Priority Criteria at 114 Ontario Acute-Care Hospitals, 2014–2019

Source of data: Ontario Hospitals

	Unmet Instances
Hospital-Wide Standards	
Medication management	181
Leadership	127
Infection prevention and control	51
Governance	120
Service-Specific Standards*	
Emergency department	209
Reprocessing of reusable medical devices	173
Perioperative services and invasive procedures	169
Medicine services	115
Diagnostic imaging services	110
Ambulatory care services	59
Obstetric services	72
Mental health services	50
In-patient services	62
Critical care	45
Community-based mental health services and supports	29
21 other service categories	135
Total	**1,707**

* Not all services are provided by every hospital.

4.5 Best Practices Not Always Followed for Medication Administration

4.5.1 Hospitals Not Always Following Best Practices to Prevent Medication-Related Patient Safety Incidents

According to the Canadian Patient Safety Institute, more than 50% of hospital patients have at least one discrepancy between the medications they take at home and those ordered for them on admission to the hospital. Many of these discrepancies in the medications patients are given have the potential to harm them.

Medication reconciliation is a patient safety best practice, to ensure that medications that were added, changed or discontinued while a patient was in a hospital are carefully evaluated against the medication that the patient was already taking at home. This reduces the possibility that medications the patient is on will be omitted, duplicated or ordered incorrectly when the patient is admitted or discharged from a hospital.

For instance, two weeks before being admitted to a hospital, a patient received from a family doctor a prescription for a narcotic pain medication. On discharge, the hospital prescribed the same narcotic, but the patient now had access to and started to take more than what was required. Shortly after that, the patient was readmitted to the hospital for a narcotic overdose.

Research by the Canadian Patient Safety Institute indicates that medication reconciliation is the most cost-effective way to prevent potential medication-related patient safety incidents, which, if not prevented, result in an average of $4,000 in additional health-care costs per incident and endanger lives.

For 2018/19, Health Quality Ontario recommended that hospitals focus on conducting medication reconciliation for patients that they discharge and add this to their Quality Improvement Plans. This is not a mandatory requirement, and only 78 hospitals included it in their 2018/19 Quality Improvement Plans. Based on information reported by these 78 hospitals to Health Quality Ontario, on average they completed medication reconciliation for only 76 out of every 100 patients where reconciliation at discharge was required. This means that, on average, about 24 out of every 100 patients discharged from the hospital did not have a medication reconciliation completed at discharge.

Hospitals that we visited informed us that medication reconciliation is a labour-intensive process and that is why sometimes they are not able to complete all the required reconciliations. Reconciling medication for patients who take a large number of medications and purchase them from several

pharmacies can take more than 24 hours, as the hospital has to contact each pharmacy to compile the patient's medication history.

We also found that some important information was not recorded during the medication reconciliation process at each of the five hospitals we visited, and that some hospitals do not report their compliance rate because they have outdated computer systems that do not allow them to track the compliance rate.

We visited five hospitals to review their medication reconciliation process. Three of the hospitals report their compliance rate to Health Quality Ontario and two do not. The compliance rates at discharge for the three reporting hospitals were 100%, 95% and only 20%.

At each of the five hospitals, we reviewed 10 completed medication reconciliations to assess how they are performed and documented. We found that each hospital documents the reconciliations differently, and at four of the five hospitals we found at least one reconciliation that was missing some important information. In total, 20 out of the 50 completed medication reconciliations we reviewed were missing information such as patients' medication history, medication dosage and quantity prescribed on discharge, and the time of the last dose taken. Without this information, on release from hospital patients may not be instructed to take their medication appropriately in order to prevent harm.

RECOMMENDATION 13

So that hospitals fully complete medication reconciliation to reduce the risk to discharged patients and that they have all the necessary patient information to properly investigate any incidents with patients' dosages or drug interactions that might occur and trigger hospital readmission, we recommend that hospitals reinforce with staff the importance of the medication reconciliation documentation processes so that all the necessary information is consistently documented.

RESPONSE FROM OHA

Ontario hospitals support documentation of medication reconciliation being consistently more complete, comprehensive and accurate.

RECOMMENDATION 14

To reduce the risk of medication errors and readmissions to hospital, we recommend that the Ministry of Health:

- require hospitals to complete medication reconciliation for all patients;
- require hospitals to include medication reconciliation in their Quality Improvement Plans; and
- in conjunction with relevant hospitals, review their IT system needs to be able to track necessary medication reconciliation information and take action for improvement where needed.

MINISTRY RESPONSE

The Ministry of Health supports this recommendation and will support:

- Ontario Health in reviewing and assessing how medication errors are reported in hospitals and explore ways to strengthen reporting mechanisms;
- Ontario Health in evaluating how to make medication incident reporting within hospitals part of their Quality Improvement Plans; and
- hospitals with their review of their IT systems and help explore opportunities to enhance tracking systems for medication reconciliation.

4.5.2 Best Practices for Safe Administration of Medication Not Consistently Followed at Some Hospitals

We found that some hospitals do not always comply with policies and best practices for the administration of high-risk medications, such as using an

Figure 19: Reported Critical Patient Safety Incidents Involving Medication in All Ontario Hospitals Occurring between October 2011 and December 2018

Source of data: Canadian Institute for Healthcare Information National System for Incident Reporting

Category	2012[1]	2013	2014	2015	2016	2017	2018	Total	% Total
Severe Harm	27	23	24	10	12	6	13	**115**	75
Death	10	7	4	7	5	0	6	**39**	25
Total	**37**	**30**	**28**	**17**	**17**	**6**	**19**[2]	**154**	**100**

1. Year 2012 includes data hospitals started to report in October 2011.
2. The rise in incidents in 2018 is due to an increase both in incidents occurring in 2018 and in incidents that occurred earlier but were not reported until 2018.

independent double-check to verify medication and dosage; witnessing patients taking and swallowing medications; or confirming the identities of patients.

According to the Canadian Institute for Health Information, events associated with medication are among the most frequent of all harmful events possible in a hospital. Medication errors can be classified into prescribing errors; dispensing errors; and administration errors, when what the patient actually received differs from what was intended. Medication errors that are discovered only after the patient has taken the medication are typically the most serious of the three types of errors. The 2004 Canadian patient safety study estimated that one out of nine adults will potentially be given the wrong medication or wrong medication dosage in hospitals.

In 2011, the Ministry of Health began requiring hospitals to report patient safety incidents causing serious harm or death involving medications to the Canadian Institute for Health Information. **Figure 19** shows the list of these incidents compiled from late 2011 through to the end of 2018.

Our expert told us that it is leading practice (and an Accreditation Canada requirement) for hospitals to implement a policy where designated high-risk medications require an independent double-check before they are administered to the patient, as errors involving high-risk medications increase the likelihood of patient harm or death.

At three hospitals, we observed nine instances where nurses did not comply with medication administration best practices in 15 situations observed. There are usually four times during the day when patients could receive their scheduled medication: morning, afternoon, evening/dinner and bedtime. At each hospital we visited, we observed a nurse administering medication to five patients during one of the scheduled times. At two hospitals on five occasions, the nurses did not request another nurse to double-check the name and amount of high-risk medication given to the patients. At one hospital, in two instances, the nurse did not wait to witness the patients actually take and swallow their medications. In one of those instances, the medication was a narcotic that could be pocketed in the mouth to be then taken out, stored and used later to overdose. At another hospital, the nurse did not confirm the identification of two patients before administering medications to them.

RECOMMENDATION 15

To improve patient safety, we recommend that hospitals reinforce with nurses necessary medication administration processes to ensure that:

- independent double-checks of high-risk medications are done to verify that correct medication and dosage are administered;
- nurses witness patients taking and swallowing high-risk medications; and
- nurses use two unique identifiers to confirm the identity of patients before administering medication to them.

RESPONSE FROM OHA

Ontario hospitals will review existing policies and processes for the administration of all medications to determine whether best practices are being followed to improve patient safety.

4.5.3 Best Practices Not Always Followed for Nursing Shift Changes

We found that six out of the 13 hospitals we visited did not always follow patient safety best practices for nursing shift changes at the patient's bedside. Nursing shift changes were not assessed at Women's College Hospital, as it is an ambulatory care facility that does not provide in-patient care, so nurses work day shifts only at this hospital.

Nurses usually work 12-hour shifts, although shifts can also be shorter. During shift changes, which usually occur at 7 a.m. and 7 p.m., the nurse whose shift is ending provides the incoming nurse with an update on the patient's condition, medication and/or treatment, as well as other patient-care specifics.

According to our expert, the best practice, if possible—based on the patient's condition—is to conduct nurse shift changes at the patient's bedside and involve the patient and the family, with the consent of the patient, in the process, rather than completing the shift change away from the patient at the nurses' station. In this way, the patient and possibly family are engaged in the care process and can identify any missing information or miscommunication between the nurses during shift change that could lead to patient safety incidents. We found, however, that this practice was followed by only six out of the 13 hospitals we observed for nursing shift changes.

RECOMMENDATION 16

To minimize patient safety incidents due to missing information or miscommunication, we recommend hospitals adopt, based on patient condition, the practice of making nursing shift changes at the patients' bedside and where possible involving the patients and their families, with the consent of the patients, in the process.

RESPONSE FROM OHA

Ontario hospitals support the review of current practices to ensure safe transfer of information between care providers. Ontario hospitals will determine what supports are needed to engage patients, where possible, to enhance nursing shift changes.

4.6 Hospital Systems for Dispensing Medication Vary from Fully Manual to Fully Automated

After a medication is prescribed for a patient, the order must be reviewed by a pharmacist, prepared and dispensed at the pharmacy, and then delivered to the patient's unit to be administered by a nurse. While all hospitals we visited have controls in place over this process, we noted that hospitals vary widely in the level of automation in this process. See **Appendix 10** for elements of automation that can impact medication dispensing and administration.

We noted that hospitals in Ontario are moving toward automating medication management but are at different stages of implementation, from fully manual to fully automated systems.

Two of the hospitals we visited have fully manual systems in at least one of their hospital sites. Two other hospitals we visited had fully automated systems. The remaining hospitals are at varying stages of implementation between manual and automated systems.

Pharmacy Staff Performing Manual Processes Could Be Better Utilized

One hospital we visited was facing a shortage of pharmacy technicians, and its pharmacy department operated with manual processes. This hospital

informed us that its pharmacy technicians were doing manual tasks that could be automated such as labelling and packaging medication and drawing medication into syringes for a single use.

With pharmacy technicians occupied by these tasks, this hospital assigned medication reconciliation to nurses, who are already busy with patient assignments. Best practice confirms that medication reconciliation can be safely and effectively performed by pharmacy technicians and pharmacists in collaboration with the prescriber. This hospital reported that in 2016, as many as 20% of all reported medication incidents in a month were due to medication reconciliation errors.

RECOMMENDATION 17

To improve patient safety with respect to medication administration and where a compelling business case for cost-effectiveness can be made, we recommend that the Ministry work with hospitals toward the automation of pharmacy-related tasks.

MINISTRY RESPONSE

The Ministry acknowledges that there may be opportunities to improve how hospitals use automation to drive efficiency and safety in their local pharmacy operations. The Ministry will encourage hospitals, as part of their annual capital planning process, to consider the cost-effectiveness of moving toward the automation of pharmacy-related tasks.

4.7 Some Hospitals Have Poor Compliance with Infection Prevention Best Practices and Standards

4.7.1 Infection Outbreak Investigations Found Key Prevention Practices Lacking at 10 Hospitals

We found that some hospitals have not consistently followed infection prevention best practices and standards. Ten hospitals contacted Public Health Ontario to help them deal with recent or recurring infection outbreaks. We obtained the resulting Public Health Ontario reports, for 2016 to 2018, from each hospital detailing the type and extent of each outbreak.

Outbreaks ranged from a large-scale outbreak affecting over 100 patients at one hospital, to repeated smaller outbreaks at another hospital with a consistently higher infection rate than peer hospitals.

In reports prepared for each hospital between 2016 and 2018, Public Health Ontario identified that the 10 hospitals had low compliance with a number of infection prevention best practices established by the Provincial Infectious Diseases Advisory Committee described in **Appendix 5**. For example:

- Eight of the 10 hospitals had either cluttered rooms, making them more difficult to clean; damaged furniture that served as a reservoir for microorganisms; or damaged equipment that was corroded, leaking fluids and visibly soiled.
- Eight of the 10 hospitals had limited screening of patients for specific resistant bacteria.
- Five of the 10 hospitals did not have sufficient processes in place to monitor and prevent the spread of infections or did not have enough dedicated staff to support infection prevention processes according to best practices.
- Common observations in the affected areas at all 10 hospitals included poor hand hygiene, use of incorrect cleaning solutions and inadequate protective equipment.

Two of the 10 hospitals had outbreaks of *Clostridium difficile* (*C. difficile*), a bacterium that can cause diarrhea, severe abdominal pain and potentially life-threatening infections.

In two studies on *C. difficile*, The Ottawa Hospital found that the average length of stay for patients who acquired *C. difficile* while in hospital was 34 days, more than four times longer than for patients who did not acquire this infection (eight days). The hospital also estimated that patients who acquired *C. difficile* while in hospital required additional treatment costing an average of $9,000 per patient. In the past five years, 12,208 hospital-acquired *C. difficile* infections were reported in Ontario, an average of about 2,440 people each year.

This suggests the additional treatment costs to the provincial health-care system as a result of these infections are substantial.

In its reports to the 10 hospitals, Public Health Ontario made recommendations on how to improve infection prevention processes. We followed up with these 10 hospitals and found that these hospitals have not yet fully implemented all of the recommendations.

As of May 31, 2019, 191 (73%) of the 263 recommendations to the hospitals had been fully implemented. The hospitals are still working toward implementing the remaining 71 (27%) recommendations such as to update their policies and procedures, provide training to staff, evaluate processes for infection prevention, and allocate resources (money and staffing) more effectively.

4.7.2 Reported Frequency of Handwashing by Hospital Staff Could Be Overstated

As previously discussed, Public Health Ontario identified poor hand hygiene compliance as a contributing factor when reviewing infection outbreaks. Hospital-acquired infections such as *C. difficile* are commonly spread by the contact route via the hands of health-care workers. Therefore, hand hygiene, either through the use of alcohol-based hand rub or soap and water, is one of the main preventive measures used to prevent and control the spread of these infections. As handwashing is a simple, quick and low-cost action to do, the prevalence of handwashing in a hospital speaks to the strength of the patient safety culture in that hospital.

Best practices developed by the Provincial Infectious Diseases Advisory Committee require hospital staff to wash their hands at several key moments when caring for patients, including before initial contact with the patient and the patient's environment; before putting on gloves when performing an invasive procedure; before administering medication to a patient; immediately after removing gloves; and after contact with a patient and the patient's environment.

As part of our special audit report *Prevention and Control of Hospital-acquired Infections* (2008), we examined the Ministry's hand hygiene pilot program. The objective of this program was to observe hospital staff to assess how often they followed hand hygiene best practices by washing their hands before and after patient contact.

In our 2008 audit we found that handwashing compliance of hospital staff ranged from only 40% to 75% at the 10 participating hospitals. Physician compliance increased from only 18% at the start of the pilot to 28% by the end. Nurse compliance rose from only 44% to 60%.

Since 2008, as reported by Health Quality Ontario, hospitals have reported improvement in hand hygiene compliance rates. Hand hygiene compliance before patient contact rose from 53.3% in 2008/09 to 89.7% in 2018/19. Hand hygiene compliance after patient contact rose from 69.0% to 92.8% over the same period.

Although reported rates have increased over this period, some hospitals have indicated that reported hand hygiene compliance is likely overstated, due to the method used to assess compliance. Since hospital staff are physically observed by a hand hygiene auditor who records whether or not they wash their hands, staff are often aware they are being observed and wash their hands more often when the auditor is present. For example:

- In 2014, the University Health Network published a study that found that hospital staff washed their hands 2.5 times more often when an auditor was visible (3.75 times per hour) than when an auditor was not visible (1.48 times per hour). The study found that the compliance rate increased after the auditor's arrival, suggesting that the presence of the auditor triggered the increase in hand hygiene.
- In 2016, Sunnybrook Hospital published a study and found that while the hand hygiene compliance rate as observed by the auditor was 84%, the rate as observed by covert observation auditors was actually 50%. The study also found that handwashing by medical residents (trainees) dropped from 79.5% to 18.9% when their supervising physician did not wash his or her hands.

The Sunnybrook residents' study, in particular, demonstrates how modelling desirable behaviour can encourage and sustain patient safety culture down the line among the people working at a hospital.

We note that some hospitals have introduced additional methods of assessing and encouraging hand hygiene compliance:

- Sunnybrook Hospital has started using electronically monitored hand hygiene pumps in some units. These pumps are equipped with a sensor that counts hand hygiene events and gives each unit a compliance rate against a predetermined number of hand hygiene opportunities based on the type of unit, and the number of care providers, visitors and patients.
- University Health Network has introduced electronic monitoring systems in some units, which use electronic badges worn by staff to produce real-time prompts for staff to use soap or alcohol-based hand rub dispensers when they move in and out of rooms in the hospital.
- Women's College Hospital has distributed survey cards to patients and asked them to observe and record the hand hygiene compliance of their health-care providers. The results are forwarded to providers on a regular basis; this process allowed patients to play a more active role in their own health care.

RECOMMENDATION 18

To improve the accuracy of reported hand hygiene compliance, while at the same time encouraging hand hygiene, we recommend that the Ontario Hospital Association work with hospitals to evaluate and further the adoption of additional methods to assess and monitor hand hygiene, such as electronically monitored hand hygiene pumps and monitoring systems, and asking patients to observe and record the hand hygiene compliance of their health-care providers.

RESPONSE FROM OHA

Ontario hospitals take hand hygiene compliance very seriously as it is the single most effective way to reduce the risk of health care–associated infections. Ontario hospitals agree with enhancing observation and monitoring methods and will examine strategies to improve hand hygiene compliance within their organizations.

4.8 Some Hospital Pharmacies Did Not Fully Comply with Training and Cleaning Standards for Sterile-Rooms

Some patients receive their medications, such as antibiotics, chemotherapeutic agents and pain medication, by injection directly into their veins. Hospital pharmacies have restricted access areas, called "sterile-rooms," where intravenous medication is prepared and mixed using clean and disinfected equipment.

Air in sterile-rooms is continuously filtered to remove particles. Pharmacy staff who work in sterile-rooms must wear masks, gloves and gowns. Cleaning and disinfecting personnel are responsible for cleaning the equipment used in the mixing and preparation of intravenous medications, and for cleaning floors and walls in sterile-rooms.

4.8.1 Sterile Preparation and Mixing of Hazardous (Chemotherapy) and Non-hazardous Intravenous Medications

We found that hospital pharmacies do not always fully comply with standards pertaining to the sterile preparation and mixing of hazardous (chemotherapy) and non-hazardous intravenous medications.

The Ontario College of Pharmacists is the registering and regulatory body for the profession of pharmacy in Ontario. In 2013, 1,202 hospital patients at four hospitals in Ontario (Windsor, London, Lakeridge and Peterborough) were infused with the wrong concentration of chemotherapy medication. Following this chemotherapy underdosing incident, in 2014 the College started annual inspections of hospital pharmacies to assess their compliance with 102 standards aimed at ensuring patient safety. Fifty of the 102 standards relate directly to the sterile preparation of injectable medications such as for chemotherapy and antibiotics.

The National Association of Pharmacy Regulatory Authorities, a voluntary association of provincial and territorial pharmacy regulatory bodies, developed these standards, which were adopted by the Ontario College of Pharmacists.

We analyzed all 163 inspections completed by the College in 2018, including 122 inspections of sterile preparation and mixing of medications, and found that hospital pharmacies on average fully met less than half of the 50 standards relating to the sterile preparation and mixing of intravenous medications such as for chemotherapy and antibiotics. On average, hospital pharmacies did not comply at all with about 10% of the 50 standards. For instance, 10% of the 122 hospital pharmacies did not train staff on how to prepare and mix intravenous medications correctly, and 26% of the 122 hospitals did not train their staff on how to clean and disinfect the sterile-room and the equipment used in preparing and mixing intravenous medications. **Figure 20** shows how many of the 102 standards relate to the eight main hospital pharmacy operating areas, and the pharmacies' 2018 average compliance rate with the standards pertaining to each area.

Our expert told us that sterile preparation and mixing of intravenous medications is a high-risk activity. For instance, patients can be harmed or even die if their intravenous medication has been contaminated with bacteria during mixing and preparation or if the medication has been mixed incorrectly and,

Figure 20: Hospital Pharmacies, Average Compliance Rate with Standards, 2018

Source of data: Ontario College of Pharmacists

Standard Categories	# of Standards (Out of 102)	Average Compliance Rate of All 163 Hospital Pharmacies* (%)		
		Met	Partially Met	Not Met
Sterile preparation and mixing of hazardous intravenous medications (chemotherapy)	25	43	45	12
Sterile preparation and mixing of non-hazardous intravenous medications (antibiotics, narcotics, etc.)	25	48	43	9
Safe and secure medication storage (including narcotics) throughout the hospital	10	80.3	19.2	0.5
Safe packaging handling, storage, distribution and monitoring of medications	17	79	21	–
Medication physician prescription review and processing	8	85	15	–
Safe and secure storage of narcotics within the pharmacy	5	68	32	–
Non-sterile preparation and mixing of medication	4	61	39	–
Other areas (record retention, auditability and traceability)	8	57	43	–
Total	**102**			

* Ontario hospitals may have more than one site; however, not all sites have a pharmacy.

for example, is the wrong dose or has the wrong ingredients.

In September 2016, the College mandated that by January 1, 2019, hospital pharmacies must be in full compliance with all 50 standards pertaining to the sterile preparation and mixing of intravenous medications. Inspection results from 91 hospital pharmacies completed by July 1, 2019, shared with us by the College, showed that pharmacies' compliance with the standards has improved. Sixty-four percent of the 91 inspected pharmacies met the standards pertaining to the sterile preparation and mixing of intravenous hazardous medications, such as for chemotherapy, and 70% of the 91 pharmacies met the standards pertaining to the sterile preparation and mixing of intravenous non-hazardous medications, such as antibiotics.

4.8.2 Sterile-Rooms Are Not Cleaned in Accordance with Best Practices

As mentioned, hospital pharmacies have restricted access areas, called "sterile-rooms," where intravenous medications are prepared and mixed using clean and disinfected equipment.

We visited five hospitals between May and July 2019 and observed that in four hospitals, pharmacy and housekeeping staff did not follow standards and best practices when cleaning sterile-rooms and the equipment used in the preparation of intravenous medications. For example, one hospital was using the wrong cleaning agent to disinfect the equipment. At another hospital, housekeeping staff did not properly gown prior to entering the sterile restricted area, and they cleaned the floors using the same mops used to clean other areas. (Mops should be for restricted use in only the sterile-room.) By January 1, 2019, hospitals were supposed to have trained all of their cleaning and disinfecting personnel on how to properly clean sterile-rooms. However, we found that two hospitals we visited had not yet conducted the required training.

RECOMMENDATION 19

So that sterile-rooms and the equipment used in the mixing and preparation of intravenous medications are cleaned according to required standards, we recommend that hospitals:

- provide their pharmacy and housekeeping staff with proper training on how to conduct the cleaning; and
- monitor the cleaning to ensure proper processes are being followed.

RESPONSE FROM OHA

Ontario hospitals will continue to work with the Ontario College of Pharmacists to implement strategies to ensure proper practices are put in place for cleaning of sterile-rooms and equipment.

4.9 Inspection Process for Cleaning Reusable Surgical Tools Not Optimal

4.9.1 Improper Cleaning of Reusable Surgical Tools Can Delay Surgeries and Impact Patients

Hospitals commonly reuse surgical tools, such as scalpels, and medical equipment, such as colonoscopy scopes, on patients, after they have been thoroughly washed and sterilized. When cleaning and sterilizing reusable surgical tools and medical equipment, hospitals are required to follow standards developed by the Canadian Standards Association (CSA) and Manufacturer's Instructions for USE (MIFU). Proper washing and sterilization of surgical tools and medical equipment ensures that they can be safely reused on other patients.

As shown in **Figure 18**, washing and sterilization of reusable surgical tools and medical devices is the second-highest service area of hospitals' non-compliance with high-priority criteria for patient safety, according to Accreditation Canada.

Improper cleaning and sterilization can potentially result in surgical-site infections for patients. It can also cause delays or cancellations of surgeries, as the surgical team waits for a complete set of properly washed and sterilized surgical tools to arrive. For example, in spring 2019, over a two-month period, one hospital cancelled and rescheduled 62 surgeries (elective complex orthopedic surgeries) after becoming aware that specialized surgical tools that are used for some complex orthopedic surgeries may not have achieved sterilization.

Approximately every four years, as part of its hospital visits, Accreditation Canada reviews the processes hospitals have in place to clean and sterilize reusable surgical tools and equipment. Hospitals' compliance with patient safety best practices or the CSA standards in this area is not verified by any other organization. In contrast, the Ontario College of Pharmacists inspects hospital pharmacies annually to assess compliance with relevant standards from the National Association of Pharmacy Regulatory Authorities.

Each hospital is therefore responsible to monitor its own compliance with cleaning and sterilization standards. Some hospitals hire experts to do this work. We compared the expert reports from three hospitals with Accreditation Canada reports and found that the experts identified more instances of non-compliance with Accreditation Canada criteria.

For example, between April 30 and May 5, 2017, Accreditation Canada identified that one hospital did not comply with four criteria. Nine months later, the expert found that this hospital did not comply with 10 Accreditation Canada criteria and two CSA standards. We noted that during hospital visits Accreditation Canada assesses hospitals' policies and procedures in many areas, including cleaning and sterilization, but it does not perform detailed checks for compliance with CSA standards.

RECOMMENDATION 20 666

To improve hospitals' compliance with the Canadian Standards Association's standards pertaining to the washing and sterilization of surgical tools and medical equipment, we recommend that hospitals have their washing and sterilization of surgical tools and medical equipment inspected internally on an annual basis.

RESPONSE FROM OHA

Ontario hospitals will review strategies to improve compliance with the Canadian Standards Association's standards pertaining to the washing and sterilization of surgical tools and medical equipment.

4.9.2 Management of Outsourcing Contracts for Sterilization of Reusable Surgical Tools and Medical Equipment Has Improved

Most hospitals in Ontario wash and sterilize their own reusable surgical tools and medical equipment in-house. Four hospitals have outsourced this work to a private company, SteriPro. The company is the only private company in Canada that offers washing and sterilization services of this kind.

Three hospitals we visited contracted with this third-party provider for sterilizing medical equipment. We found that the three hospitals did not have processes in place to ensure the contract was managed effectively. Specifically, the lack of key performance indicators prevented the hospitals from reliably assessing the third-party provider's performance. For example:

- One hospital entered into a contract with the third-party provider in 2011. The contract included key performance indicators such as requirements for availability of instruments and timely delivery. These indicators were not enforced until 2014.

- Another hospital entered into an agreement in 2012, although the key performance indicators were not put in place until 2015.
- The third hospital entered into a contract with the third-party provider in 2015. The hospital has informally used key performance indicators to track performance and quality issues; however, we noted that the agreement does not include specific indicators. This hospital informed us that it will negotiate indicators to be included in the next contract, due as a renewal in 2020.

A fourth hospital that entered into an agreement with a third-party provider in 2011 decided in 2015 to bring sterilization back in-house. This hospital noted that due to the lack of published key performance measures and industry benchmarks, it is difficult to evaluate sterilization practices and drive improvement. The hospital developed a framework that built on established guidelines and included service standards, key performance indicators and targets to evaluate surgical tools and medical device cleaning and sterilization processes. The framework, published in a health-related journal, includes 25 service standards and 10 key performance indicators.

RECOMMENDATION 21

In order for contracts with private providers of sterilization services to be managed effectively by hospitals, we recommend that hospitals:

- include all the necessary service standards and performance indicators in these contracts; and
- on a regular basis, assess the private service provider's compliance with all contract terms.

RESPONSE FROM OHA

Where the use of external providers for sterilization services exists, Ontario hospitals will closely review existing processes and contracts to ensure that the quality and safety of care is not compromised.

4.10 Hospital Overcrowding Limits Availability of Beds to Critically Ill Patients

Overall, between April 2003 and the end of March 2018, according to Statistics Canada and Ministry data, the number of acute-care hospital beds in Ontario decreased from 1.5 beds to 1.3 beds per 1,000 people.

We obtained data from the Ministry for the 25 acute-care hospitals with the highest overcrowding over the 12-month period ending February 2019. Over the year, these hospitals were at 110% of capacity on average, while on some days in winter months one hospital exceeded 120% of capacity.

Critically ill patients depend on receiving timely and appropriate care. In 2013, the Ministry issued a policy statement directing emergency medical services, hospitals and other stakeholders to work together to ensure that "no patient with a life or limb threatening condition shall be refused care."

CritiCall, a Ministry-funded organization, is a 24-hour medical emergency referral service that Ontario's hospital-based physicians can call when a critically ill patient requires an assessment and/or transfer to a more specialized facility with resources beyond what is available at their hospital to care for a life-or-limb patient. CritiCall, on behalf of the referring hospitals, co-ordinates inter-facility transport of a life-or-limb patient.

According to CritiCall, from April 2016 to the end of March 2019, 784 life-or-limb patients were denied inter-facility transfer to the closest hospital that could provide the appropriate level of care, because the hospital had no bed available to receive the patient. Some of these patients were denied inter-facility transfer more than once. Ten of these patients died while CritiCall was trying to facilitate inter-facility transfer to another hospital that could provide appropriate care, after at least one hospital had denied the patient's transfer because no beds were available.

In addition to these critically ill patients, we found that in the same period about 5,356 non-critically ill

patients were denied inter-facility transfers due to a lack of available beds (some multiple times). Given that these patients were not critically ill, there was less urgency for them to transfer to another hospital; however, these denied transfers further illustrate instances where available beds were lacking in the hospital system.

In August 2019, CritiCall issued a proposal for a province-wide "command centre" initiative, which would collect and analyze, in real-time, the patient bed flow of each acute-care hospital in Ontario. This would help CritiCall identify hospitals with free beds so that it could manage the transfer of life-or-limb, urgent and emergency patients more effectively. In recent years, hospitals such as Humber River Hospital have begun to create hospital-based command centres. Humber River Hospital feeds real-time data to artificial intelligence that analyzes the data and provides the command centre staff with information that they can use to monitor and manage patient flow in the hospital. In June 2018, Humber River Hospital found that since implementing the command centre, the information provided to staff has enabled rooms to be cleaned more quickly and beds to be managed more efficiently. As a result, the time a patient in the emergency department waits for a hospital bed had been reduced by 33%.

RECOMMENDATION 22

So that patients with a life- or limb-threatening condition receive timely care from the closest hospital, we recommend that the Ministry of Health leverage learned lessons from hospitals that utilize "command centres" and work with CritiCall toward the development of a provincial bed command centre.

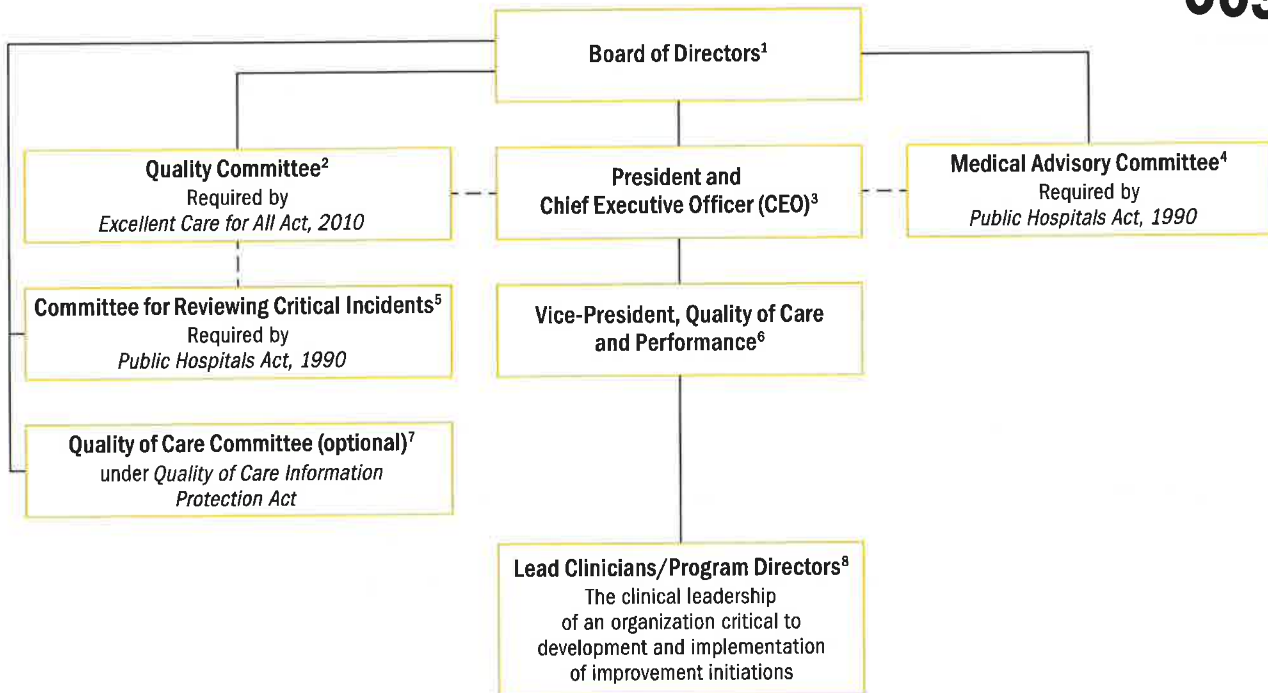
MINISTRY RESPONSE

The Ministry will work with CritiCall to explore the potential of a provincial bed command centre, including lessons learned from Humber River Hospital Command Centre.

Appendix 1: Acute-Care Hospital Governance Structure for Patient Safety

Prepared by the Office of the Auditor General of Ontario

669



Note: This governance and reporting structure specifically pertains to the hospitals' patient safety responsibilities under the *Excellent Care for All Act, 2010.*

1. Board of Directors: Has the ultimate authority and responsibility for the administration of the hospital and is also responsible for overseeing quality of care within the hospital.
2. Quality Committee: Oversees preparation of the Hospital's annual Quality Improvement Plan (QIP), reports to the Board on quality of care issues at the hospital and on the implementation progress of the Quality Improvement Plan.
3. President and CEO: Responsible for putting in place systems to improve quality of care in the hospital. Must establish a system for reviewing and disclosing critical incidents in the hospital, for implementing measures to avoid or reduce the risk of recurrence and for providing aggregated critical incident data to the hospital's Quality Committee at least twice a year. The CEO is also responsible for reporting to the College of Physicians and Surgeons of Ontario any disciplinary action taken with respect to physicians. Ensures the Board has the information required to understand the QIP and develops and provides progress reports to the Board on QIP.
4. Medical Advisory Committee: Monitors and approves initiatives for improving the quality of care provided to patients and promotes the standards of medical care in the hospital. Assists and advises the Board and the CEO in appointment and granting of hospital privileges to the professional staff (physicians, dentistry and midwifery), and provides general supervision over the practice of professional staff. Reports to the Board and Quality Committee any systemic or recurring quality of care issues it identifies to the Board and the Quality Committee.
5. Committee for Reviewing Critical Incidents: Investigates critical incidents, and develops recommendations on how to improve and prevent future incidents.
6. Vice-President, of Quality of Care and Performance (VP of Quality): Responsible for the planning, development and implementation of programs and initiatives to enhance patient experience in the hospital.
7. Quality of Care Committee: A special committee established to evaluate the provision of health care, which may include conducting reviews of critical incidents and which includes restrictions on disclosures from legal proceedings and most other disclosures.
8. Lead Clinicians/Clinical Directors/Program Directors: Act as the link between front-line staff, Quality Committees and the VP of Quality by reporting on progress on quality and patient safety initiatives in the organization. Involved in QIP development and implementation.

670

Appendix 2: Risk-Specific Patient Safety Standards and Best Practices

Prepared by the Office of the Auditor General of Ontario

Hospital Department/ Risk Area	Patient Safety Standards and Best Practices	Organizations Following Standards/Practices
Medication administration	Best practices to guide nurses on how to safely administer medication to patients	College of Nurses of Ontario
	Best practices to prevent medication errors	Institute for Safe Medication Practices Canada
Cleaning and sterilizing surgical tools	To ensure the sterilization of surgical tools and medical equipment is done according to standards	Canadian Standards Association Provincial Infectious Disease Advisory Committee
	The sterilization department should meet certain standards for employees' safety	ISO9001 (facility standards)
Hospital pharmacy	Various standards to ensure the pharmacy department operates in a safe manner	Ontario College of Pharmacists
Housekeeping	Follow provincial standards on cleaning and disinfecting health-care facilities	Provincial Infectious Disease Advisory Committee
Infection prevention and control	Follow provincial standards on screening of, isolation of and surveillance processes for micro-organisms	Provincial Infectious Disease Advisory Committee Public Health Ontario
Surgical safety	Various best practices to prevent complications from surgeries, e.g., foreign body left inside patients and surgical site infections.	National Surgical Quality Improvement Program

Appendix 3: Organization-Wide Patient Safety Requirements

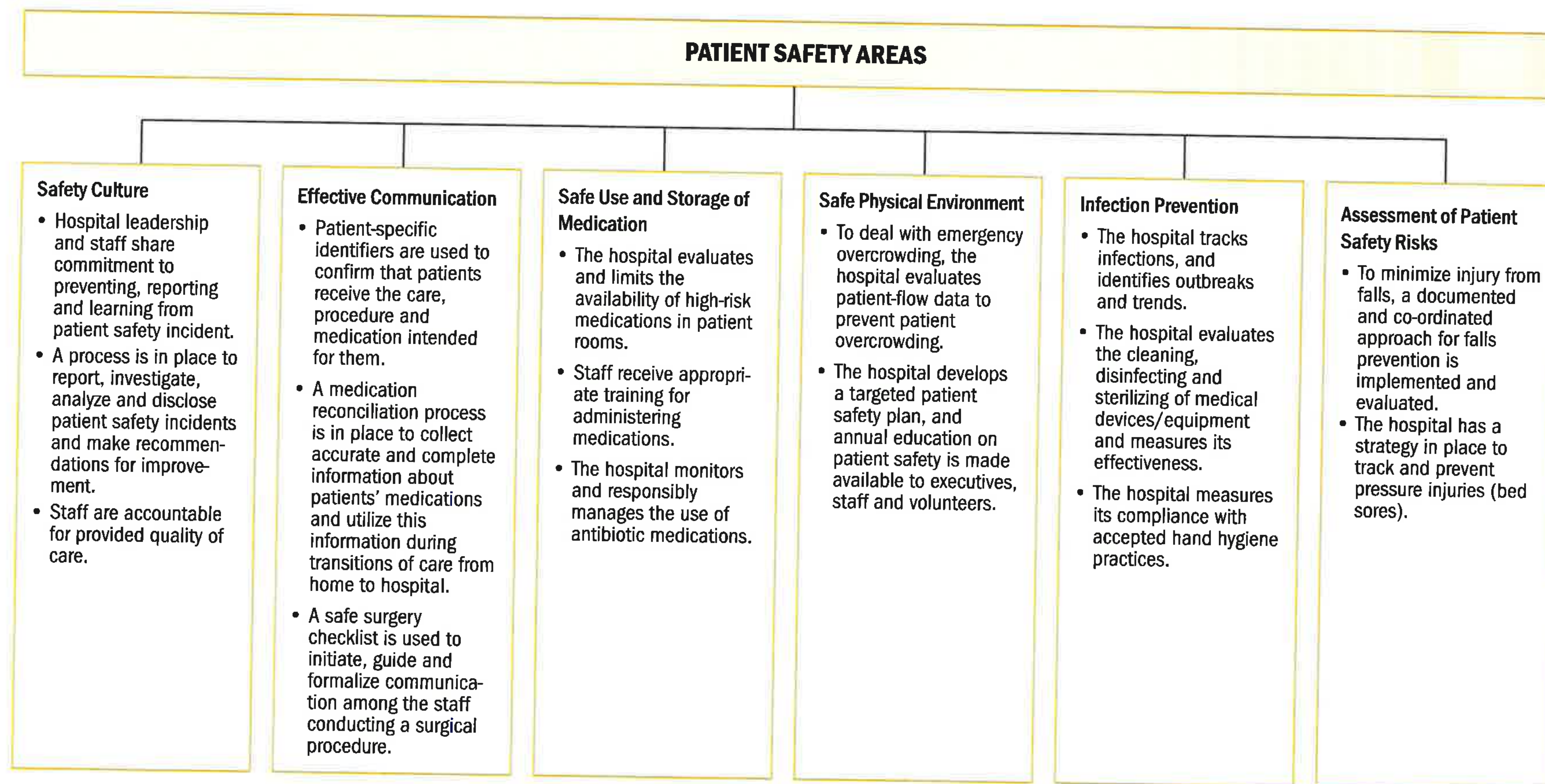
Prepared by the Office of the Auditor General of Ontario

Organizational Focus	Patient Safety Requirements
Oversight of patient safety	The board of governors is required to have a Quality Committee, responsible for overseeing the quality and safety of care provided to patients.
Reporting patient safety incidents	Hospital staff are expected to report patient safety incidents so that they can be appropriately addressed, investigated and prevented in the future.
Survey of hospital staff and patients	Hospitals are required to survey patients and staff regularly to assess the quality and safety of care, and to incorporate survey results in annual Quality Improvement Plans.

Appendix 4: Key Required Practices for Hospital Patient Safety Reviewed for Compliance by Accreditation Canada

Source of data: Accreditation Canada

672



Note: Each required practice is assessed by Accreditation Canada using applicable standards.

Appendix 5: Other Patient Safety Stakeholder Organizations

Prepared by the Office of the Auditor General of Ontario

Organization	Function
Canadian Institute for Health Information	An independent not-for-profit organization that provides essential information on Canada's health systems and the health of Canadians.
Canadian Patient Safety Institute	A not-for-profit organization established by Health Canada in 2003. The Institute works with hospitals, governments and health-care providers to improve patient safety.
College of Nurses of Ontario	A regulating body for Registered Nurses (RNs), Registered Practical Nurses (RPNs) and Nurse Practitioners (NPs) in Ontario.
College of Physicians and Surgeons of Ontario	Registering and regulating body for physicians and surgeons practicing medicine in Ontario
Health Quality Ontario	A government of Ontario agency that advises the government and health-care providers on the evidence to support high-quality care and improvements in quality, and monitors and reports to the public on the quality of health care provided in Ontario.
Institute for Safe Medication Practices Canada	A national not-for-profit organization committed to the advancement of medication safety in all health-care settings.
Ontario College of Pharmacists	Registering and regulating body for the profession of pharmacy in Ontario. It ensures that pharmacies within the province meet certain standards of operation and are accredited by the College.
Ontario Hospital Association	A not-for-profit organization serving Ontario's hospitals to build a better health system.
Ontario Medical Association	A not-for-profit organization representing the political, clinical and economic interests of the province's medical profession.
Ontario Nurses Association	The union representing registered nurses and health-care professionals, as well as nursing student affiliates, across the province.
Provincial Infectious Disease Advisory Committee	A multidisciplinary committee of health-care professionals with expertise and experience in infection prevention and control.
Public Health Ontario	A government of Ontario agency that provides scientific evidence and technical advice on infection surveillance, prevention and controls in hospitals.

Appendix 6: Audit Criteria

674

Prepared by the Office of the Auditor General of Ontario

1.	Effective and cost-efficient hiring and disciplinary processes are in place to ensure that safe, competent care is delivered by doctors, nurses and hospital staff.
2.	Effective processes are in place to prevent, report, investigate, disclose and learn from patient safety incidents, including patient falls, medication errors, procedure-related errors and hospital-acquired infections.
3.	Effective and cost-efficient processes are in place to ensure that surgical tools and medical devices are properly cleaned, sterilized and handled, and are available when needed.
4.	Effective processes are in place to ensure that hospital areas are cleaned and disinfected properly.
5.	Effective processes are in place to ensure that patients receive the right dose of the right medication at the right time and by the right method.
6.	Effective processes are in place to ensure that high-risk medications are securely stored and accounted for, and safely administered to patients.

Appendix 7: Hospitals Visited and Patient Safety Areas Examined

Prepared by the Office of the Auditor General of Ontario

	Patient Safety Area Examined				
Hospital Name (Type)*	**Human Resources**	**Infection Prevention**	**Medication Administration**	**Pharmacy**	**Quality**
Halton Healthcare (large community)	✓	✓	✓	✓	✓
Hamilton Health Sciences (acute teaching)	✓	✓	✓	✓	✓
Humber River Hospital (large community)	✓	✓	✓	✓	✓
Nipigon Memorial Hospital (small community)	✓	✓	✓	✓	✓
Pembroke Regional (medium community)	✓	✓	✓	✓	✓
Thunder Bay Regional Health Sciences Centre (acute teaching)	✓	✓	✓	✓	✓
The Ottawa Hospital (acute teaching)	✓	✓	✓	✓	✓
Women's College Hospital – Ambulatory Care	✓	✓		✓	✓
Chatham-Kent Health Alliance (medium community)			✓	✓	
Grand River Hospital (large community)			✓	✓	
Northumberland Hills Hospital (medium community)			✓	✓	
Stratford General Hospital (medium community)			✓	✓	
St. Thomas Elgin General Hospital (medium community)			✓	✓	

Note: During the audit planning stage, we conducted walkthroughs at Trillium Health Partners (THP), which was one of the hospitals audited in our 2016 report on Large Hospital Operations. In this audit, we limited our audit work at Trillium to Human Resources.

* These are the funding categories for hospitals we visited:

- Acute teaching: Approved as a teaching hospital by the Ministry.
- Small community: Acute inpatient/day surgery activity <4,000 weighted cases per year. Weighted cases based on five years of data.
- Medium community: Acute inpatient/day surgery activity between 4,000 and 12,000 weighted cases per year.
- Large community: Acute inpatient/day surgery activity >12,000 weighted cases per year.

Appendix 8: Recommendations and Responsible Organizations

Prepared by the Office of the Auditor General of Ontario

Recommendation	Ontario Hospitals	Ontario Hospital Association	College of Nurses of Ontario	Ministry of Health
1. To further emphasize patient safety as a foundation for hospitals' organizational culture, we recommend that hospitals explicitly incorporate the words "patient safety" in their mission, vision, and/or as one of their core values, and communicate this to their staff, ensuring that related actions demonstrate this emphasis.	✓	✓ (lead)		
2. To determine and reduce the impact of never-events on patient safety and the health-care system, we recommend that the Ministry of Health: • work with internal and external partners to leverage an existing system that can accumulate and track hospital never-event data; • upon implementation and rollout completion of this system, analyze the frequency of never-events occurring at Ontario hospitals, estimating their cost to the health-care system; and • partner with hospitals and best practice organizations/stakeholder groups to develop a plan to prevent them from happening.	✓	✓		✓ (lead)
3. To minimize the occurrence of serious preventable patient safety incidents, we recommend that hospitals: • enhance patient safety practices to eliminate the occurrence of never-events; • set a formal target to eliminate the occurrence of never-events and include this target in their Quality Improvement Plans; and • track and report never-events to the Ministry of Health.	✓	✓ (lead)		✓
4. To better enable hospitals to prevent similar patient safety incidents, including never-events, from recurring at different hospitals, we recommend that the Ministry of Health work with the Ontario Hospital Association and applicable stakeholder groups to establish a forum where hospitals can share their knowledge and lessons learned from patient safety incident investigations.	✓	✓		✓ (lead)
5. To enable nurses' prospective employers to obtain a more complete record of nurses' employment history and performance and make well-informed hiring decisions, we recommend that the Ministry of Health have the Ontario Hospital Association work with the College of Nurses of Ontario and other regulatory stakeholders to: • identify gaps in the current information available to prospective employers regarding past performance issues and terminations; and • take steps to address gaps identified.	✓	✓	✓	✓ (lead)

Recommendation	Ontario Hospitals	Ontario Hospital Association	College of Nurses of Ontario	Ministry of Health
6. In order for hospitals that hire nurses to have access to the complete record of nurses' past places of employment and disciplinary history, we recommend that hospitals: • use the National Council of State Boards of Nursing public database to determine whether nurses they hire and employ have faced disciplinary actions in the United States; and • if the hospital uses agency nurses, require nursing agencies to confirm these nurses have been screened through this database.	✓	✓ (lead)		
7. To help ensure that when hospitals hire nurses they have access to their full disciplinary record, we recommend that the Ministry of Health request that the Ontario Hospital Association and the College of Nurses of Ontario work together with their provincial and territorial counterparts to: • explore a national system for provincial and territorial nursing regulatory bodies to report their disciplinary actions; and • put in place an effective process that will ensure that all places of past employment and disciplinary records from other jurisdictions for each nurse are in its database, including records from US nursing databases.	✓	✓	✓	✓ (lead)
8. To better inform employers in their hiring decisions and protect patients from the risk of harm, we recommend that the Ministry of Health assess for applicability in Ontario the actions taken by US states to protect hospitals and other health-care providers from liability associated with any civil action for disclosing a complete and truthful record about a current or former nurse to a prospective employwer.				✓ (lead)
9. In the interest of patient safety and in order for hospitals and agencies to hire nurses fully aware of their past employment and performance history, we recommend that the Ministry of Health explore means to: • enable hospitals and agencies to provide and receive truthful references and information to make informed nursing hiring decisions; and • require these organizations to disclose such information when it is requested by a prospective employer.	✓	✓		✓ (lead)
10. So that hospitals can make optimally informed hiring and staffing decisions, we recommend that the Ministry of Health require all hospitals in Ontario to: • perform criminal record checks before hiring nurses and other health-care employees; and • periodically update checks for existing staff.	✓	✓		✓ (lead)

Recommendation	Ontario Hospitals	Ontario Hospital Association	College of Nurses of Ontario	Ministry of Health
11. To enable hospitals to take timely action to improve patient safety, we recommend that the Ministry of Health explore means to make it easier and less costly for hospitals and ultimately the taxpayer to address physician human resources issues, especially in cases when doctors may have harmed patients.	✓	✓		✓ (lead)
12. To improve patient safety, we recommend that the Ministry of Health: • review the Accreditation Canada hospital reports and identify areas where hospitals may consistently not be meeting required patient safety practices and high-priority criteria; and • follow up with hospitals in respect of problem areas to confirm that actions are taken to correct deficiencies.	✓	✓		✓ (lead)
13. So that hospitals fully complete medication reconciliation to reduce the risk to discharged patients and that they have all the necessary patient information to properly investigate any incidents with patients' dosages or drug interactions that might occur and trigger hospital readmission, we recommend that hospitals reinforce with staff the importance of the medication reconciliation documentation processes so that all the necessary information is consistently documented.	✓	✓ (lead)		
14. To reduce the risk of medication errors and readmissions to hospital, we recommend that the Ministry of Health: • require hospitals to complete medication reconciliation for all patients; • require hospitals to include medication reconciliation in their Quality Improvement Plans; and • in conjunction with relevant hospitals, review their IT system needs to be able to track necessary medication reconciliation information and take action for improvement where needed.	✓	✓		✓ (lead)
15. To improve patient safety, we recommend that hospitals reinforce with nurses necessary medication administration processes to ensure that: • independent double-checks of high-risk medications are done to verify that correct medication and dosage are administered; • nurses witness patients taking and swallowing high-risk medications; and • nurses use two unique identifiers to confirm the identity of patients before administering medication to them.	✓	✓ (lead)		
16. To minimize patient safety incidents due to missing information or miscommunication, we recommend hospitals adopt, based on patient condition, the practice of making nursing shift changes at the patients' bedside and where possible involving the patients and their families, with the consent of the patients, in the process.	✓	✓ (lead)		

Recommendation	Ontario Hospitals	Ontario Hospital Association	College of Nurses of Ontario	Ministry of Health
17. To improve patient safety with respect to medication administration and where a compelling business case for cost-effectiveness can be made, we recommend that the Ministry work with hospitals toward the automation of pharmacy-related tasks.	✓	✓		✓ (lead)
18. To improve the accuracy of reported hand hygiene compliance, while at the same time encouraging hand hygiene, we recommend that the Ontario Hospital Association work with hospitals to evaluate and further the adoption of additional methods to assess and monitor hand hygiene, such as electronically monitored hand hygiene pumps and monitoring systems, and asking patients to observe and record the hand hygiene compliance of their health-care providers.	✓	✓ (lead)		
19. So that sterile-rooms and the equipment used in the mixing and preparation of intravenous medications are cleaned according to required standards, we recommend that hospitals: • provide their pharmacy and housekeeping staff with proper training on how to conduct the cleaning; and • monitor the cleaning to ensure proper processes are being followed.	✓	✓ (lead)		
20. To improve hospitals' compliance with the Canadian Standards Association's standards pertaining to the washing and sterilization of surgical tools and medical equipment, we recommend that hospitals have their washing and sterilization of surgical tools and medical equipment inspected internally on an annual basis.	✓	✓ (lead)		
21. In order for contracts with private providers of sterilization services to be managed effectively by hospitals, we recommend that hospitals: • include all the necessary service standards and performance indicators in these contracts; and • on a regular basis, assess the private service provider's compliance with all contract terms.	✓	✓ (lead)		
22. So that patients with a life- or limb-threatening condition receive timely care from the closest hospital, we recommend the Ministry of Health leverage learned lessons from hospitals that utilize "command centres" and work with CritiCall toward the development of a provincial bed command centre.	✓	✓		✓ (lead)

Appendix 9: Overall Patient Safety Culture Staff Survey Results at 123 Acute-Care Hospitals, 2014–2019

Source of data: Ontario Hospitals

			Overall Grade on Patient Safety (%)			
Hospital	**Funding Category***	**# of Staff Surveyed**	**Excellent or Very Good**	**Acceptable**	**Poor or Failing**	**Total**
Hamilton Health Sciences	Teaching	1,744	54	33	13	**100**
Health Sciences North	Teaching	580	41	39	20	**100**
Kingston Health Sciences Centre	Teaching	810	47	39	15	**100**
London Health Sciences Centre	Teaching	502	38	38	24	**100**
Montfort Hospital	Teaching	339	70	23	7	**100**
Sinai Health System	Teaching	751	68	29	3	**100**
St. Joseph's Health Care London	Teaching	n/a	n/a	n/a	n/a	**n/a**
St. Joseph's Healthcare Hamilton	Teaching	2,244	58	34	9	**100**
Sunnybrook Health Sciences Centre	Teaching	1,434	66	30	4	**100**
The Ottawa Hospital	Teaching	2,584	58	35	7	**100**
Thunder Bay Regional Health Sciences Centre	Teaching	461	48	39	13	**100**
Unity Health Toronto	Teaching	n/a	n/a	n/a	n/a	**n/a**
University Health Network	Teaching	n/a	n/a	n/a	n/a	**n/a**
University of Ottawa Heart Institute	Teaching	658	66	30	4	**100**
Bluewater Health	Large community	296	56	34	10	**100**
Brant Community Healthcare System	Large community	462	28	39	33	**100**
Grand River Hospital	Large community	968	56	35	10	**100**
Grey Bruce Health Services	Large community	503	63	31	6	**100**
Guelph General Hospital	Large community	474	56	34	10	**100**
Halton Healthcare Services	Large community	628	53	34	13	**100**
Humber River Hospital	Large community	995	41	38	21	**100**
Joseph Brant Hospital	Large community	530	36	42	22	**100**
Lakeridge Health	Large community	519	55	35	11	**100**
Mackenzie Health	Large community	359	52	35	13	**100**
Markham-Stouffville Hospital	Large community	515	58	34	8	**100**
Niagara Health System	Large community	883	53	34	13	**100**
North Bay Regional Health Centre	Large community	307	41	44	16	**100**
North York General Hospital	Large community	477	65	28	6	**100**
Peterborough Regional Health Centre	Large community	552	44	44	13	**100**
Queensway-Carleton Hospital	Large community	439	51	39	10	**100**
Quinte Healthcare Corporation	Large community	433	47	38	15	**100**
Royal Victoria Regional Health Centre	Large community	1,949	46	39	15	**100**
Sault Area Hospital	Large community	449	52	35	14	**100**
Southlake Regional Health Centre	Large community	503	42	34	24	**100**
St. Mary's General Hospital	Large community	295	42	31	27	**100**

Hospital	Funding Category*	# of Staff Surveyed	Overall Grade on Patient Safety (%)			
			Excellent or Very Good	Acceptable	Poor or Failing	Total
The Scarborough Network	Large community	n/a	n/a	n/a	n/a	**n/a**
Toronto East Health Network	Large community	578	53	30	17	**100**
Trillium Health Partners	Large community	3,392	61	34	5	**100**
William Osler Health System	Large community	715	52	38	10	**100**
Windsor Regional Hospital	Large community	589	61	33	5	**100**
Brockville General Hospital	Medium community	233	42	41	17	**100**
Cambridge Memorial Hospital	Medium community	364	49	40	11	**100**
Chatham-Kent Health Alliance	Medium community	364	37	46	17	**100**
Collingwood General and Marine Hospital	Medium community	203	49	37	14	**100**
Cornwall Community Hospital	Medium community	343	54	34	12	**100**
Georgian Bay General Hospital	Medium community	197	42	42	17	**100**
Headwaters Health Care Centre	Medium community	239	53	35	13	**100**
Muskoka Algonquin Healthcare	Medium community	224	49	38	13	**100**
Norfolk General Hospital	Medium community	181	46	39	14	**100**
Northumberland Hills Hospital	Medium community	252	59	33	9	**100**
Orillia Soldiers' Memorial Hospital	Medium community	n/a	n/a	n/a	n/a	**n/a**
Pembroke Regional Hospital	Medium community	223	52	40	9	**100**
Perth and Smiths Falls District Hospital	Medium community	219	79	20	1	**100**
Ross Memorial Hospital	Medium community	251	49	38	13	**100**
St Thomas-Elgin General Hospital	Medium community	203	59	28	13	**100**
Stratford General Hospital	Medium community	214	59	37	4	**100**
Strathroy Middlesex General Hospital	Medium community	146	64	31	5	**100**
Timmins and District Hospital	Medium community	352	49	39	12	**100**
West Parry Sound Health Centre	Medium community	165	60	30	10	**100**
Woodstock General Hospital Trust	Medium community	499	70	26	4	**100**
Alexandra Hospital	Small	29	79	17	3	**100**
Alexandra Marine and General Hospital	Small	n/a	n/a	n/a	n/a	**n/a**
Almonte General Hospital	Small	150	67	26	7	**100**
Anson General Hospital	Small	56	52	36	13	**100**
Arnprior Regional Health	Small	63	48	44	8	**100**
Atikokan General Hospital	Small	74	70	27	3	**100**
Bingham Memorial Hospital	Small	61	56	39	5	**100**
Campbellford Memorial Hospital	Small	74	59	31	10	**100**
Carleton Place and District Memorial Hospital	Small	65	63	29	8	**100**
Casey House Hospice	Small	n/a	n/a	n/a	n/a	**n/a**
Clinton Public Hospital	Small	28	50	43	7	**100**
Deep River and District Hospital	Small	49	51	16	33	**100**
Dryden Regional Health Centre	Small	93	68	27	5	**100**
Englehart and District Hospital	Small	31	77	19	3	**100**

682

Hospital	Funding Category*	# of Staff Surveyed	Overall Grade on Patient Safety (%)			
			Excellent or Very Good	Acceptable	Poor or Failing	Total
Erie Shores HealthCare	Small	196	50	31	11	**100**
Espanola General Hospital	Small	42	83	17	0	**100**
Four Counties Health Services Corporation	Small	37	57	35	8	**100**
Geraldton District Hospital	Small	84	70	25	5	**100**
Glengarry Memorial Hospital	Small	105	72	21	7	**100**
Groves Memorial Community Hospital	Small	129	43	44	13	**100**
Haldimand War Memorial Hospital	Small	122	76	20	4	**100**
Haliburton Highlands Health Services Corporation	Small	149	57	34	9	**100**
Hanover and District Hospital	Small	113	81	16	3	**100**
Hawkesbury and District General Hospital	Small	234	45	42	13	**100**
Hornepayne Community Hospital	Small	n/a	n/a	n/a	n/a	**n/a**
Kemptville District Hospital	Small	100	64	31	5	**100**
Kirkland and District Hospital	Small	73	77	22	1	**100**
Lady Dunn Health Centre	Small	43	60	33	7	**100**
Lady Minto Hospital	Small	88	48	43	9	**100**
Lake-of-the-Woods District Hospital	Small	153	40	45	15	**100**
Lennox and Addington County General Hospital	Small	110	77	16	6	**100**
Listowel Memorial Hospital	Small	n/a	n/a	n/a	n/a	**n/a**
Manitoulin Health Centre	Small	87	74	24	2	**100**
Mattawa General Hospital	Small	121	74	24	2	**100**
Nipigon District Memorial Hospital	Small	n/a	n/a	n/a	n/a	**n/a**
North of Superior Healthcare Group	Small	77	73	15	12	**100**
North Shore Health Network	Small	88	77	15	8	**100**
North Wellington Health Care	Small	111	67	31	3	**100**
Notre Dame Hospital	Small	60	82	15	3	**100**
Red Lake Margaret Cochenour Memorial Hospital	Small	50	72	26	2	**100**
Renfrew Victoria Hospital	Small	228	80	18	2	**100**
Riverside Health Care Facilities Inc	Small	107	47	43	10	**100**
Santé Manitouwadge Health	Small	n/a	n/a	n/a	n/a	**n/a**
Seaforth Community Hospital	Small	29	72	28	0	**100**
Sensenbrenner Hospital	Small	117	47	38	15	**100**
Services de Santé de Chapleau Health Services	Small	74	89	8	3	**100**
Sioux Lookout Meno Ya Win Health Centre	Small	174	66	29	5	**100**
Smooth Rock Falls Hospital	Small	54	80	19	2	**100**
South Bruce Grey Health Centre	Small	161	53	34	14	**100**

Grey Areas ITEM 7.7

SML Steinecke Maciura LeBlanc Barristers & Solicitors

A COMMENTARY ON LEGAL ISSUES AFFECTING PROFESSIONAL REGULATION

The Trouble with Awards

by Erica Richler
January 2020 - No. 242

Awards season has arrived in North American popular culture. Some critics argue that such recognitions are flawed for numerous reasons including the use of non-inclusive selection criteria and providing a platform for celebrities to speak out on issues outside of their expertise.

Regulators often also bestow awards to leaders or members of the profession who inspire by their dedication, altruism or talent. Such recognition can encourage the profession to aspire to excellence. It can also remind the profession that the regulator does not just enforce minimum standards, but also fosters superior performance. The broader pride in the profession that can result from such acknowledgements can counter-balance the discouragement that many practitioners face and which can negatively affect both their performance and attitude. Properly structured awards criteria can actually promote values such as diversity and advances within the profession.

However, these benefits need to be balanced against the risks. One risk from regulatory awards arises where the recipient later requires an investigation, discipline or other enforcement measures. There have been a number of media reports of such situations including a best teacher of the year recipient accused of sexual abuse, and a lawyer/politician who received a prominent award, later alleged to have sexually harassed women for decades. See, for example: https://www.ctvnews.ca/world/teacher-of-the-year-accused-of-sex-acts-with-student-1.4706767 and https://www.theglobeandmail.com/opinion/article-everyone-turns-to-lawyers-for-metoo-advice-but-the-legal-community/.

These circumstances bring discredit to the regulator. More importantly, the ability of the regulator to perform its primary public protection functions is compromised. Harmed clients, colleagues and other witnesses may be reluctant to come forward because of the public accolades previously bestowed on the practitioner. Apparent conflicts of interest may arise as those involved in the recognition of the practitioner may not be seen as impartial in an investigation of that same person. Public confidence in the process or the appropriateness of the outcome could be undermined.

Additional risks exist. The time, energy and cost of the awards process are not available for core regulatory activities. Registration applications, investigations and discipline activities may be delayed to the extent that staff, Board and committee members take time to prepare for and attend the events. The amount of time committed to such an occasion may be surprising, especially if it takes the form of a gala event.

Public perception can also be an issue. Awards and recognitions are often seen as a professional association activity. Self-congratulatory functions can confuse members of the public and even the profession as to the public protection role of the regulator.

Regulators who confer awards to practitioners should constantly evaluate whether the public interest benefits outweigh the risks. There is a strong case to be made that this activity should be left to a separate

FOR MORE INFORMATION
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WANT TO REPRINT AN ARTICLE
A number of readers have asked to reprint articles in their own newsletters. Our policy is that readers may reprint an article as long as credit is given to both the newsletter and the firm. Please send us a copy of the issue of the newsletter which contains a reprint from Grey Areas.

professional association. A candid debate should be held as to the real reason why those in favour of continuing with the awards like them.

Regulators who decide to continue with this activity might consider some or all of the following safeguards:

- The public interest purpose of the award should be clearly articulated.
- All communications related to the award, including its name, should promote that public interest purpose.
- The criteria and process for selecting award recipients should be transparent and should reflect the public protection values of the regulator.
- There should be a rigorous screening of award candidates.
- There should be consideration as to whether the event can be downscaled so as to use an appropriate level of resources.

The selection and administration of the award should be separated as much as possible from the regulatory functions of the regulator. Ideally a separate awards committee or group, which does not involve compliance and enforcement staff or committee members, is ideal. It is even preferable that as few Board members as possible participate.

Should a concern about the conduct of an awards recipient arise, specific measures should be taken to avoid even a perception of a conflict of interest. For example, those involved in the acknowledgement should, as much as is possible, not be involved in the investigation, screening or adjudication of the concern.

Regulators should include explicit terms and conditions for the award that include the possibility of rescinding the award should the recipient, in the past or future, engage in conduct incompatible with the values of the regulator.

At first glance it may seem that acknowledging outstanding contributions by members of the profession is innocuous. However, further reflection may identify substantial risks to regulators who grant awards to practitioners.

From: Jo-Ann Willson
Sent: Thursday, December 19, 2019 6:51 PM
To: Rose Bustria
Subject: Fwd: Vavilov decision

Exec and Council.

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Begin forwarded message:

> **From:** Rebecca Jones <rjones@litigate.com>
> **Date:** December 19, 2019 at 4:32:37 PM EST
> **To:** Jo-Ann Willson <jpwillson@cco.on.ca>
> **Cc:** Kelly Hayden <khayden@litigate.com>
> **Subject: Vavilov decision**

Hi Jo-Ann,

If you haven't seen it yet, this morning the Supreme Court of Canada released a significant administrative law decision about the tricky issue of standard of review.

You can read the Case Law in Brief summary by clicking here.

We also just published a short blog post which you can read by clicking here.

Speak to you soon!

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686

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SUPREME COURT OF CANADA

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Case Law in Brief: *The Standard of Review (taken from Vavilov in the "Administrative Law Trilogy")*

Judgments of December 19, 2019 | On appeal from the Federal Court of Appeal
Neutral citations: 2019 SCC 65 and 2019 SCC 66

The Supreme Court has changed how courts look at administrative (non-court) decisions, to make the law clearer and more predictable.

Decisions made by governments, or those acting on their behalf, are called "administrative decisions." They are part of "administrative law." Most legal decisions that affect people are administrative decisions, not court ones.

An administrative decision can be anything from a letter from a benefits agency, to a town by-law, to a decision by a tribunal. Administrative decision-makers often aren't judges or lawyers. Their decisions usually don't look like court decisions. But judges and courts have a role. Under the Constitution, courts can make sure administrative decision-makers follow the rules. They do this through a process called "judicial review."

When a court looks at an administrative decision, it applies a certain "standard of review." The standard of review is the legal approach to analyzing the decision. Which standard applies depends on what kind of decision it is. But there was a lot of debate about which standard of review applied in which situation. There was also debate about how each standard should be applied.

The majority of judges at the Supreme Court confirmed there are two standards of review when a court looks at administrative decisions. These are "reasonableness" and "correctness."

"Reasonableness" and "correctness" may sound like normal everyday words. But they have special meanings in law. A "reasonable" decision is based on a logical chain of reasoning. It has to *make sense* in light of the law and the facts. A "correct" decision is the *only right answer* in light of the law and the facts.

The majority set out a new way for courts to decide whether they need to ask if a decision is "reasonable," or whether it needs to ask if it is "correct." It also gave courts guidance for looking at "reasonableness."

The majority said that the default (usual) standard of review should be "reasonableness." This means a court has to look at whether the decision is "reasonable." There can be more than one "reasonable" outcome. Courts have to accept any decision that's "reasonable." They have to accept it even if they would have decided something different themselves. If a decision isn't "reasonable," a court should normally send it back to the decision-maker for another look. The decision-maker may come to the same result, or something different. Rarely, a court may just decide to replace the decision-maker's outcome with its own.

The majority said there are some cases where decision-makers don't have to give reasons. But people need to understand the decisions that apply to them. So it's usually important for decision-makers to explain why they made the decision they did.

The majority said there are two exceptions where the standard won't be "reasonableness." The first exception is where lawmakers specifically say something different. There are two ways they can do this. The first is by saying in a law which standard applies. The second is giving a right of appeal to a court. An appeal is different than judicial review, so different standards apply. These are called "appellate" standards. They are the same standards courts use to decide appeals from lower court decisions. An "appellate" standard ends up being a "correctness" standard if a decision is about the law or the decision-maker's power to decide the question.

The second exception where the standard won't be "reasonableness" is for the rule of law. The rule of law is the principle that everyone should follow the same basic legal rules in society. This includes constitutional questions. It includes general questions of law that affect the legal system as a whole. It also includes cases where powers of two administrative bodies overlap. For all of these, courts have to ask whether the decision is "correct." There can only be one "correct" decision. If a decision isn't "correct," the court will always change it without sending it back to the decision-maker.

The Supreme Court creates "precedents" that other courts have to follow. It is the only court that can overturn these precedents. But this is rare. In most cases, the Court interprets laws or decides what to do when something isn't clear. In this case, the Court overturned (changed) some of its past precedents. Precedents are important because they make the law certain and predictable. But some of the precedents on standard of review weren't doing that. The majority overturned those precedents to make the law clearer and more predictable.

...cont'd

Breakdown:

- Chief Justice Richard Wagner and Justices Michael Moldaver, Clément Gascon, Suzanne Côté, Russell Brown, Malcolm Rowe, and Sheilah Martin set out the new approach
- Justices Rosalie Silberman Abella and Andromache Karakatsanis said administrative decision-makers should be given more deference and that the majority's approach gave judges too much room to substitute their own decisions for those of experts

Cases in Brief for Individual Decisions:

688

- *Canada (Minister of Citizenship and Immigration) v. Vavilov*, 2019 SCC 65
- *Bell Canada v. Canada (Attorney General)*, 2019 SCC 66 (two appeals)

Cases in Brief are prepared by communications staff of the Supreme Court of Canada to help the public better understand Court decisions. They do not form part of the Court's reasons for judgment and are not for use in legal proceedings.

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December 19, 2019

689

All I Want for Christmas Is a New Standard of Review: The Supreme Court Changes Course on the Standard of Review for Administrative Decisions

In the season of giving the Supreme Court of Canada has given lawyers and legal scholars the greatest gift of all: a new approach to the standard of review.

A much anticipated trilogy of cases was released today, finally ending all of the speculation on what would change and what would stay the same in the review of administrative decisions in Canada. The Supreme Court, in *Canada (Minister of Citizenship and Immigration) v Vavilov* charted a new course for the standard of review, which was then applied in two appeals heard together as *Bell Canada v Canada (Attorney General)*.

The *Vavilov* case was an appeal from the Federal Court of Appeal which had quashed a Canadian Registrar of Citizenship's decision to deny citizenship to two children of foreign nationals working for a foreign intelligence service under cover of Canadian identities.

While the facts of the *Vavilov* case are themselves interesting, the Court used the case as an opportunity to address what has become the hallmark issue of Canadian administrative law: what to do about the standard of review.

The majority decision brings a new approach to standard of review of administrative decisions. The Court provided coherence and predictability to the standard of review, and in the process reduced the amount of time that will be spent arguing about the standard of review instead of the merits of any case. Under the new analysis, the presumption will be that a reasonableness standard of review applies. That presumption can be rebutted either where the legislature makes a design choice that suggests a different standard or where the rule of law requires a correctness standard.

When considering the legislative design, the Court will look to whether the legislature itself prescribes a different standard than reasonableness and will also consider any statutory

appeal mechanism in the legislation. This means that appeal provisions (depending on their wording) will be viewed as intent from the legislature that an appellate standard of review applies. In practice, this shift will open a large swath of administrative decisions to review on a correctness standard which had previously been categorized as reasonableness reviews.

The second category of cases where the presumption of reasonableness will be rebutted are cases properly considered on a correctness standard even under the prior regime, including constitutional questions and general questions of law central to the legal system. Notably, the Court has done away with pure questions of jurisdiction and replaced it instead with consideration of jurisdictional boundaries between administrative bodies, harkening back to the issues addressed by the three dissenting decisions *West Fraser Mills Ltd v Workers' Compensation Appeal Tribunal and Workers' Compensation Board of British Columbia*, released last year.

The majority also provided guidance on the application of the reasonableness standard, including helpful direction on how a reviewing court should review the internal coherence of a decision and consideration of the decision as a whole.

Having set the new course in *Vavilov*, the majority determined that the Registrar's decision should be considered on a reasonableness standard, and concluded that it was unreasonable.

In *Bell*, the majority applied the *Vavilov* approach to a decision of the CRTC. The appeal in that case had been brought under a statutory appeal provision which permitted an appeal on a question of law or jurisdiction. The Court held that a correctness standard applied and the decision of the CRTC was quashed.

Both cases included a substantive dissent from Justice Karakatsanis and Justice Abella. While the dissenting Justices agreed that reasonableness should be the presumptive standard, they took issue with the expanded scope of correctness review. Justices Karakatsanis and Abella describe the majority as creating a fundamentally new view of administrative law in Canada by overturning the status quo without sufficient regard for precedent.

The Court has provided welcome clarity on what has been a thorny issue in Canadian administrative law. That said, we won't know the true impact of the majority's decision until lower courts have an opportunity to apply it. Only when courts begin to apply the decision will its simplicity be borne out or its fault

lines become evident.

For the moment, both cases are sure to make good holiday reading as we look forward to seeing how litigants and the Courts navigate the new approach to the standard of review.

Simpson Chiropractic & Manual Therapies (2019) 27:30

RESEARCH

ITEM 7.9

Open Access

At-risk advertising by Australian chiropractors and physiotherapists

692

J. Keith Simpson

Abstract

Background: Society expects professionals to promote their businesses in an ethical manner, refraining from misleading or deceptive marketing due to the potential to harm members of the community. In Australia this expectation resides in the Australian registration board advertising guidelines or the Health Practitioner Regulation National Law. Registration board data indicate there are many health care professionals failing to meet these expectations. The aims of this research were to determine the frequency, type and nature of at-risk advertising by Australian chiropractors and physiotherapists and whether there is a correlation between professional association membership and advertising guideline compliance.

Method: A cross sectional audit examining practitioner advertising was performed on representative samples of Australian chiropractors and physiotherapists. Two auditors examined advertising by 380 physiotherapists and 359 chiropractors for material potentially in breach of the regulatory authorities' advertising guidelines. The advertising appeared on practitioner websites and linked Facebook pages.

Results: Two-hundred and fifty-eight (72%) audited chiropractors and 231 (61%) audited physiotherapists had breaches of the Advertising Guidelines on their websites and linked Facebook pages. The frequency of breaches by chiropractors was higher. The type and nature of the breaches by chiropractors was potentially more harmful. Membership in a professional association influenced neither the frequency nor the severity of breaches with chiropractors.

Discussion: Advertising breaches were common in both samples even though regulators and professional associations provide practitioners with explicit information on how to comply with advertising guidelines. Breaches by chiropractors were more numerous and more serious due to their greater potential to lead consumers to make inappropriate and potentially harmful healthcare decisions.
Stronger enforcement strategies may have a positive effect on compliance.

Keywords: Chiropractor, Physiotherapist, Advertising breaches, Misleading and deceptive conduct

Background

Advertising by health professionals is an integral part of practise. Providing consumers with ethical accurate advertising assists with making informed health related decisions.

Chiropractors and physiotherapists are amongst Australia's 15 regulated health professions. All must abide by the same advertising guidelines. The guidelines stipulate what constitutes unacceptable advertising. Unacceptable advertising includes advertising that is false, misleading or deceptive or likely to deceive. Unacceptable advertising has the potential to cause harm. Recent Australian court cases have highlighted the potential harm to consumers when health care providers publish false advertising [1, 2]. Although the regulatory authorities' annual reports provide the numbers of advertising complaints made for each profession, they contain no details about the frequency, type and nature of the complaints.

This research examined advertising by a representative sample of Australian chiropractors and physiotherapists. Practitioner websites and linked Facebook pages were audited. It reports on the frequency, type and nature of advertising at risk of being non-compliant with the advertising guidelines. In addition, this research determined whether there is a correlation between professional association membership and advertising guideline compliance.

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Advertising and the National law in Australia Since 2010 all registered Australian health care providers have had uniform nationwide legislation – The National Law (NL). The NL outlines the regulatory obligations for advertising a regulated health service. Obligations include: advertising must not be false, misleading or deceptive or likely to be misleading or deceptive and must not include testimonials; any claims made must be able to be substantiated; offers of gifts, discounts or other inducements must come with terms; advertising must neither create and unreasonable expectation of beneficial treatment nor directly or indirectly encourage the indiscriminate or unnecessary use of regulated health services [3].

Under the NL, the definition of a regulated health service is very broad and is not restricted to direct clinical services. Uniform Advertising Guidelines (AG) are in place for each of the 15 regulated health professions governed by its own Board. A breach of advertising provisions of the NL is a criminal offence punishable by fine. Other enforcement approaches include the respective Board placing restrictions on an individual's registration and their ability to practise. Legislative authorities in other countries including the United States of America, Canada, and the United Kingdom have also legalised advertising by health care professionals and have similar regulations governing professionals' advertising.

Understanding misleading or deceptive or likely to be misleading or deceptive

Before considering the regulatory authorities' compliance and enforcement strategy, it is appropriate to consider one of the most challenging aspects of the AG, namely what is meant by misleading or deceptive. The Chiropractic Board of Australia (CBA) advises that misleading someone may include lying to them, leading them to a wrong conclusion, creating a false impression, leaving out important information, or making false or inaccurate claims [4]. And the CBA correctly points out, "the ways which advertising can be false, misleading or deceptive are almost limitless" [4]. Additionally, silence may constitute misleading or deceptive conduct where there is a duty to reveal relevant facts [5]. The courts have determined that people who are misled are almost by definition deceived as well. Regarding the phrase 'likely to mislead': there is no requirement to prove that a person was misled or deceived, rather, the sufficient test is whether there is a real and not remote chance to mislead. As far as who is misled or deceived, the courts have determined that the misleading and deceptive conduct provisions are concerned with the public at large, or as it is sometimes referred to, the "target audience". Members of the "target audience" include:

> the astute and the gullible, the intelligent and the not so intelligent, the well-educated as well as the poorly educated, men and women of various ages pursuing a variety of vocations. ... all persons exposed to the conduct should be considered although conduct which is only likely to mislead or deceive an extraordinarily stupid person would not fall within the ambit of the provisions [6].

The courts will consider whether a reasonably significant number of potential purchasers would be likely to be misled or deceived. Intent is not a necessary element for conduct to breach the misleading conduct provisions. Conduct may be regarded as misleading or deceptive even if the originator of the conduct did not intend to mislead or deceive members of the target audience. The test is objective. The factor is conduct taken at face value [7].

AHPRA's compliance and enforcement strategy: education & engagement

The Australian Health Practitioner Regulation Agency (AHPRA) prosecutes breaches of the AG. The high volume of complaints received by AHPRA during 2016 triggered the establishment of a dedicated Advertising Compliance Team which works closely with the Legal Team and the Policy and Communications Team. To assist in their decision making, AHPRA utilise experts to evaluate advertising claims.

AHPRA considers that education and engagement are effective tools as part of its strategy to achieve behaviour change and compliance with the regulations. AHPRA has developed advertising education tools accessible via the AHPRA website under the heading: Check, Correct, Comply. This section of the website includes numerous examples of non-compliant advertising common to all professions and examples specific to chiropractors. In addition, the National Boards consider that some words have a greater capacity to mislead or deceive when used in advertising and recommend that advertisers be cautious when using them. The "words to be wary [of]: cure, safe, effective, and can help/ improve/treat or effectively treats" [8]. In addition, the Chiropractic Board of Australia has issued position statements on Paediatric Care [9] and on Care of the Pregnant Patient [10] which

deal with inappropriate claims of benefit and antivaccination advice.

In response to a recognised need to reduce non-compliant advertising AHPRA announced a pilot audit of chiropractic and dentist advertising commencing in the 2019 registration period. This step marks a shift from reactive enforcement to proactive enforcement and is expected to improve compliance across the entire sector. The data generated by AHPRA will inform a review of the compliance strategy, identify profession-specific differences in compliance rates, inform future strategic directions and ensure sustainable change [11].

Conduct notifications & advertising breaches: the Australian scene

In Australia there are 657,621 registered health practitioners across 15 professions. The 5167 registered chiropractors make up 0.8% of the total health practitioner registrant base, while the 28,885 registered physiotherapists make up 4.5% of the base [12].

Advertising complaints are considered separately from conduct complaints. AHPRA Annual Reports covering the period 2013–2017 [12–15] demonstrate the growing challenge of regulatory control of practitioner advertising. (Table 1).

A clear picture exists regarding conduct complaints against chiropractors and physiotherapists in Australia [16] and where the complaints come from [17] providing regulatory bodies with valuable information for developing preventive strategies. Recent research demonstrates that the Australian chiropractic profession generates a disproportionate number of professional conduct complaints. Professional conduct refers to: procedures, treatment, communication, assessment, diagnosis and other professional conduct issues (advertising and titles), sexual boundaries, honesty in fees, interpersonal behaviour, records and reports. Chiropractors have a higher rate of conduct complaints than psychologists, optometrists, podiatrists, nurses, physiotherapists or occupational therapists per 100 practitioners [18]. Only dentists and medical practitioners generate more complaints per 100 practitioners [18]. The chiropractic conduct complaints are 6 times higher than those of physiotherapists and 3 times higher than those of osteopaths [16].

The reactive nature of AHPRA's approach has obvious limitations. Spittal, Bismark and Studdert [19] suggest that a predictive proactive approach to identify practitioners at risk of becoming the subject of repeated patient complaints would assist medicolegal agencies such as malpractice insurers, medical boards and complaints handling bodies in fulfilling their role of protecting the public. Spittal et al. have developed an algorithm for predicting a doctor's risk of conduct complaints. Dubbed the PRONE (Predicted Risk of New Event) score, their algorithm may be adaptable to other health care professions such as chiropractors and physiotherapists [19].

A less clear picture exists regarding advertising complaints. Regulatory authority reports confirm that Australian chiropractors and physiotherapists are the subject of significant numbers of advertising complaints [12–15]. In 2016 these matters were noticed by the Australian Health Minister's Advisory Council which issued a 'please explain' notice to the Chiropractic Board of Australia (CBA) [20]. In response, the CBA acknowledged the unacceptable false advertising practices of some chiropractors, stating:

> There is no evidence chiropractic care benefits babies or can treat them for medical conditions and there is not enough evidence to suggest it [chiropractic] can achieve general wellness or treat various organic diseases and infections.
>
> it [CBA] was concerned about a number of practitioners who were falsely advertising that chiropractic care for spinal problems could also treat a range of other ailments [21].

Emphasising the need for concern, a 2018 high profile Australian case establishes that serious breaches do occur and that misleading advertising by health practitioners can harm members of the community [2]. Until now no research has been conducted into the frequency, type and nature of advertising breaches by chiropractors or physiotherapists in Australia.

Objectives

This research had two objectives: 1) to determine the frequency, type and nature of Australian advertising guideline breaches by Australian chiropractors and physiotherapists and 2) to determine if there is a correlation between compliance with advertising guidelines and professional association membership.

Table 1 Advertising Complaints by Profession: 2013–2017

Advertising Complaints	2013/14	2014/15	2015/16	2016/17	2017/18
Chiropractic	186	120	601[a]	162	15
Physiotherapy	28	25	44	903[b]	8
Total	547	300	1013	1895	1043

Explanatory Notes: [a]No explanation could be found for the spike in advertising complaints against chiropractors [b] According to the Physiotherapy Board of Australia (PBA) the 1300% increase in advertising complaints over the previous year was due to the lodgement of bulk complaints by several organisations about suspected advertising breaches [49]. The PBA further stated that the vast majority of the 903 advertising complaints did not require action [50]

Methods

This study was a cross-sectional audit of chiropractors' and physiotherapists' online marketing material examining practitioner compliance with advertising guidelines. The audit was conducted over a 4-week period between July 15, 2018 and August 15, 2018.

In Australia, chiropractors and physiotherapists are registered by separate regulatory boards – CBA and PBA – under the umbrella of a National Health Practitioner Regulation Scheme. There were 5284 registered chiropractors and 31,995 registered physiotherapists across Australia as at 30 June 2018. Sample size was calculated using Table 1 in Krejcie and Morgan [22] and confirmed using the National Statistical Service online calculator using a 95% confidence level and 5% confidence interval [23]. For the chiropractic population of 5284 a sample size of 359 was required while for the physiotherapist population of 31,995 a sample size of 380 was required.

Advertising appearing on the websites and associated Facebook pages of 359 chiropractors and 380 physiotherapists was audited. Because of the prevalence of group private practice (in 2016, 54.1% of chiropractors and 28.1% of physiotherapists were in group private practice [24, 25]) 151 chiropractor websites and 72 physiotherapist websites and linked Facebook pages were inspected to obtain data on 359 chiropractors and 380 physiotherapists.

Data collection

Two auditors collected the data. Both auditors have been registered chiropractors for over 30 years and have extensive experience in professional regulation compliance and enforcement matters. Each auditor collected data for ½ of each sample (≈179 chiropractors, 190 physiotherapists) with minimal overlap. When overlap occurred, there was agreement on numbers and categories of breaches. If a question arose regarding how to classify a particular aspect of a practitioner's advertising, the auditors discussed the matter and reached a consensus. These points were a guide:

- Where breaches in multiple categories were found only one example per practitioner per category was recorded.
- Where multiple breaches were found in a single category, only one example was recorded.
- The auditors were careful to attribute breaches to individual practitioners where it was clear the utterance applied to an individual, and to attribute the breach to all practitioners where the utterance reasonably applied to all practitioners in the practice.
  - Example: Use of association membership as postnominals or a specialisation claim was attributed only to the individual practitioner.
  - Example: A claim made on a home page or FAQ section was attributed to all practitioners in the practice.
- If a claim could be allocated into more than one category, it was registered in the category deemed to have the greatest potential for harm. For example, the claim:

If you're a frequent flyer, make the best of it and remember to come in for your chiropractic adjustments often.

is a misleading unsubstantiated claim breach and a breach of the "encourages inappropriate, indiscriminate, unnecessary or excessive" use category. The greatest potential for harm would be by encouraging inappropriate or excessive use of a health service therefore this example was only counted as a breach of that category. (Please refer to Breach Categories below for details of how breaches were classified).

Locating and auditing practitioner websites & linked facebook pages

A three-step process was followed to locate practitioner websites and linked Facebook pages.

Step 1.

Practitioner lists were created using the appropriate Board's search engine: 359 chiropractors and 380 physiotherapists. The lists were compiled by entering the letter A in the Board's "Check your health practitioner is registered" search field. This retrieved a list of all registrants with a surname beginning with A. Every 5th name was used to compile the list. The same procedure was used with each letter of the alphabet until the required number of names was retrieved.

Step 2.

The practitioner's practice was located using a web search either for the practitioner by name or by suburb. If the web search for the practitioner by name located their practice website, the audit began. If the search failed to locate the practitioner's website, a second web search using postcode, suburb name and practitioner name was conducted. Typically, these approaches located the practitioner's website. In the limited number of cases where a practitioner's website could not be located, the next name on the practitioner list was used. It is estimated that less than 10% of practitioners' names resulted in a negative search.

Step 3.

The practitioner's website and associated Facebook page were audited. Typically, practitioner websites included these sections, each of which was audited:

! Home page

! About/Meet the Team

! What is chiropractic/physiotherapy?

! Frequently Asked Questions !

Conditions treated

! Blog postsHow it works/Research1 ! ! Testimonials ! Facebook

- Videos
- Reviews
- Info & Ads
- Photos

Association membership

Membership in a professional association was determined by using the "locate a chiropractor" search engine for both the Chiropractors Association of Australia and Chiropractic Australia. The "Find a Physio" search engine of the Australian Physiotherapy Association (APA) proved unreliable and the APA would not assist with membership details, so this aspect of the research was abandoned.[2]

Breach categories

The Guidelines For Advertising Regulated Health Services (AG) [26] were jointly developed and are used by all National Boards under section 39 of The National Law. The guidelines were developed to help practitioners and others understand their obligations when advertising a regulated health service. Before March 2014 when the AG were revised, Section 5 of the 2014 AG (§5) was entitled "What is unacceptable advertising?" [3, 27]. This section described examples of unacceptable advertising providing practitioners with a clear indication of what the boards considered objectionable advertising practices. In other words, advertising at-risk of breaching the AG. For this research, §5 provided the criteria against which to audit practitioner advertising.

In addition, the AG contain statements on the substantiation of claims, specialization claims, advertising titles, qualifications or memberships, and using scientific information in advertising.

After considering the explanatory notes within the 2014 and subsequent AG, 32 categories of unacceptable advertising emerged. To assist with coding breaches, the §5 category "Mislead, either directly, or by implication, use of emphasis, comparison, contrast or omission" was subdivided into 9 classes (c1-c9) and classified as Major or Minor based on information provided within the AG and explanatory notes. (Table 2).

Recording and data analysis

The raw data was recorded onto separate Excel spreadsheets for each profession. Data captured included: practice URL; practice location by State; practitioner name(s); and breaches. NVivo 12, a qualitative data analysis software package, was used to organise and analyse the breaches data for both professions.

Breaches were identified by the corresponding letter or number from the 2014 AG §5 + Table 2. When a contravening statement was located it was copied and pasted into the Excel spreadsheet. The following example was recorded as a breach of 'b' – "encourage (directly or indirectly) inappropriate, indiscriminate, unnecessary or excessive use of health services" by a chiropractor.

> If you're a frequent flyer, make the best of it and remember to come in for your chiropractic adjustments often.

Results

No practitioners from either profession emerged from the Northern Territory during the sampling process. Practitioner webpages were audited from all other Australian jurisdictions.

Breaches by the numbers

Seventy-two percent (259) of audited chiropractors and 61% (232) of audited physiotherapists had breaches in one or more categories. Chiropractors had breaches in 11

of the 15 categories with the most frequent being misleading representations such as unsubstantiated claims and misuse of the scientific literature. Physiotherapists had breaches in 6 of the 15 categories with the most frequent being testimonials and misleading representations such as displaying association membership as postnominals or specialisation claims. There were no breaches in categories e, g, i, and n by either category of practitioner (Fig. 1). Two hundred and five chiropractors (57%) made misleading claims on their website or linked Facebook page and 78 physiotherapists (20%) did so. Of the 326 misleading claims made by chiropractors 231 (71%) were considered major misleading claims based on the criteria outlined in Methods. Physiotherapists made no major misleading claims (Fig. 2). The results from each §5 breach category with de-identified examples from practitioner websites and Facebook pages appear in Tables 3, 4, 5, and 6.

Association membership and AG compliance

There are 2 voluntary professional chiropractic associations within Australia: The Australian Chiropractors Association and Chiropractic Australia. At the time of the audit, the Australian Chiropractors Association (CAA) and Chiropractic Australia (CA) advised that 62% of the chiropractic population were members of a professional association nationally [CAA & CA personal communication 10 August 2018]. Overall, 55.0% (198) of the chiropractic dataset were members of a chiropractic professional association. Amongst these, 72.3% (142) had a breach, whereas 70.7% (114) of non-members had a breach. A chi-square test was performed using Microsoft Excel® to determine whether there was any difference in numbers of breaches between association members and non-members. The chi-square statistic is 0.036 and the p value is .85. At $p < .05$ this indicates no significant

Table 2 Misleading Claims: Major or Minor Misleading Classes

Category	Minor: Unlikely to harm	Major: Likely to harm
c1 Association membership presented as postnominals.	Persons displaying association membership in this way are presumably abiding by their association's code of ethics when dealing with clients so the potential for harm is lessened.	
c2 Use of the title Dr. without professional clarification.	Relatively unlikely that a member of the public would be misled into thinking a chiropractor using the title Dr. is also a medical practitioner.	
c3 Use of Doctor of Chiropractic or DC without holding the qualification but having graduated with a chiropractic qualification from an accredited chiropractic program.	Unlikely to mislead the target audience because members of the public would be unlikely to know the distinction although if they misrepresent their academic qualifications they may do so in other areas.	
c4 Specialisation claim.	Practitioners using this designation presumably have a special interest in a particular area however this does not necessarily mean qualifications that would deem them 'specialists' and hence the public may be misled.	
c5 Claims to affect positioning of an unborn child.[a]		Any advertisement claiming or implying that a technique can affect an obstetric breech presentation is misleading and potentially harmful.
c6 Misuse of the literature.		High likelihood of misleading the target audience because almost inevitably the advertiser omits critical information from the literature cited or fails to provide a balanced report of the literature.
c7 Failure to mention possible adverse outcomes.		Failure to mention possible adverse outcomes has a relatively high chance of misleading the target audience into believing that a form of treatment is free from possible adverse outcomes.
c8 Making unsubstantiated claims.		An advertiser must have reasonable grounds for making a claim of effectiveness.[b]
c9 Misrepresenting awards. Eg. Presenting a business award as though it is a clinical award.	A practice which has won a business award may be more likely to comply with required practice standards and is therefore less likely to mislead patients in clinical practice areas.	

Explanatory Note:
[a]The CBA published clear advice on advertising care of pregnant patients in its March 2016 statement on advertising:
Chiropractors are not trained to apply any direct treatment to an unborn child and should not deliver any treatment to the unborn child. Chiropractic care must not be represented or provided as treatment to the unborn child as an obstetric breech correction technique [51]. [b]The courts have shown that determining what constitutes reasonable grounds is not left to the discretion of the advertiser. Rather, reasonable grounds in the view of the courts equates to "sufficient scientific knowledge" [52].

difference between numbers of breaches by members versus those by non-members. Association membership did not influence the advertising compliance of registered chiropractors.

Discussion

These data demonstrate that within the samples audited, neither profession exhibited a high level of compliance with the advertising guidelines. As a group, chiropractors had more at-risk advertising and the nature of the at-risk advertising had a greater potential to cause harm. Membership of a professional chiropractic association did not appear to increase compliance by chiropractors. No physiotherapist had at-risk advertising classified as a major misleading breach. Physiotherapist breaches were confined to minor misleading breaches: displaying association membership as postnominals and using testimonials.

Previous research has examined conduct breaches by these professions and claims made in chiropractic patient brochures and on chiropractic college web sites. Within Australia, research in 2018 indicated that both professions

had conduct breaches with chiropractors having 6 times more complaints than physiotherapists [16]. Ryan, Too and Bismark found that only a small percentage of the professions' members are the subject of conduct complaints [16]. Bismark et al. analysed 43,256 complaints against Australian registered health care providers to determine who typically makes complaints. They found 67% of complaints were made by patients or relatives. The rest were made by fellow practitioners

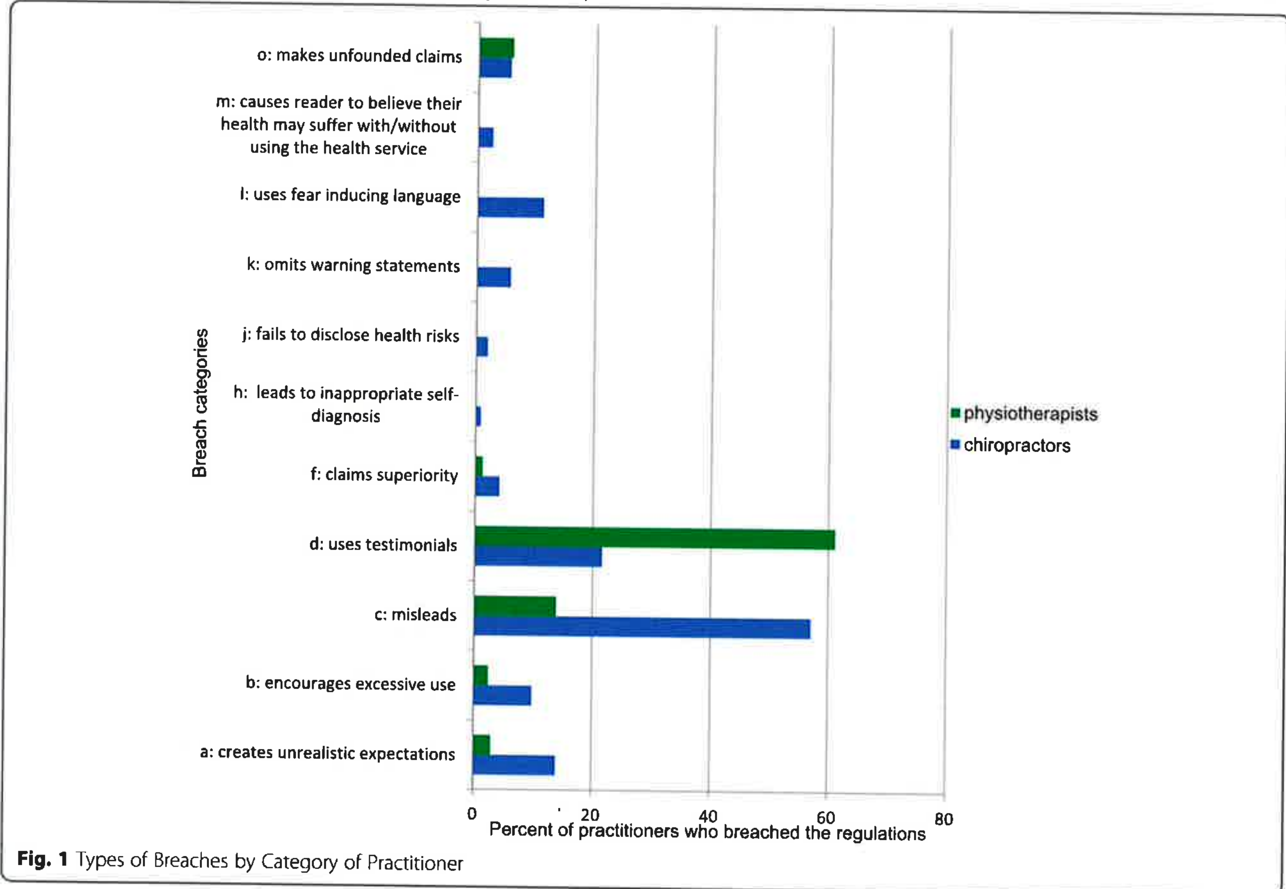

Fig. 1 Types of Breaches by Category of Practitioner

700

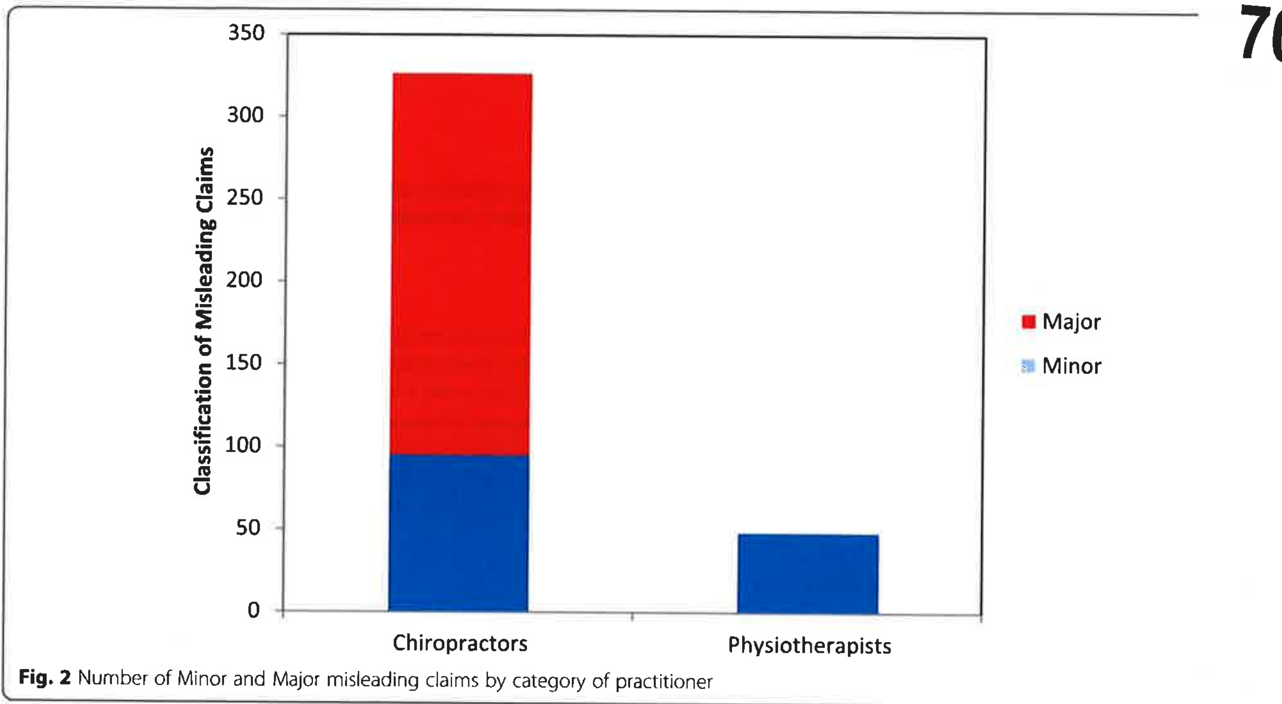

Fig. 2 Number of Minor and Major misleading claims by category of practitioner

Table 3 All Breaches by Chiropractors (Number and %) with Examples

Section 5 of the 2014 AG (§5) Category	Chiropractors with Breaches: Number & (%)	Example
(a) Create unwarranted and unrealistic expectations about service effectiveness	75 (21%)	Research has shown chiropractic to be an effective form of health care for back pain, neck pain, headaches, reflux, bedwetting, ear aches, otitis media, leg pains, headaches, migraine, visual disturbances, dizziness, breathing difficulties, asthma, constipation and dysmenorrheal [sic].
(b) Encourage (directly or indirectly) inappropriate, indiscriminate, unnecessary or excessive use of health services;	42 (12%)	Wellness Care. Once your condition has stabilised you then have a choice of continuing Chiropractic care with a focus on preventing the initial condition returning and new conditions appearing. By having regular check-ups and adjustments we can help you maintain and achieve your ideal level of health. Most patients find that periodic chiropractic check-ups help keep them in tip-top shape. Those who are active, have stressful jobs, or want to be their very best, find that a schedule of preventative visits are helpful in the maintenance of good health.
(c) Mislead, either directly, or by implication, use of emphasis, comparison, contrast or omission	205 (57%)	Given the frequency and variety of misleading claims uncovered, examples are presented in table form. (Table 5: Minor Misleading Claims & Table 6: Major Misleading Claims)
(d) Use testimonials or purported testimonials	80 (22%)	Thanks 'Chiropractor', I was dead in bed for 3 days and thanks to you I was back on my feet within few days! Strongly recommend. Example of a visual testimonial: Normal Scan · My Child's 1st scan · My Child's scan after 12 visits
(e) compare professions without evidence	no breaches found	

(f). Claim or imply that a practitioner provides superior services to those provided by other registered health practitioners	5 (1.4%)	Traditional chiropractic vs NeuroStructural Correction. Traditional chiro aka band-aid care ...
(g) exaggerate recovery time;	no breaches found	
(h) Lead Audience to Self-Diagnosis	3 (0.8%)	links to videos encouraging viewers to perform each of Contracted leg length test; cervical range of motion test; carpal tunnel test; and a spinal health test.
(i) Abuse the trust of or exploit a lack of knowledge by the target audience (unconscionable conduct)	no breaches found	
(l) Contain language that could cause undue fear or distress	58 (16%)	A LITTLE SECRET: Don't let symptoms, or the absence of them, be your guide as to how you are doing. Many cancer patients never have a symptom until the first tumor is detected. By then, for many, it is already too late.
(m) Contain any information or material likely to make a person believe his or her health or wellbeing may suffer from not taking or undertaking the health service	16 (5%)	As a short-term solution to overwhelming physical, chemical or emotional stress, spinal joint dysfunction is a brilliant coping strategy. Yet, when this stress response doesn't resolve in a timely manner, or the stress is chronic, it may lead to other con sequences. Do you have undetected spinal joint dysfunctions? Find out!
(n) misrepresent price information	no breaches found	
(o) Unfounded Claims: a practitioner has an exclusive or unique skill or remedy, or that a product is 'exclusive' or contains a 'secret ingredient'	9 (3%)	Integrative Diagnosis is the only complete system for the diagnosis and conservative treatment of muscle, nerve and joint problems ... [unlike other chiropractors] we can accurately and quickly diagnose what is causing your lower back pain.
(o)4. Claim or imply that results are always effective	1 (0.3%)	"every adjustment has a positive effect on the brain"

Table 3 All Breaches by Chiropractors (Number and %) with Examples (Continued)

Section 5 of the 2014 AG (§5) Category	Chiropractors with Number & (%)	Example Breaches:
(j, k & p) Combined: Failure to disclose risks, warn of material risks, omit warning statements	32 (9%)	How safe is chiropractic: If the vertebrae are misaligned, the nerves will lack the ability to carry messages that in turn can affect how well our body functions. This can cause problems in the digestive system, anxiety, uneasiness, depression, headaches or ear infections to name a few. A clear example is of an ear infection which can be caused by a bone that is out of alignment. Commonly, migraines, neck pain, back pain or foot pain can be treated or prevented by chiropractic care. Studies have also proved that it can improve blood pressure in patients who have hypertension.
(q) provide a patient or client with an unsolicited appointment time not requested by the patient or client	no breaches	
(r) promote tobacco products, smoking, alcohol, or any other addictive substances or products known to affect health adversely	no breaches	
(s) be vulgar, sensational, contrary to accepted standards of propriety or likely to bring a health profession into disrepute, for example, because the advertising is sexist.	no breaches	

Examples are direct quotes from practitioner advertisements

(11.9%), employers (10.1%), subjects themselves (5.4%), and other agencies (6.7%) [17].

Elsewhere, at the turn of the twenty-first century, patient brochures from the largest State, Provincial, and National Chiropractic Associations and Research Agencies in Canada and the USA were found to contain many

702

unsubstantiated, potentially harmful claims [28, 29]. More recently, researchers examined World Wide Web claims by chiropractors, amongst others, in Australian, New Zealand, Canada and the United Kingdom and found unsubstantiated, potentially harmful claims to be abundant [30, 31]. These studies provide a clear picture about the volume and distribution of unsubstantiated claims, conduct and advertising complaints and the instigators of complaints.

AHPRA's annual reports only provide the number of advertising complaints broken down by profession. The rate of advertising compliance and the types of at-risk advertising within the professions is unknown. This appears to be the first study to examine the extent and the nature of practitioner advertising breaches in a representative sample of Australian chiropractors and physiotherapists using advertising guidelines as a standard.

The chiropractic findings are of major concern for two reasons, the first being public safety. Society expects and accepts that professionals advertise their services to assist consumers in making informed choices. To meet societal expectations and legal obligations, advertising must be socially responsible, truthful, appropriate and not misleading or deceptive. Advertising that fails to meet these expectations has the potential to harm. To assist practitioners in fulfilling their obligations, regulators formulated specific rules about advertising of health services to protect the rights of consumers however the data indicate that both professions and chiropractors in particular are not fulfilling their obligations.

The second reason is the high percentage of chiropractors advertising in an unacceptable manner. This raises questions about the profession's culture and understanding of its obligations under the social contract. It is beyond the scope of this paper to examine this; however, this topic has been the subject of papers by observers both within the profession and external to it over several decades [32–41]. The consensus is, although the profession has many of the trappings of a mainstream healthcare provider, (legislative recognition, high utilization rates, growing global footprint etc.), it is lacking in other key areas such as civic professionalism and upholding the social contract, both of which are critical components within health care [42, 43]. This research reinforces that position.

In this electronic age most health care providers have a web presence and increasingly use social media in their practices in response to consumer demand [44–46]. With the rising use of electronic communication comes increased risk of misleading and deceptive advertising by practitioners. The principal role of health practitioner regulatory authorities is to protect the public from harm.

Traditionally regulatory authorities have been reactive to complaints; however, there is an argument to be made for increased public protection by the authorities becoming proactive. Recent experience by the College of Chiropractors of British Columbia (CCBC) demonstrates that auditing practice websites and linked Facebook pages is a simple, comprehensive and cost-effective way of identifying breaches and achieving compliance with its Efficacy Claims

703

Table 4 All Breaches by Physiotherapists (Number and %) with Examples

Section 5 of the 2014 AG (§5) Category	Physiotherapists with Breaches: Number & (%)	Example
(a) Create unwarranted and unrealistic expectations about service effectiveness	2 (0.53%)	Your physiotherapist will use a combination of joint mobilization, stretching, manual therapy, electrotherapy, ultrasound and structured exercise programs to get you back to 100% health.
(b) Encourage (directly or indirectly) inappropriate, indiscriminate, unnecessary or excessive use of health services;	8 (2%)	Book your Free Initial Assessment today [without terms or conditions]
(c) Mislead, either directly, or by implication, use of emphasis, comparison, contrast or omission	78 (20%)	Given the frequency and variety of misleading claims uncovered, examples are presented in table form. (Table 5: Minor Misleading Claims & Table 6: Major Misleading Claims)
(d) Use testimonials or purported testimonials	179 (47%)	I started going to 'Suburb' Physio last year after getting some terrible neck pain from a combination of bad sitting posture at work, and a heavy training schedule. Bob and Jane have done an amazing job at relieving my neck pain! Bob gave me a comprehensive assessment and really took the time to understand what was causing my pain. He gave me exercises to help strengthen the affected muscles and to prevent further injury.
(e) compare professions without evidence	no breaches found	
(f). Claim or imply that a practitioner provides superior services to those provided by other registered health practitioners	51 (11%)	'Y' Physiotherapy is Australia's leading physiotherapy clinic for swimmers.
(g) exaggerate recovery time;	no breaches found	
(h) Lead Audience to Self-Diagnosis	no breaches found	
(i) Abuse the trust of or exploit a lack of knowledge by the target audience (unconscionable conduct)	no breaches found	
(l) Contain language that could cause undue fear or distress	no breaches found	
(m) Contain any information or material likely to make a person believe his or her health or wellbeing may suffer from not taking or undertaking the health service	no breaches found	
(n) misrepresent price information	no breaches found	
(o) Unfounded Claims: a practitioner has an exclusive or unique skill or remedy, or that a product is 'exclusive' or contains a 'secret ingredient'	no breaches found	
(o)4. Claim or imply that results are always effective	8 (2%)	we will find out what the problem is and treat to fix it. We can help you, no matter what your goal is
(j, k & p) Combined: Failure to disclose risks, warn of material risks, omit warning statements	no breaches found	
(q) provide a patient or client with an unsolicited appointment time not requested by the patient or client	no breaches	
(r) promote tobacco products, smoking, alcohol, or any other addictive substances or products known to affect health adversely	no breaches	
(s) be vulgar, sensational, contrary to accepted standards of propriety or likely to bring a health profession into disrepute, for example, because the advertising is sexist.	no breaches	

Examples are direct quotes from practitioner advertisements

Policy [advertising policy]. The CCBC's 1200 registrants had 1 months' notice of an upcoming audit of webpages and social media. Within 2 weeks of commencement of the audit procedure, 97% of the practitioners notified of a potential breach had voluntarily complied with the CCBC's directive [47]. The CCBC recognizes its audit does not capture all registrant advertising because only just over 70% of registrants have a web presence and only 50% have associated social media pages. However, those registrants who rely on printed material have generated no recent advertising complaints and therefore do not appear to pose the same risk to the public. The CCBC expects that the web

Table 5 Examples of Minor Misleading Claims as They Appeared on Practitioner's Websites[a]

Misleading Claim Category	Chiropractors	Physiotherapists
Misrepresenting awards	'X' Chiropractic: The Award Winning Spine Experts.[b]	No examples found.
Misrepresenting Qualification	John Chiropractor DC.[c]	No examples found.
Association membership presented as postnominals	Mary Chiropractor BSc, DC, MCAA.[d]	Bob Physiotherapist B AppSc (Physio) MAPA.[e]
Specialization claim	• a specialist chiropractor for more than a decade.	• specialising in the diagnosis and treatment of musculoskeletal dysfunction and sports injuries
Use of the title Dr. without professional clarification	67 of breaches found. No example required. See explanation below.[f]	No examples found.

Explanatory Notes: [a]These are quotes from practitioners' webpages [b]This was a small business award unrelated to spinal expertise
[c]John Chiropractor did not graduate with a Doctor of Chiropractic, rather he graduated with a double degree (Bachelor/Master or double Bachelor) in chiropractic [d]The letters MCAA mean: Member Chiropractors Association of Australia
[e]The letters MAPA mean: Member Australian Physiotherapy Association. Membership also appears as APAM [f]If practitioners choose to adopt the title 'Dr' in their advertising, and they are not registered medical practitioners, then (whether or not they hold a Doctorate degree or PhD) they should make it clear that they do not hold registration as medical practitioners [26]. Eg. Dr. Walter Lin (Chiropractor)

page audit will also have a positive effect on non-webpresent practitioner behaviour. [E-mail to CCBC (info@chirobc.com) November 21, 2018].

It is conceivable a greater understanding of advertising practices by each profession will encourage practitioners to comply and provide regulators, educators, professional associations with an in-depth understanding of the number and nature of breaches. Perhaps the CBA's and AHPRA's enhanced Advertising compliance and enforcement strategy for the National Scheme [11, 48] will have a positive effect on compliance.

Study strengths and limitations

705

A key strength of this study is its comprehensiveness. Using representative samples, advertising by 739 practitioners was audited on 214 websites plus associated Facebook pages. Staff profiles, frequently asked question sections, video presentations, and educational materials were scrutinised. When scientific publications were referenced within the advertising they were sourced and reviewed for accuracy. The audit was conducted using a detailed template based on 33 categories of inappropriate advertising. The template was prepared using examples provided within registration board advertising guidelines.

Table 6 Examples of Major Misleading Claims as They Appeared on Chiropractors' Websites[a,b]

Misleading Claim Category	Chiropractors
Failure to mention adverse outcomes	1. There is ample evidence that chiropractic care is safe for children and NOT A SHRED of evidence that it is harmful or dangerous.
Misuse of the literature	1. In relation to the treatment of neck and back pain, studies have shown that a course ofchiropractic care was 250 times safer than a course of anti-inflammatory drugs.[c] 2. Studies show that mothers under chiropractic care, delivering the first baby, have 25%reduced labour time in comparison to women without care and even 31% shorter labour time in case of pregnancy after the first child.[d] 3. An Australian study indicates that women consulting with chiropractors during pregnancyare less likely to require a caesarean section after onset of labour or to have a premature birth.[e] 4. chiropractic care may help with: asthma & allergies, reflux & colic, blood pressure & more. [f]
Webster technique or claims to affect positioning of an unborn foetus.	1. However, a realignment method, known as the Webster Technique, has a 92% success rate in optimal foetal positioning.
Making unsubstantiated claims.	1. If I had cancer or any illness, I'd rather remove my subluxations, so my nervous system is functioning at 100%. It would be many times worse if I had cancer and a nervous system that isn't working well.

Explanatory Notes: [a]There were no Major Misleading Claims by physiotherapists [b]These are direct quotes from chiropractors' webpages

[c]This is a commonly seen overreach referenced to Dabbs et al. [52]. Dabbs et al. state "NSAIDs are the most common conventional first-line treatment for most musculoskeletal neck pain". Dabbs et al. inappropriately reference this to Dillin's 1992 [53] paper which focuses on the scientific design and concepts of drug management of cervical disk disorders in which steroids, nonsteroidal anti-inflammatory medicines, narcotics, antidepressants and muscle relaxants were discussed. Nowhere in the Dillin paper does it state that NSAIDS are the most common conventional first line treatment for most musculoskeletal neck pain. Dabbs et al. confirm they were unable to find an estimate of the number of patients who are treated with NSAIDs specifically for neck pain of musculoskeletal origin but somehow conclude "This review of the literature found that NSAID treatment for neck pain has a significantly greater risk of serious complications or a death than the use of cervical manipulation". The number 250 cited by many chiropractors never appears in the Dabbs et al. paper [d]This is a common claim by chiropractors. The figures are referenced to one poorly conducted, uncontrolled and un-replicated study by J. Fallon reported in 2 publications in 1990 and 1991 [54, 55] [e]This is an example of selective reporting. This is referenced to a paper highlighting the incidence of adverse birth outcomes and alternative medicine use by Steel et al. [56]. Although the chiropractor's claim is accurate, important information was omitted. Steel et al. also noted: women under chiropractic care during pregnancy are more likely to experience emotional distress and are also more likely to have an instrumental childbirth

[f]This is an example of claims supported by out of date research. This claim is referenced to the Winsor Autopsies, published in 1921 [57]

The study had limitations

Confirmation bias is frequently a problem with this type of research. Both auditors are registered chiropractors with careers involving chiropractic guideline compliance matters and consumer law. This could have made them more sensitive to breaches by chiropractors and, due to their comparative lack of experience with physiotherapist compliance matters, less sensitive to compliance breaches by physiotherapists. While the auditing may have been strengthened by having a physiotherapist conduct the physiotherapy audit, both professions work in musculoskeletal medicine and have the same advertising guidelines. Both auditors are conversant with the musculoskeletal medicine literature and are confident that the physiotherapist audit data are accurate.

Comparability of individual auditor's findings could be a limitation. This was minimized because each auditor performed ½ the audits in each profession's sample using a comprehensive breach template developed from the AGs and associated explanatory notes/examples. While there was no formal check of the reliability of the auditors' findings, an informal check emerged when the data was being inputted into NVivo. Due to the number of group practices, there were about 10 instances in which both auditors had examined the same website for a different group member. In all instances the breach allocation was the same.

Clustering of practitioners due to group practices may skew the results. Locating webpages for 380 physiotherapists required 72 practice websites versus 141 for 359 chiropractors which indicates that the number of physiotherapists per group practice is larger than the number of chiropractors per group practice. While a larger sample from each profession would reduce the possibility of skewed results due to group practice clustering, this limitation can largely be discounted because of the

distinction between the physiotherapy results and chiropractic results as depicted in Figs. 1 and 2.

An additional limitation is underreporting of breaches amongst chiropractors. It was not uncommon to find multiple breaches within a single category on a practitioner's website but only one example was recorded. Similarly, many breaches could be indexed into multiple categories however only the category with the greatest harm potential was used. This was in keeping with the aim of the research, namely to determine what percentage of each profession had websites containing AG breaches with examples included for explanatory purposes.

Conclusions

Advertising by health care professionals is an accepted part of practice. It informs the public about the profession and the professional enabling the public to make better health care choices. Advertising by the 15 Australian registered health care professions is regulated by a registration board and AHPRA governed by specific advertising guidelines and the National Law. The main objective of this study was to examine advertising by chiropractors and physiotherapists to determine the frequency and nature of advertising guideline breaches. While both professions had advertising that breached the guidelines, breaches by chiropractors were more frequent and more serious.

The study highlights areas for future research. Given that chiropractors are over-represented in both conduct and advertising breaches is there a nexus between the two? Are chiropractors who breach advertising guidelines more likely to generate conduct breaches? Are there alternate compliance measures that would be more effective for chiropractors? Is there something in the professional development of chiropractors and physiotherapists that makes them prone to breaching advertising guidelines? AHPRA, professional associations and educational bodies may find the data from this audit helpful in designing further research and developing interventions that raise compliance by chiropractors and physiotherapists and protect the public from harm.

Endnotes

[1]Where references were used on the website to substantiate claims, these were sourced, and the accuracy of the claims assessed.

[2]Both the National Australian Physiotherapy Association and Western Australian APA State Branch were contacted by email and telephone requesting assistance by JKS. Neither would assist on member privacy grounds.

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Availability of data and materials
The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

Authors' contributions
J Keith Simpson is the sole author of this paper. The author read and approved the final manuscript.
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Ethics approval and consent to participate
Not applicable. No ethics approval was required for this research.

Consent for publication Not
applicable.

Competing interests
The author declares that he has no competing interests.

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707

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708

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Council Member Terms as at February 21, 2020 [1]

ITEM 7.10

Name	District	Date First Elected/Appointed	Date Re-elected/ Reappointed	Date of Expiry of Current Term
Elected Members				
Dr. Peter Amlinger	5 (Central West)	April 2017	NA	April 2020
Dr. Brian Budgell	4 (Central)	April 2018	NA	April 2021
Dr. Janet D'Arcy	4 (Central)	April 2019	NA	April 2022
Dr. Paul Groulx	2 (Eastern)	April 2019	NA	April 2022
Dr. Cliff Hardick	6 (Western)	May 2011	April 2014 April 2017	April 2020
Dr. Steven Lester	4 (Central)	April 2019	NA	April 2022
Dr. Dennis Mizel	5 (Central West)	April 2018	NA	April 2021
Dr. Kristina Peterson	1 (Northern)	April 2017	NA	April 2020
Dr. David Starmer	7 (Academic)	April 2014	April 2017 April 2020	April 2023
Appointed Members [2]				
Ms Georgia Allan	Smiths Falls	September 8, 2014	September 8, 2017	September 7, 2020
Ms Karoline Bourdeau	Toronto	July 17, 2017	N/A	July 17, 2020
Ms Robyn Gravelle	Burlington	May 16, 2019	N/A	May 16, 2020
Mr. John Papadakis	Scarborough	June 30, 2019	N/A	June 30 2022
Ms Sheryn Posen	Toronto	November 28, 2018	N/A	July 1, 2020 [3]
Mr. Rob MacKay	Thunder Bay	November 28, 2018	N/A	November 27, 2021
Vacant				

[1] Please advise Ms Rose Bustria a.s.a.p. if you aware of aware of any discrepancies.
[2] CCO requires at least 6 public members to be properly constituted.
[3] Ms Posen moving to British Columbia in late Spring 2020 (order in council will be revoked).