

COLLEGE OF CHIROPRACTORS OF ONTARIO



**PUBLIC ELECTRONIC INFORMATION PACKAGE FOR
COUNCIL VIRTUAL MEETING
WEDNESDAY, JUNE 17, 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 interests¹;
9. refrain from including or referencing Council or committee positions held at the College in any personal or business promotional materials, advertisements and business cards;²

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

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

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

Potential Breaches of the Code of Conduct

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

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

Signature: _____ Witness: _____

Date: _____

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

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

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

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

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

List of Commonly Used Acronyms at CCO

as at September 2017

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



COUNCIL MEETING

Wednesday, June 17, 2020 (8:30 a.m. – 12:00 noon) ¹

**Virtual Meeting using Zoom Platform
(During COVID-19 Pandemic)**

AGENDA – Business Meeting ² (Public)

Attendees

Council members ³

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 AND WELCOME		Mizel	<u>High</u>	<u>8:30 a.m.</u>
		Parliamentarian ⁶		All members	<u>Medium</u>	
		1. Consent Agenda	Approve	Council	<u>High</u>	
		1.1 Fitness to Practise Committee Report ⁷				
	9	1.2 Inquiries, Complaints and				

¹ Subject to Council's direction.

² If you would require the complete background documentation relating to any item on the agenda for CCO council or committee work, please speak to Dr. Mizel, President and Ms Willson (information may be subject to confidentiality provisions).

³ Regrets: Mr. Gagan Singh.

⁴ Subject to Council's direction.

⁵ Approximate (subject to Council's direction).

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.

⁷ No meetings since April 15, 2020.

SECTIONS OF THE CODE FOR IN-CAMERA SESSIONS IF DIRECTED BY COUNCIL	Page No.	ITEM	Action Required	Action By	Priority Level ⁴	Time ⁵
		Reports Committee Report (ICRC)				
	11	1.2.1 HPARB Decision dated February 27, 2020 re: Airyn Lodge and David Weyrauch, D.C.				
	23	1.2.2 HPARB Decision dated May 12, 2020 re: Howard Bargman and Cary Chousky, D.C.				
		1.3 Patient Relations Committee Report ⁸				
	38	1.4 Registration Committee Report				
	40	1.4.1 CCO Policy on Considering Applications for Registration during the COVID-19 Pandemic (draft) ⁹				
	48	1.4.2 Various notifications from the Canadian Chiropractic Examining Board (CCEB)				
		1.5 Quality Assurance Committee Report ¹⁰				
		2. Main Agenda	Adopt	Council	<u>High</u>	
		2.1 Conflict of Interest	Review/ Declare any real or perceived conflicts	Council	<u>High</u>	

⁸ No meetings since April 15, 2020.

⁹ Please forward any feedback concerning the draft policy to Dr. Groulx and Ms Willson. All feedback is being considered at the next Registration Committee meeting on July 7, 2020.

¹⁰ No meetings since April 15, 2020.

SECTIONS OF THE CODE FOR IN-CAMERA SESSIONS IF DIRECTED BY COUNCIL	Page No.	ITEM	Action Required	Action By	Priority Level ⁴	Time ⁵
			of interest as agenda item reached			
		3. Adoption of Minutes ¹¹				
		4. Committee Reports				
		4.1 Executive Committee Report	Report/ Approve Recommendations	Mizel/ Council	<u>High</u>	<u>8:45 a.m.</u>
<i>Ss. 7(2) Code</i>		<i>Move in Camera</i>				
		<i>Move Out of Camera and Ratify Decisions</i>				
		<i>Communications/Strategic Planning</i>	Review/ Verbal Report	Council/ Mizel	<u>High</u>	<u>9:00 a.m.</u>
		<i>President's Messages During Pandemic</i>				
	238	4.1.18 President's Message # 10 (June 9, 2020) with links				
	273	4.1.19 President's Message # 9 (May 26, 2020)				
	275	4.1.20 President's Message # 8 (May 15, 2020) with graphics				
	279	4.1.21 President's Message # 7 (April 27, 2020)				

¹¹ 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
	284	4.1.22 President's Message # 6 (April 17, 2020)				
	394	4.1.24 Various other media re: chiropractic/CCO <i>Ministry of Health</i>				
	455	4.1.27 News Release dated June 2, 2020 re: Extension of Declaration of Emergency until June 30, 2020 <i>Public Members</i>	FYI			
	461	4.1.29 Correspondence dated April 21, 2020 to Ms Bourdeau from Deputy Premier and Minister of Health, Christine Elliott	FYI			
	462	4.1.30 Correspondence dated April 23, 2020 to Mr. Gagandeep Dhanda from Deputy Premier and Minister of Health, Christine Elliott	FYI			
	466	4.1.31 Correspondence dated May 20, 2020 to Ms Sheryn Posen from Deputy Premier and Minister of Health	FYI			
		<i>By-laws/Policy Review</i>				
	473	4.1.33 Recommended By-law Amendments	Approve	Council	Medium	
	499	4.1.35 I-017: Procurement of Goods and/or Services	Approve	Council	Medium	
	502	4.1.36 Rules of Order (revised and current)	Approve	Council	Medium	
	506	4.1.37 Advertising Committee Terms of Reference (revised)	Approve	Council	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
	509	4.1.38 Advertising Committee Terms of Reference (current)	Revoke	Council	Medium	
	511	4.1.39 Policy P-004: Advertising Committee Protocol	FYI			
	512	4.1.40 Executive Committee Terms of Reference (revised)	Approve	Council	Medium	
		<i>Chiropractic/Health Related Stakeholders</i>	Primarily FYI/ Verbal Report (time permitting)	Willson	Medium	
		<i>Canadian Memorial Chiropractic College</i>				
	514	4.1.41 Thank you note dated April 6, 2020 re: Virtual Presentation to CMCC students				
		<i>Canadian Chiropractic Protective Association</i>				
	516	4.1.42 Various bulletins <i>Ontario Chiropractic Association</i>				
	535	4.1.44 Correspondence dated May 20, 2020 to Ms Tina Yuan re: use of masks	FYI			
		<i>Alliance for Chiropractic (AFC)</i>				
	543	4.1.46 Various bulletins/exchanges				
		<i>Canadian Chiropractic Association (CCA)</i>				
		<i>Canadian Chiropractic Guideline Initiative</i>				
	566	4.1.49 Stakeholder Report				

SECTIONS OF THE CODE FOR IN-CAMERA SESSIONS IF DIRECTED BY COUNCIL	Page No.	ITEM	Action Required	Action By	Priority Level ⁴	Time ⁵
		from Canadian Chiropractic Guideline Initiative				
	573	4.1.50 Canadian National Alliance for Chiropractic (CNAC) introduction dated June 11, 2020	FYI			
	607	4.2 Discipline Committee Report	Report/ Approve Recommendations	Bourdeau / Council	High	10:00 a.m.
	608	4.2.1 Notice to the Chiropractic Profession and Members of the Public, undertaking and e-mail to observers	Approve	Council	High	
	612	4.2.2 CCO v Dr. Dirk Keenan (Resolution Agreement)				
	625	4.2.3 CCO v Dr. Randell Ricohermoso (Resolution Agreement)				
		5. New Business	TBD			
		6. For Your Information	FYI (subject to questions)			
	630	6.1 Correspondence dated April 24, 2020 to Ms Hadley, Sun Life from Ms Willson et al				

SECTIONS OF THE CODE FOR IN-CAMERA SESSIONS IF DIRECTED BY COUNCIL	Page No.	ITEM	Action Required	Action By	Priority Level ⁴	Time ⁵
		<i>Various Articles re: Chiropractic/Immune System</i> ¹²				
	635	6.2 Chiropractic students call for action against unsubstantiated claims (May 13, 2020)				
	652	6.3 The Use of internet analytics by a Canadian provincial chiropractic regulator to monitor, evaluate and remediate misleading claims regarding specific health conditions, pregnancy, and COVID – 19, <i>Chiropractic & Manual Therapies</i> (2020)				
	661	6.4 A united statement of the global chiropractic research community against the pseudoscientific claim that chiropractic care boosts immunity, <i>Chiropractic & Manual Therapies</i> (2020)				
	668	6.5 Misinformation about spinal manipulation and boosting immunity: an analysis of Twitter activity during the COVID-19 crisis, <i>Chiropractic & Manual Therapies</i> (2020)				

¹² Some documents/research papers may be relevant for future strategic planning session (depending on topic(s) selected by Council.

SECTIONS OF THE CODE FOR IN-CAMERA SESSIONS IF DIRECTED BY COUNCIL	Page No.	ITEM	Action Required	Action By	Priority Level ⁴	Time ⁵
	682	6.6 <i>The Effect of Spinal Adjustment/ Manipulation on Immunity and the Immune System: A Rapid Review of Relevant Literature</i> , World Federation of Chiropractic (March 19, 2020)				
	686	6.7 Immune Function and Chiropractic What Does Evidence Provide? International Chiropractors Association (March 28, 2020)				
	712	6.8 Critical Evaluation – A Critical Evaluation of the World Federation of Chiropractic’s Fatally Flawed Review of Immunity & Chiropractic (May 7, 2020);				
	716	6.9 The Chronicle of Chiropractic, WFC Review of Immunity & Chiropractic Fatally Flawed – Says Foundation for Vertebral Subluxation (March 28, 2020)				
	719	6.10 Communication from Dr. Mark Foullong re: Chiropractic & Immunity				

SECTIONS OF THE CODE FOR IN-CAMERA SESSIONS IF DIRECTED BY COUNCIL	Page No.	ITEM	Action Required	Action By	Priority Level ⁴	Time ⁵
		<i>Legal Publications</i>				
	725	6.11 Weir Foulds – <i>Ontario Regulators and COVID-19</i> (March 30, 2020)				
	728	6.12 Grey Areas - <i>Raising the Bar</i> (May 2020)				
	731	6.13 Grey Areas – <i>When Should Regulators Enforce “Someone Else’s Law”?</i> (June 2020)				
	737	6.14 Information from the Information and Privacy Office re: protecting privacy etc. (March 16, 2020)				
	740	6.15 Council Member Terms				
		DATE AND TIME OF MEETINGS 13				

¹³ Please mark your Calendar and Advise Rose Bustria ASAP if you are unable to attend any meetings.

Executive Committee Meeting Dates to December 2020

Although Executive Committee meetings are usually at CCO and are scheduled from **8:00 a.m. – 4:00 p.m.** unless otherwise noted, during the COVID-19 pandemic, meetings will be held virtually until it is safe to meet in person and the times (but not the dates) are subject to change.

Year	Date	Time	Event	Location
2020	Friday, August 14	8:30 a.m. – 12:00 noon	Meeting	Virtual
	Tuesday, October 20	8:00 a.m. – 4 p.m.	Meeting	CCO (TBD)

SECTIONS OF THE CODE FOR IN-CAMERA SESSIONS IF DIRECTED BY COUNCIL	Page No.	ITEM	Action Required	Action By	Priority Level ⁴	Time ⁵
		ADJOURNMENT				10:15

Council Meeting Dates to December 2020

Although Council meetings are usually at CCO and are scheduled from **8:30 a.m. – 4:30 p.m.**, unless otherwise noted, during the COVID-19 pandemic, meetings will be held virtually until it is safe to meet in person and the times (but not the dates) are subject to change.

Year	Date	Time	Event	Location
2020	Tuesday, June 16	6 p.m. – 9:30 p.m.	Annual General Meeting	Cancelled
	Wednesday, June 17	8:30 a.m. – 12:00 noon	Council Meeting	Virtual
	Friday, September 11	1:00 p.m. – 4:30 p.m.	Strategic Planning/Topic Specific Focused Meeting (in camera items)	Cancelled
	Saturday, September 12	8:30 a.m. – 4:30 p.m.	Council Meeting	Virtual
	Sunday, September 13	8:30 a.m. – 12 noon	Strategic Planning/Topic Specific Meeting (as required)	Cancelled
	Thursday, November 26	8:30 a.m. – 4:30 p.m.	Council Meeting	CCO
	Friday, November 27	8:30 a.m. - noon	Council Training (TBD)	CCO
	Friday, November 27	Evening	Holiday Party	TBD

ITEM 1.2

Submitted to CCO on June 8, 2020

**College of Chiropractors of Ontario
Inquiries, Complaints and Reports Committee Report to Council
June 17, 2020**

Members: Dr. David Starmer, *Chair*
Ms Georgia Allan, *Public Member*
Dr. Sarah Green, *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*

During this unprecedented time, it has been quite busy for the Inquiries, Complaints & Reports Committee (ICRC). From March 20, 2020 to April 20, 2020, the College received 158 complaints relating to inappropriate advertising and social media posts. The increased number of complaints puts a significant burden on the Committee. However, I am happy to say the Committee was quite productive during the past few months and has made timely decisions on these matters.

Since the last written report meeting, the ICRC met on three occasions and reviewed 174 complaints and two reports. ICRC made decisions on 146 complaints. Eight section 75(c) investigator appointments were requested by the ICRC. The Health Professions Appeal and Review Board (HPARB) upheld two Committee decisions (attached).

See below for a summary chart of complaints received/completed in 2019 vs 2020 to date.

	2019	Jan 2020 to June 5, 2020
Complaints Received	95	175
Inquiries Received	3	80
Reports Received	1	0
Total Complaints, Inquiries & Reports Received	98	255
Decisions Completed(not all decisions made were complaints/reports received in 2019 or 2020)	97	175

The committee is going to continue to review if there is a need for additional meetings and any budgetary implications from the increased number of complaints.

I would also like to thank Dr. Peter Amlinger for his time on ICRC, he will be greatly missed, and I would also like to welcome Dr. Sarah Green for stepping in and fulfilling the mandate of the Committee.

Respectfully submitted,

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



Ontario

ITEM 1.2.1

In reply please quote: File # 19-CRV-0226

CONFIDENTIAL

February 25, 2020

11

Ms. Airyn Lodge

Applicant Complainant

Dr. David Weyrauch, D.C.

Respondent



Dear Ms. Lodge, Dr. Weyrauch

**RE: COMPLAINT REVIEW - CHIROPRACTIC
AIRYN LODGE AND DAVID WEYRAUCH, 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

For: Natalie Moskowitz
Case Officer

Encl: Decision dated February 25, 2020

cc: College of Chiropractors of Ontario (CCOPRA File # WEYRAUCH-18-JL-11(LO))

HEALTH PROFESSIONS APPEAL AND REVIEW BOARD**PRESENT:**

Bonnie Goldberg, Vice-Chair, Presiding
 Christine Moss, Chair
 Katherine Ball, Board Member

Review held on February 5, 2020 at Toronto, Ontario

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

B E T W E E N:

AIRYN LODGE

Applicant

and

DAVID WEYRAUCH, DC

Respondent

Appearances:

The Applicant:	Airyn Lodge
For the Applicant:	Brett Lodge, Support
For the Applicant:	Tracey Lodge, Support
For the College of Chiropractors of Ontario:	Christine McKeown (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 Airyn Lodge, (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 care provided to the Applicant by David Weyrauch, DC (the Respondent). The Committee investigated the complaint and decided to take no further action.

II. BACKGROUND

3. The Respondent is a chiropractor. The Applicant first presented at the Respondent's clinic on April 3, 2017. She continued to see him throughout April for approximately four weeks.

The Complaint and the Response

4. The Applicant made the following complaint about the Respondent:
 - The Respondent said he could fix her scoliosis;
 - The Respondent said he could fix her whole body to be in perfect alignment;
 - The Respondent said he could fix all her insomnia and anxiety problems;
 - The Respondent said that her left shoulder was higher than her right, her hips were a bit out of alignment, and her rib cage was a tad off centre. The Respondent wanted to lower her left shoulder, adjust her hips, her tailbone, and her rib cage. Why he would take such a risk in trying to do something so dangerous I am not sure of; and
 - He was practicing on the Applicant some days 1-2 hours in total, doing manual manipulations the entire time. He was using his adjustor tool 20- 60 pumps on the same spots over her body in one session. After a few sessions (about a month) the Applicant started to feel pain, like never before. She was crying and screaming in pain. The Respondent told her to return during her lunch or after work for further treatment. When the Applicant returned, the Respondent continued to manually adjust for hours at a time using manual force and that adjustor tool constantly. He kept thumping that adjustor tool all over her back, neck, shoulder, ribs and tailbone. He also gave her numerous neck adjustments, and bear hug spinal cracks.
 - The Respondent kept saying it was normal, all part of the process. He said he needed the muscle to stay where he was trying to move it.
5. The Applicant provided additional context for her complaint. The Applicant explained that she was an athlete who was working out at the gym when the Respondent approached her to suggest she consider chiropractic care. She recalled the promises he made to her. However, she explained that since he provided chiropractic care, she has been diagnosed with scapular muscular detachment and rib injuries. She can no longer work and has had to have multiple surgeries. She explained that this injury usually occurs as a result of blows of blunt force, in other words, the 1-2 hours that the Respondent pounded away at her body with his hands, and his adjusting tool. She stated that he also gave her numerous neck adjustments, and bear hug spinal cracks, and again pounded away with his adjustor tools all over her body.

6. The Applicant explained her physical injuries, her extreme pain, her misaligned body, and that she has developed a severe skin sensitivity.
7. The Applicant provided an October 17, 2017 email response to the Respondent's suggestion that she continue treatment. She told him that she has had to have 4 MRIs, see 15 specialists, have bone scans and x-rays, and take medication to address the pain he caused her.
8. The Respondent provided a response. He stated that the Applicant first presented at his clinic on April 3, 2017, with complaint of constant stiffness and soreness. She advised she had been diagnosed with scoliosis and disclosed she was involved in an MVA in 2010. She identified concern areas in her upper back, thoracic, left lumbar and left anterior ribs. The Applicant indicated pain between her shoulders, joints and problems walking. She advised that she suffered from stress, anxiety, loss of sleep and gas/bloating. The Respondent diagnosed vertebral subluxation complex and provided care for a period of approximately 4 weeks. He stated she had mixed results.
9. The Respondent denied promising to fix her scoliosis or that he could perfectly align her whole body. He stated that he did not treat her insomnia or anxiety but explained that he does educate patients with respect to the associated symptoms related to the neurologic component of spinal dysfunction. The Respondent stated that results cannot be guaranteed.
10. The Respondent stated that he allocated considerable additional time to providing care to the Applicant. He stated that most patient appointments routinely reserve no longer than 15 minutes for a treatment session. He stated that she would exhaust most of her 15 minute time slot simply expressing the nature of her presenting symptoms. This began to impact patient scheduling. As such, given the proximity of her work location, he would ask her to return to his office to continue care on his breaks so as to permit adequate time to attend to her needs. The Applicant presented as emotional and was quick to cry, which made it difficult for the Respondent to differentiate between actual pain versus her emotions associated with her condition. He stated that some visits were 90 minutes. Treatment was scheduled after regular hours as a result.

11. The Respondent denied that the activator tool could have led to her claims of extensive injury. He stated that her injuries are more consistent with physical trauma than chiropractic care. He stated that as the Applicant possessed an unusually high amount of tension through her symptomatic areas, it would not be uncommon to deploy 2-3 consecutive thrusts on the same contact. He stated that it was not unusual for him to locate at least 5-7 areas of spinal dysfunction/vertebral subluxation throughout her skeletal system. This in turn could lead to a total of 20 or more deployments of the activator tool in one session. He stated that the methodology and frequency were clinically reasonable and appropriate.
12. The Applicant provided a reply. She added information about her surgery and its impact. She provided photographs from April 2017 in which she identified the injuries to her body that occurred while she was under the Respondent's care. She wrote that it was clearly apparent that the lower trap was already detached after 1-2 weeks in his care. She denied being in any pain when she presented to the Respondent and emphasized that it was the Respondent who suggested the chiropractic care. She stated she was perfectly fine after the 2010 car accident.
13. The Applicant emphasized that she has worked out 7 days a week for 14 years. She stated that she was in "disbelief" after having seen her intake forms, as the information does not make any sense to her given that she had no problems before seeing the Respondent and any description of injuries or pain was in the past. She denied filling out the forms to reflect that her pain was constant or current. She denied ever having shoulder pain. She agreed she identified as having stress, sleep loss and bloating which were the issues she first saw the Respondent for. She described that her nervous system remains impacted by the Respondent's care and that she must take medication to address this. She described having been a healthy pain free athlete who worked full time and had become someone who is now in extreme pain and cannot work.

The Committee's Decision

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

III. REQUEST FOR REVIEW

15. In a letter dated April 19, 2019, the Applicant requested that the Board review the Committee's decision.

IV. POWERS OF THE BOARD

16. 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.
17. 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

18. 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.
19. The Applicant made written and oral submissions to the Board. The Applicant submitted that she disputed the reasonableness the Committee's decision given that the Committee agreed that the photo demonstrated an injury on April 11, 2017 during which time she was being treated by the Respondent and she continued in his care until April 28, 2017. Thus, she queried how the Committee accepted that he continued to work on her when that was the state of her body and injuries at that time. She emphasized that the Respondent provided more than 12 adjustments and she was seeing him multiple times. She stated he never reassessed her and did not recognize the obvious muscle detachments that occurred. She attributed her strong emotions at the appointments to her pain. The Applicant explained that the Committee's assumption that her injuries were caused by her fitness activity at the gym was unreasonable given how careful and conscientious she always was when working out. As well, she noted that the pain she was in while she was treated by the Respondent in April 2017 meant she actually was not working out regularly at that time.

20. The Applicant described her years' long medical journey after the Respondent injured her to find a diagnosis for her pain. She has been unable to work since October 2017 after a lifetime of good health and athleticism. She is no longer in contact with anyone at the gym or at her former place of employment. She described the Respondent's culpability for her injuries and queried why he was not held accountable for causing the injuries, for not recognizing the injuries, for not referring her for help, and for wanting to continue treating her after the injuries occurred. She told the Board that she has had to have two surgeries, with a third one pending, and that she has yet to resolve all her injuries. She explained that she has had to seek treatment at great expense out of the country given the rarity of her condition. The Applicant described that the chiropractors (and other health care providers) she has seen since 2017 have told her that the Respondent was not practicing within the accepted standard of care.
21. The Applicant emphasized that the photographs she provided to the College enabled the College to clearly see that the muscles were obviously detached. She explained that the photo was taken on April 11, 2017. She directed the Board to the Respondent's appointment notes which on April 10, 2017, the day before she took the photo, stated: "April 10- left scapula pain, symptoms recorded this session." She explained that he saw her a second time that same day and again treated her left scapula region. She explained that she took the photo because she knew something very bad had happened. She submitted that the chart notes verify that the Respondent was aware of her scapula pain. She described the extreme force that he used repeatedly and regularly on her, many times a day.
22. The Applicant emphasized her concerns about why a doctor would continue to manipulate someone, instead of sending her to the hospital, or at the very least, to her family doctor. She explained that she believed she could trust the Respondent when he told her that pain was part of the process because he was making changes in the body. She trusted him to know what he was doing and to have her best interest at heart even though she felt something was very wrong. She described her long history of an anxiety disorder and how she relied on the Respondent to help her given his promises about the way in which he could cure her conditions.

23. The Applicant described other information that she thought the Committee should have obtained, including information from her family physician and from co-workers, friends and family who were in her life at the time, all of whom could attest to her good health prior to April 2017. The Applicant emphasized that she was not seeking to sue or punish the Respondent; rather she wanted to protect other people from having the same thing happen to them and she wished for the Respondent to take responsibility for the damage he did to her body.
24. The Applicant's parents provided submissions at the Review as well. The Applicant's parents identified just how outside the norm the chiropractic care that the Respondent provided was in their opinion, including that it was provided outside regular office hours, and that it was provided for much longer appointments than common. They submitted that there really was no other explanation for their daughter's injuries but for the Respondent's treatment. The Applicant's parents noted that the College could have obtained additional information from the Applicant as well as from a variety of other sources.
25. In a written submission to the Board, the Respondent indicated that he was not participating in the Review process. He submitted that the Committee adequately investigated the matter and obtained information sufficient to enable it to reasonably assess the complaint. He submitted that the Committee's decision was reasonable and supported by both the information in the record of investigation and the circumstances. He stated that the request for review was without merit. The Board notes that there is no obligation for a party to participate in the Review process and it draws no inference from the Respondent's decision not to attend the review.
26. 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

27. 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.

28. In the course of its investigation, the Committee obtained the Applicant's correspondence about the complaint and further communication, including photographs and the October 2017 email correspondence, as well as her OHIP records from the relevant time period. The Committee obtained a response from the Respondent. He provided a statement of account enclosing the Applicant's medical records, which include her personal history and synopsis of her current health condition as filled out on a new patient questionnaire. The Respondent provided a transcription of the patient's history and examination notes. The Applicant provided a response to the Respondent's reply.
29. The Board notes that the Applicant indicates that at the time of the investigation, the Committee could have obtained witness information from the people in her life who could attest to her many years of good health as well from her previous treating physicians. The Board recognizes that the Applicant has indicated she would have difficulty obtaining witness information now, and that three years have passed since the events in question. Thus, the Board is cognizant that the witness information would likely not be available now (and that it would be less reliable now in any event given the passage of time) should the Committee now seek it.
30. In any event, the Board finds that the Committee did not require this information in order to conduct an adequate investigation. While the Board is mindful that the Applicant feels that the Committee disbelieved her, the Board notes that the Committee's task as a screening Committee assessing the Respondent's conduct was to obtain the information that would enable it to assess the Applicant's complaint. This would necessarily include information from both parties and the Respondent's medical charts. This information was obtained. Thus, the Board finds that the Committee did not require additional witness information in order to assess the complaint as no other information would have led the Committee to a different outcome.
31. Similarly, regarding whether the Committee should have obtained medical records from other health care providers, the Board opines that the Applicant did provide her OHIP records but even so, the task for the Committee was to consider whether the Respondent met the standard of care. The Board finds it could do so without reference to the medical records of other treating physicians given that it obtained the Respondent's medical records and was entitled to rely on its expertise (discussed more fully in the Reasonableness section below).

32. Thus, the Board concludes that the Committee's investigation covered the events in question and yielded relevant documentation to assess the complaint regarding the Respondent's care and conduct. There is no indication of further information that might reasonably be expected to have affected the decision, should the Committee have acquired it.
33. Accordingly, the Board finds that the Committee's investigation was adequate.

Reasonableness of the Decision

34. 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.
35. The Committee concluded it would take no further action. The Committee considered the Applicant's concern that the Respondent caused or contributed to her Scapular Muscular Detachment and rib injury. The Committee noted that the photographs provided by the Applicant did demonstrate a woman whose trapezius was fully detached on one side and the rhomboid was partially detached on one side. However, the Committee opined that these are very painful conditions that can neither be fixed nor caused by chiropractic care.
36. Further, the Committee determined based on its professional expertise, that there was no way an activator tool could cause or exacerbate these conditions. The Committee explained that the activator tool is a spring-loaded device and although the thrust is sudden and may be perceived as jarring, the tool delivers a precise and gentle force, noting that it is commonly used on babies and children for this reason. The Committee opined that working out aggressively could have caused the Applicant's condition. The Committee also noted that some chiropractic treatment, such as muscle work involving ischemic pressure and/or bringing a joint to its end range of motion, may be painful.
37. The Committee determined that it would take no action with respect to the Applicant's concern that the Respondent promised to fix her condition (ie scoliosis) or be treating non-musculoskeletal conditions. The Committee noted the Respondent's denial that he said this and that it was faced with a he said/she said situation. The Committee expressed no concern about any changes to the Applicant's record of personal health information.

38. Having considered the Applicant's submissions, the Committee's decision and the information in the Record, the Board concludes that the Committee's decision was reasonable. The reasons for this conclusion follow.
39. The Committee had before it a detailed patient record for the Applicant encompassing the four-week period during which the Respondent provided treatment. This included the Respondent's chart notes and a new patient questionnaire. The Committee's reasons demonstrate that it considered the available documentation in light of the Applicant's concerns and the photographs and emails she provided and the Respondent's explanation of what occurred while the Applicant was under his care. The contemporaneous documentation before the Board supports the Committee's conclusions.
40. The Applicant has expressed concern that the Committee appeared to both recognize that she was injured but was unwilling to attribute these injuries to the Respondent's treatment and inappropriately inferred she injured herself working out.
41. The Board recognizes that the Applicant remains dismayed by the Committee's conclusions. However, the Board is not persuaded that the Committee, which is a Committee composed primarily of chiropractors as well as a public member, lacked the requisite knowledge to review the Respondent's treatment, nor is the Board persuaded that there is any information to support a finding that the Committee applied this expertise inappropriately.
42. The Board accepts that the Applicant has thoroughly researched her conditions, has undertaken numerous investigations and continues to require surgery; thus, she is well-placed to understand the medical difficulties she has and to form opinions about what caused them.
43. Nonetheless, the Board finds that the Committee's decision to take no action is reasonable. The Committee examined each aspect of the Applicant's complaint regarding the Respondent and linked its decision to the Record. It exercised its medical judgement and experience in assessing the quality of the care provided. The Committee properly exercised its screening function by not making findings of credibility where the parties presented different versions of their communications.

44. The Board understands that one of the Applicant's primary goal in pursuing this process is to protect the public. The Board notes that this complaint will remain in the Respondent's record at the College and the Committee's decision in this case must be considered if there is a complaint to the College regarding the Respondent's conduct and actions in the future.
45. The Board recognizes that the Applicant and her family will continue to question the cause of her injuries and the Board appreciates that the Applicant has struggled in the years since to regain her health. However, for the reasons articulated above, the Board finds that the Committee conducted an adequate investigation and arrived at a reasonable decision based on the information in the Record and provided reasons that are justifiable, transparent and cogent.

VI. DECISION

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

ISSUED February 25, 2020


Bonnie Goldberg


Christine Moss


Katherine Ball



In reply please quote: File # 19-CRV-0412

CONFIDENTIAL

May 12, 2020

ITEM 1.2.2

Mr. Howard Bargman

Applicant Complainant

Dr. Cary Chousky, D.C.

Respondent

Dear Mr. Bargman and Dr. Chousky:

**RE: COMPLAINT REVIEW - CHIROPRACTIC
HOWARD BARGMAN AND CARY CHOUSKY, 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.

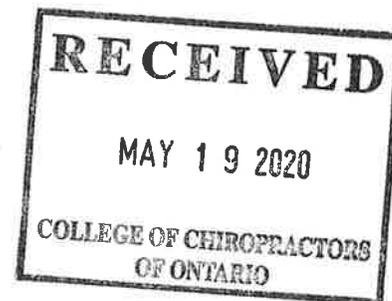
While your file is now closed, please note that parties to Complaint Reviews of the Health Professions Appeal and Review Board have the right to request a judicial review of the Board's decision. You may wish to consider obtaining legal advice to determine what options are available to you. To request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

Yours sincerely,

HEALTH PROFESSIONS APPEAL AND REVIEW BOARD

A handwritten signature in black ink, appearing to read 'S.C.' or similar initials.

Sofiea Choudhary
FOR: Margaret Bolinas
Case Officer



Encl: Decision dated May 12, 2020

cc: College of Chiropractors of Ontario (CCOPRA File # CHOUSKY-18-SE-13)

HEALTH PROFESSIONS APPEAL AND REVIEW BOARD**PRESENT:**

Beth Downing, Designated Vice-Chair, Presiding
 Yasmeen Siddiqui, Board Member
 Bonita Thornton, Board Member

Review held on March 19, 2020, 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:

HOWARD BARGMAN

Applicant

and

CARY CHOUSKY, DC

Respondent

Appearances:

The Applicant:	Howard Bargman
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 require Cary Chousky, DC to:

- successfully complete the following Specified Continuing Education and Remediation Program:

- Program to educate Dr. Chousky regarding his advertising practices. This program will be conducted with expert consultant, Ms Gail Siskind. The consultant will determine how many sessions are required; however, the program is to be completed within 3 months of the date of the decision and before he undertakes any new advertising;
 - Dr. Chousky and the consultant shall provide documentation of completion of the above to the Registrar forthwith after each item is performed so that the Registrar can assess whether the program has been successfully completed;
 - The Registrar may, if requested, approve a reasonable extension of any portion of the program if so requested by the consultant, or by Dr. Chousky providing reasonable grounds. In the absence of a letter issued by the Registrar granting an extension, Dr. Chousky is required to successfully complete each portion of the program by the time specified above;
 - Dr. Chousky is required to complete the above program at his own expense; and
- attend an oral caution with respect to adhering to Standard of Practice S-016: Advertising and Guideline G-106: Advertising, specifically to ensure his advertising is not misleading to the public.
2. This decision arises from a request made to the Health Professions Appeal and Review Board (the Board) by Howard Bargman (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 Cary Chousky, DC (the Respondent). The Committee investigated the complaint and decided to require the Respondent to successfully complete the Specified Continuing Education and Remediation Program (SCERP) and to attend an oral caution, as set out above.

II. BACKGROUND

3. The Applicant is not a patient of the Respondent. The Applicant noticed two advertisements which appeared in the Toronto Star on behalf of the Respondent in September 2018. The first one appeared on September 11, 2018. The second one appeared on September 17, 2018. The Applicant was concerned that the advertisements were misleading and non-compliant with applicable standards.

The Complaint and the Response

4. In a letter of September 11, 2018 to the College, the Applicant raised the following concerns about the advertisement of September 11, 2018:
 - Nowhere in the advertisement does it indicate that the Respondent is a chiropractor;
 - The first paragraph beginning 'Local Doctors & ingenious ... ' is not attributed to anyone or anything and the public would have no way of knowing or confirming any truth that might be contained in the paragraph. It also seems to sway the reader that [the Respondent] is a medical doctor, because chiropractors must indicate that they are chiropractic doctors and the title 'Doctors' usually refers to medical doctors;
 - The second paragraph beginning 'Health Canada/FDA cleared technologies ... ' might lead the reader to conclude that [the Respondent's] instruments have both Health Canada and FDA clearance. The reader cannot reach any meaningful conclusion from that paragraph and there is no attribution;
 - The sentence 'But there are doctors in the Greater Toronto area turning peripheral neuropathy on its head ... ' is hardly accurate and once again leaves the impression that [the Respondent] is a medical doctor;
 - The first reference to the Mayo Clinic lists 12 broad causes of peripheral neuropathy and only one of them MIGHT be in the purview of a chiropractor. It does not list 'Modification Treatment' anywhere that [he] could find;
 - The second reference to ncbi contains one paragraph dealing with diabetic neuropathy and the only physical modality listed as treatment is trans-electrical stimulation;

- The 3rd reference is a 1 minute 6 second slide show entitled 'The basics: diabetic neuropathy';
 - Interestingly, the 1st and 3rd references advise the reader to consult their doctor- nowhere does it recommend that they consult their chiropractor;
 - Which brings [him] to the question- in what circumstances is the treatment of neuropathy fall [sic] under the scope of practice of chiropractors? [He] [suspects] that diabetic neuropathy is not one of them;
 - There is a photograph of 3 people wearing white coats. Is any of them [the Respondent] or do any of them work in the office with [the Respondent]? If not, why are they pictured? Do chiropractors wear stethoscopes around their neck, or just for photographs?
 - [The Respondent] is offering a discounted fee to attend his office for consultation of neuropathy. As [he] [understands] it, a chiropractor can offer free visits to discuss chiropractic in general, or how chiropractic might help a given patient, but he advertises 'Comprehensive Evaluation' which includes testing, all for the bargain-basement price of \$47.00 (a regular \$200 value).
 - The paragraph 'The TRUTH is this ... neuropathy is most commonly not ONE problem but a 'collection' of problems often made worse by certain lifestyle behaviour' is patently not accurate. Also, he is holding out results that likely exceed his ability to provide.
5. In a letter of September 23, 2018 to the College, the Applicant raised the following concerns about the advertisement of September 17, 2018:
- The advertisement starts 'Local Doctors ... Tingling Become Pain Free.' Once again, there may well be the presumption that [the Respondent] is a medical doctor because it does not indicate that he is a chiropractor.
 - [He] could find nothing of a scientific nature for 'Modification Treatment' as it might pertain to the field of chiropractic.
 - Web sites are offered in the advertisement but are meaningless because they do not indicate a specific URL that can be accessed.
 - The picture shows 3 people, one of whom is wearing a stethoscope draped around his neck. Do chiropractors wear stethoscopes? If not, what is the public to believe as to the profession of the man wearing one?
 - 'Powerful Results'. 'Innovative Treatment.' '... results we have witnessed so far are quite promising'. Do these statements meet the threshold of honest, verifiable advertising??

6. In a letter of October 23, 2018, to the College, the Respondent provided information in response to the complaint including the following:

- [The Applicant's] various concerns arise as a result of two advertisements [their] office published in the Toronto Star on September 11, 2018 and September 17, 2018, respectively. Historically, all promotional materials are screened by [him] prior to release for publication. [He] can advise the Committee that [their] communications officer inadvertently failed to submit these particular advertisements to [him] for approval prior to release to the Toronto Star for placement. On September 19, 2018, during an office meeting the advertisements in question came to [his] attention. Upon review, [he] independently determined they did not meet the standards for advertising. [He] instructed that the advertisements in question be retracted and not placed again. The meeting and remedial action occurred one week prior to [his] actual notice of the Applicant's complaint to the CCO.
- That said, [he] acknowledges that it is his ultimate responsibility to ensure that all advertisements associated with the Chousky Centre comply with the College standards for advertising. In this instance, it is accepted that the two advertisements in question were non-compliant. To [the Applicant], he would offer [his] sincere apology for the publishing of the content and trusts that he too now appreciates that the misleading effects of the material were neither deliberate nor contemplated by [him] as a healthcare professional. Furthermore, [he] can assure the Committee that [he] has instituted measures that will serve to ensure this unfortunate sequence of circumstances is not repeated.

7. The Applicant provided further comments on the Respondent's response including the following:

- A full page advertisement in the Toronto Star costs between \$10,000 and \$13,000... [the Respondent] is asking the College to believe that he had no input or alternatively, he had input but his staff changed the input in such a fashion that the advertisement broke the standard in many ways...

[The Respondent] would further have us accept that his 'communications officer inadvertently failed to submit these particular advertisements to me'. And they did that TWICE because there were two advertisements!!

In the past, [he has] seen other newspaper advertisements from the Chousky Centre and felt that they pushed the bounds of honesty, scientific correctness and verifiability. Is the treatment of peripheral neuropathy a condition that properly falls under the scope of practice of chiropractors? Is 'Modification Treatment' anywhere near a scientific method and did Health Canada clear THIS

technology? [He] [hopes] the College won't take the position that symptoms of neuropathy fall under the scope of chiropractors. Doing so would be disingenuous. If [he] were an investigator with the college, [he'd] do the following: ...meet with the 'communications officer' and ask for confirmation to see if it corroborates [the Respondent's] position in this regard [He'd] then ask to see previous newspaper advertisements to see how honest and accurate they were and whether they met the standards of the College. Is this indeed a 'one-off' occurrence or in fact, did [the Respondent] fail to maintain the standard in past advertisements? Yesterday's in-depth article in the Globe and Mail proves to [him] that it is an uphill battle to have the College protect the public-their main mandate. Does the College condone fallacy or does it condemn members practicing outside of their scope? Does it allow false and misleading advertising?

The Committee's Decision

8. The Committee investigated the complaint and decided to require the Respondent to successfully complete a SCERP and attend a caution, as set out above.
9. In reaching its decision, the Committee made the following findings:
 - The advertisements convey the impression that the Respondent is a physician, which is prohibited by subsection 9(3) of the *Medicine Act, 1991*.
 - The advertisements included a stock photo of three people in lab coats, and then the logos of MayoClinic.com, PubMed and WebMD, each with a tick mark beside it, suggesting that the statement or treatment is found or endorsed on these sites. The Committee stated this was misleading.
 - Some forms of neuropathy are clearly within the scope of practice of chiropractic as they are related to the spine and/or joints. The Committee opined that diabetes is a condition that may or may not have neurological manifestation. The Committee is not familiar with the term "modification treatment" in this context.
 - The advertisements are hyperbolic and contain unverifiable statements such as "local doctors and ingenious..." Although they do not use the words "cure" or "guarantee" they raise vulnerable patients' hopes with phrases such as "...and ELIMINATE or reduce the need for pain medication." The prescription of drugs

is a controlled act outside the scope of practice of chiropractic as set out in Standard S-001: Chiropractic Scope of Practice.

- The ad offers a reduced fee “if you are one of the first 21 qualified callers” which is contrary to Standard S-016: Advertising.

III. REQUEST FOR REVIEW

10. In a letter dated May 16, 2019, the Applicant requested that the Board review the Committee’s decision.

IV. POWERS OF THE BOARD

11. 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.

12. 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

13. 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.

14. The legislation does not require that parties attend the Review. The Board draws no inference from the Respondent's non-attendance. The Board was assisted by the Respondent's written submissions of July 12, 2019.
15. 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

16. 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.
17. The Committee obtained the following documents:
 - the Applicant's communications about the complaint including the newspaper ads in question;
 - the Respondent's response;
 - the Applicant's comments on the response; and
 - Standard of Practice S-016 Advertising, Guideline G-016 Advertising, and Standard of Practice S-001 Chiropractic Scope of Practice.
18. The Respondent submitted that the investigation was adequate.
19. The Applicant submitted that the investigation was inadequate in several respects including the following.
20. The Applicant submitted that the Committee should have interviewed the Respondent's communications officer to determine whether the Respondent was truthful in his statement that he was unaware of the content of the ads before they were released. The Board is not persuaded that it is necessary for the Committee to interview the

communications officer. The Respondent acknowledged to the College that the ads were non-compliant and misleading and that he is ultimately responsible for the compliance of ads from his office. The Committee agreed. Therefore, whether or not the communications officer had the Respondent's approval before sending the ads to be published would not likely have affected the Committee's decision.

21. The Applicant submitted that the Committee should have further investigated the "FDA cleared technology" referred to in the advertisement of September 11, 2018. He submitted that without knowing what this technology is, the Committee could not verify whether it was FDA approved. The Board notes that this concern of the Applicant was before the Committee in his submissions to them. The Committee could have investigated this further had it found that to be necessary. The Committee found the advertising to be misleading and non-compliant in many respects and required a SCERP and oral caution specifically on misleading advertising. The Board finds that further information about the "technology" and other possible ways that the ad was misleading is not likely to have affected the Committee's decision.
22. The Applicant provided materials at the Review that were not contained in the Record. He provided another advertisement from the Respondent's office which the Applicant submits was published April 15, 2019, two weeks before the Committee issued its decision. The Board observes that it was not possible for the Committee to review an ad that was not contained in the Record. If the Applicant has new concerns about the content of this ad, it is open to him to file a new complaint with the College.
23. The Board has reviewed the newspaper articles and other articles filed by the Applicant at the Review. Some of this information raises concerns regarding the profession as a whole, rather than the Respondent, and is, therefore, unlikely to affect the Committee's decision.
24. Finally, the Applicant submitted that the Committee should have broadened the investigation to include complaints of a similar nature against other chiropractors. He

submitted that there are many examples of advertising by other chiropractors who also claim to offer treatments that, in the Applicant's view, are beyond the scope of practice of chiropractors. Under the *Code*, neither the Committee nor the Board can broaden the investigation in this manner. The Applicant may bring complaints regarding other individual chiropractors if he has concerns regarding their individual practices.

25. The Board finds that the Committee obtained the essential information it needed to make an informed decision regarding the concerns raised in the complaint. It is clear from the Committee's decision that it considered all of the Applicant's communications about the complaint. The Committee had the Respondent's response and the advertisements in question. The Committee also considered the relevant standards and guidelines set out above, as well as the Respondent's complaints history with the College. The Board concludes that there is no additional information that had it been obtained might reasonably be expected to have affected the Committee's decision.
26. Accordingly, the Board finds the Committee's investigation to be adequate.

Reasonableness of the Decision

27. In considering the reasonableness of the Committee's decision, the question for the Board is not whether it would arrive at the same decision as the Committee, but whether the Committee's decision can reasonably be supported by the information before it and can withstand a somewhat probing examination. In doing so, the Board considers whether the decision falls within a range of possible, acceptable outcomes that are defensible in respect of the facts and the law.
28. The Respondent submitted that the decision was reasonable.
29. The Applicant submitted that the decision was unreasonable in several respects including the following. He maintained that the Respondent was dishonest in his statement to the Committee about not having seen the ad before it went out. He submitted that the

Committee failed to answer his question about whether treatment of diabetic neuropathy is within the scope of practice of chiropractors. He asked the Board to direct the College to opine on which diseases fall within the scope of practice of chiropractors and to have the College confirm that “low level light therapy” meets the College scope of practice standards/guidelines. He expressed scope of practice concerns about the profession as a whole and cited examples. He submitted that the Board must address these broader concerns because the Committee has failed to do so.

30. The Board finds that the Committee’s decision to require the Respondent to complete a SCERP and attend for an oral caution was reasonable for the following reasons.
31. Regarding the Applicant’s assertion that the Respondent was untruthful in his response to the Committee, the Board observes that the Committee’s task is not to make findings of fact or assess credibility. Rather, the Committee’s mandate is to screen 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. Dispositions available to the Committee upon considering a complaint include directing remedial measures intended to improve an aspect of a member’s practice.
32. From the Committee’s decision it is apparent that it considered the information provided by both parties, the advertisements in question and the applicable standards and guidelines. It applied its professional judgement in considering this information and found the advertisements to be misleading and non-compliant with the relevant standards of the profession in several respects as set out above in paragraph 9. While the Applicant wanted the Committee to go further in finding other aspects of the ads to be misleading or beyond the scope of practice of chiropractic, the Board observes that the Committee had before it all of the relevant information but chose not to make further findings. Apart from the submissions of the Applicant, there is no information in the Record, or advanced

at the Review, to indicate that the Committee applied the wrong standards or improperly applied those standards in reviewing the concerns raised in the complaint.

33. The Board notes that in assessing the appropriate disposition in a complaint, a Committee will consider many factors, including the seriousness of the deficiency, whether there is a single concern or a number of concerns about the care at issue, the content of a member's response, his or her insight as to areas for improvement, and the member's complaints or discipline history.
34. The Board observes that the Respondent admitted in his response to the Committee that the ads were misleading and non-compliant, showing insight. The Committee considered the Respondent's complaints history, as it is required to do, and there were no previous complaints regarding the Respondent's advertising. Nevertheless, the Committee required the Respondent to complete a SCERP. The terms of the SCERP stipulate that the Respondent will complete a program to educate him about his advertising practices. The program will be conducted with an expert consultant and is to be completed within three months of the decision date and before the Respondent undertakes any new advertising. In addition, the Respondent is required to attend for an oral caution to ensure his advertising is not misleading to the public. The Board finds that these remedial measures will address the specific concerns identified by the Committee and will help improve the Respondent's practice, thereby protecting the public going forward.
35. Regarding the Applicant's request that the Board address his broader concerns about scope of practice issues in the profession as a whole, the Board observes that the Committee, and the Board, are mandated to consider individual complaints about the conduct or actions of a member not broader concerns about the profession as a whole. If the Applicant has concerns about other chiropractors, he can file a complaint with the College regarding those individuals.
36. The Board acknowledges that the Applicant remains dissatisfied with the Committee's decision. Nonetheless, the Board is satisfied that the investigation was adequate and the

decision is reasonable. The Board observes that a summary of the complaint and disposition of a SCERP and oral caution will be posted on the College's public registry and the Committee's decision must be considered in the event there is a complaint to the College regarding the Respondent's conduct and actions in the future.

VI. DECISION

37. Pursuant to section 35(1) of the *Code*, the Board confirms the Committee's decision to require the Respondent to:

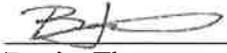
- successfully complete the following SCERP:
 - Program to educate the Respondent regarding his advertising practices. This program will be conducted with expert consultant, Ms Gail Siskind. The consultant will determine how many sessions are required; however, the program is to be completed within 3 months of the date of the decision and before he undertakes any new advertising;
 - The Respondent and the consultant shall provide documentation of completion of the above to the Registrar forthwith after each item is performed so that the Registrar can assess whether the program has been successfully completed;
 - The Registrar may, if requested, approve a reasonable extension of any portion of the program if so requested by the consultant, or by the Respondent providing reasonable grounds. In the absence of a letter issued by the Registrar granting an extension, the Respondent is required to successfully complete each portion of the program by the time specified above;
 - The Respondent is required to complete the above program at his own expense; and

- attend an oral caution with respect to adhering to Standard of Practice S-016: Advertising and Guideline G-106: Advertising, specifically to ensure his advertising is not misleading to the public.

ISSUED May 12, 2020


Beth Downing


Yasmeen Siddiqui


Bonita Thornton

**College of Chiropractors of Ontario
Registration Committee Report to Council
June 17, 2020**

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Members:	Dr. Paul Groulx, <i>Chair</i> Dr. Colin Goudreau Ms Georgia Allan Mr. John Papadakis Mr. Gagandeep Dhanda
Staff Support:	Mr. Joel Friedman, <i>Director, Policy and Research</i> Ms Madeline Cheng, <i>Registration Coordinator</i> Ms Jo-Ann Willson, <i>Registrar and General Counsel</i> Ms Andrea Szametz, <i>Recording Secretary</i>

I. Report

The Registration Committee met once on June 2, 2020 via Zoom. The Committee conducted an orientation on the objectives, roles and processes of the Registration Committee. This included a review of relevant legislation, regulations, policies, by-laws and decision-making tools and flowcharts, as well as a review of various oversight organizations, such as the Office of the Fairness Commissioner.

The Committee reviewed several applications for registration that were referred to the Committee, applying regulations, policies, decision-making tools and past precedents to make its decisions.

The Committee reviewed a draft policy on how to address future applicants for Registration who have not successfully passed the CCEB examinations and CCO's legislation and ethics examination, due to cancellations as a result of COVID-19. This policy would allow applicants to become registered with CCO under a provisional registration with various terms, conditions and limitations applied to the certificate of registration. The Registration Committee is further reviewing this policy, while collecting information and receiving feedback on the practices of other regulatory colleges in Ontario and other chiropractic regulators across Canada. The Registration Committee has scheduled a virtual meeting for early July to further this issue.

Ms Gemma Beierback, CEO of the CCEB, joined the Registration Committee meeting to provide an update on the administration of the CCEB examination. Ms Beierback reported that the CCEB is conducting a town hall virtual meeting on June 12, 2020 to provide an update on its examination administration. CCEB is exploring all options for the Fall 2020 examination sitting, including securing PPE and applying physical distancing, while ensuring the examination's validity is not compromised. Ms Beierback reported that the CCEB is confident that there are measures in place to safely administer Parts A and B, while Part C will be more challenging.

I would like to thank the members of the Registration committee, with special acknowledgement to the newest committee members, Dr. Colin Goudreau and Mr. Gagandeep Dhanda, faced with very challenging policy decisions at their first meeting, and the support staff for their time and commitment.

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Respectfully submitted,

Dr. Paul Groulx,
Chair, Registration Committee

Current Member Status

Chart 1: Membership Statistics as at June 5, 2020

Status	Total
Active	4672
Inactive – Resident	230
Retired	138
All categories	5040

Chart 2: Change in Registration statistics for February 12, 2020 – June 5, 2020

Description	Total
New registrants	14
Female	7
Male	7

Chart 3: Colleges of Graduation for New Registrants

CMCC	4
University of Western States	1
Life'CC	2
NYCC	3
NZCC	1
Palmer FL	1
Palmer IOWA	1
Palmer CA	1

ITEM 1.4.1Draft
June 2, 2020**CCO Policy on Considering Applications for Registration during the COVID-19 Pandemic**

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

Intent

The COVID-19 pandemic has prevented new graduates and other applicants for registration with the CCO from being able to complete the requirements for registration. Most notably, the Canadian Chiropractic Examining Board (CCEB) examinations scheduled for Spring of 2020 have been postponed until at least October of 2020. There is no assurance that the examination can proceed even then. In addition the Legislation and Ethics examination is also currently unavailable. Also, some documents used to verify information are not available resulting in the inability for some applicants to provide a notarized copy of pictures of themselves and the inability of some applicants to provide a Canadian Police Information Centre (CPIC) Vulnerable Sector Check. In addition, the requirement to successfully complete the CCO's Record Keeping Workshop within one year of being registered may not be achievable either. Similarly, re-registering applicants may not be able to successfully complete a Peer and Practice Assessment within six months of being registered.

There are compelling public interest reasons for accommodating applicants for registration who cannot attempt the examinations, cannot provide all of the documentary verification and cannot complete the required activities after registration. Accommodating such applicants enables members of the public to have greater access to chiropractic services, particularly as the pandemic has reduced access to them (e.g., due to voluntary and mandatory self-isolation and practice closure orders). In addition, accommodating applicants appropriately enables them to keep their competence current at the crucial period of time between completing their education and beginning independent practice.

The registration regulation provides for only two types of practising certificates of registration: General and Temporary. The Temporary class of certificate is only available for those who are registered in another jurisdiction and generally lasts for only a maximum of twelve weeks. So it is not easily available to address the issue and the CCO should look to adapting the General class of certificate. In terms of the General class of registration, only the educational requirement is non-exemptible. While it is extremely rare to exempt the examination requirements, it is legally permissible to do so in appropriate circumstances.

The intent of this policy is to assist the Registration Committee to accommodate applicants for registration during the pandemic on a principled and consistent basis. The principles underlying this policy include the following:

1. The public interest requires that anyone registered as a chiropractor in Ontario must be competent and ethical who will practise safely and professionally.
2. The COVID-19 pandemic calls for exceptional measures to be taken to accommodate applicants in the public interest who cannot meet all of the registration requirements because of the pandemic.
3. Exempting successful completion of the examinations, even temporarily, is a major concession that requires adequate alternative safeguards.
4. Any accommodations should be available to applicants from any jurisdiction or to graduates of any equivalent educational program. Such accommodations should not be limited to just the graduates of the two Canadian schools.
5. Any accommodations must be transparent to the public.
6. Any accommodations should be temporary. As soon as practicable, applicants who have been exempted from a requirement should have to complete them. Certificates of registration for those who attempt but are unsuccessful in completing a requirement will expire automatically.
7. While the Registration Committee strives to be consistent, nothing in the policy prevents a panel of the Registration Committee from making a different decision where the individual circumstances of the case warrant a different approach.

Description of Policy

Content

A panel of the Registration Committee may offer the following accommodations to the applicant, during the COVID-19 pandemic only, where an applicant meets all of the other registration requirements (e.g., graduation from a recognized chiropractic education program, graduation within the last two years, liability insurance).

1. The CCEB examination requirement may be exempted with the following terms, conditions and limitations (TCLs):
 - a. The applicant shall only practise under the supervision of a chiropractor who holds a General certificate of registration with no individually imposed TCLs on their certificate of registration and who is in good standing with CCO so long as the supervising chiropractor effectively supervises the applicant's performance of patient-related activities at the supervisor's place of practice including through regular physical attendance at the place of practice pursuant to a written agreement.
 - b. The applicant shall use the title "Chiropractor (Provisional)" in all written and oral communications describing the applicant's professional or registration status.
 - c. When providing a professional service to a patient for the first time, the applicant shall inform each patient that the applicant's registration status is provisional because the applicant has not yet completed their registration

- examinations. The applicant shall ensure that the patient has confirmed this disclosure in writing in the patient record (e.g., through a consent form).
- d. The certificate of registration shall expire at the earlier of being notified of an unsuccessful attempt of any component of the CCEB or six weeks after the first available sitting of the three components of the CCEB examinations unless, at that time, the applicant has successfully passed those examinations, at which point the applicant may be issued a new certificate of registration without these TCLs.
2. The Legislation and Ethics examination requirement may be exempted with the following TCLs:
 - a. The applicant shall only practise under the supervision of a chiropractor who holds a General certificate of registration with no individually imposed TCLs on their certificate of registration and who is in good standing with CCO so long as the supervising chiropractor effectively supervises the applicant's performance of patient-related activities at the supervisor's place of practice including through regular physical attendance at the place of practice pursuant to a written agreement.
 - b. The applicant shall, before providing services to any patients, provide an undertaking in writing to the Registrar that the applicant has read, understood, and will comply with the standards, guidelines and policies posted on the CCO's website and has read, understood, and will comply with the communications on COVID-19 posted on the CCO's website along with the pandemic orders and directives mentioned in those postings.
 - c. The applicant shall use the title "Chiropractor (Provisional)" in all written and oral communications describing the applicant's professional or registration status.
 - d. When providing a professional service to a patient for the first time, the applicant shall inform each patient that the applicant's registration status is provisional because the applicant has not yet completed their registration examinations. The applicant shall ensure that the patient has confirmed this disclosure in writing in the patient record (e.g., through a consent form).
 - e. The certificate of registration shall expire four weeks after the first available sitting of the Legislation and Ethics examination unless, at that time, the applicant has successfully passed that examination, at which point the applicant may be issued a new certificate of registration without these TCLs.
 3. The usual TCL that the applicant complete the record keeping workshop within one year of being issued a certificate of registration shall be reworded to state that the certificate of registration be issued with the following TCLs:
 - a. The applicant shall, before providing services to any patients, provide an undertaking in writing to the Registrar that the applicant has read, understood, and will comply with the standards, guidelines and policies posted on the CCO's website related to record keeping.
 - b. The certificate of registration shall expire if the applicant has not provided evidence satisfactory to the Registrar that the applicant has successfully

completed the record keeping workshop within twelve months of its first being offered again to the profession.

4. Where the applicant has provided two inch by two inch coloured photograph of themselves taken within the past year but states that, because of the pandemic, they are not able to provide a notarized statement as to the authenticity of the photographs and a signature on the photographs by a notary public, a certificate of registration shall be issued with the following TCLs:
 - a. The applicant shall, before providing services to any patients, provide an undertaking in writing to the Registrar that the two inch by two inch coloured photograph of themselves accompanying the application for registration were taken within the past year and accurately and fairly depict their appearance.
 - b. The certificate of registration shall expire if the applicant has not provided to the Registrar within six months of the date of the issuance of the certificate of registration, or such longer time as specified by the Registrar in writing, a notarized statement as to the authenticity of identical photographs and a signature on the identical photographs by a notary public.
5. Where the applicant has stated that because of the pandemic they are unable to provide a CPIC Vulnerable Sector Check, a certificate of registration shall be issued with the following TCLs:
 - a. The applicant shall, before providing services to any patients, provide an undertaking in writing to the Registrar that there have been no investigations, charges, findings or other legal event that would be revealed by such a document or that would raise concerns about their ability to practise safely and ethically.
 - b. The certificate of registration shall expire if the applicant has not provided to the Registrar within six months of the date of the issuance of the certificate of registration or such longer time as specified by the Registrar in writing, a CPIC Vulnerable Sector Check that is clear of any concerns or issues.
6. Where an applicant was previously registered with the CCO and would usually be subject to a TCL that the applicant successfully complete a Peer and Practice Assessment within six months of being issued the certificate of registration, the TCL shall be reworded as follows:
 - a. The certificate of registration shall expire if the applicant has not provided evidence satisfactory to the Registrar that the applicant has successfully completed a Peer and Practice Assessment within six months of such assessments first being offered again to the profession.

Applicants obtaining exemptions from the examinations should understand that, while these certificates of registration are technically General certificates of registration, they are in substance a different type of registration: provisional. As such applicants obtaining such a certificate of registration should not assume that they will be able to register as general or independent chiropractors in other Canadian jurisdictions under the Canada Free Trade Agreement.

Process

Applicants wishing to take advantage of the accommodations described in this policy shall complete an application form specifically designed by the CCO for such applications.

Under the *Health Professions Procedural Code (Code)*, exemptions must be granted by the Registration Committee.

An expedited process is available where the applicant consents to TCLs proposed by the Registrar. In such a case, the applicant will be registered with those TCLs if a panel of the Registration Committee approves. Where the Registrar indicates to the panel of the Registration Committee that the application falls within the parameters of this policy and also indicates that the Registrar does not believe there are any special circumstances and the applicant indicates consent to the applicable TCLs, the Registration Committee will generally approve the issuance of the certificate of registration expeditiously.

Where the applicant does not consent to the TCLs, or the Registrar is unable to indicate that the application falls within the parameters of this policy or where the Registrar indicates that the Registrar believes there are special circumstances, the Registrar shall refer the application to the Registration Committee under s. 15(2) of the *Code* for more rigorous individual consideration.

The reasons for decision of the panel of the Registration Committee issuing a certificate of registration with the conditions outlined above will typically include the following points:

- The exemptions provided are exceptional and are only made because of the pandemic. There is a temporary, but compelling, public interest in ensuring public access to chiropractic services and in ensuring that applicants who have completed comprehensive training do not lose their competence by a pandemic-caused inability to practice or sit examinations.
- The TCLs related to examinations, courses and assessments are necessary to protect the public by ensuring that applicants provide safe and ethical services.
- The TCLs related to verifying information are necessary to ensure that applicants do not permanently escape the usual scrutiny of such information.

Legislative Context

Section 15 of the *Code* reads as follows:

Registration

- 15 (1)** If a person applies to the Registrar for registration, the Registrar shall,
(a) register the applicant; or
(b) refer the application to the Registration Committee. 1991, c. 18, Sched. 2, s. 15 (1).

Referrals to Registration Committee

(2) The Registrar shall refer an application for registration to the Registration Committee if the Registrar,

- (a) has doubts, on reasonable grounds, about whether the applicant fulfils the registration requirements;
- (a.1) is of the opinion that terms, conditions or limitations should be imposed on a certificate of registration of the applicant and the applicant is an individual described in subsection 22.18 (1);
- (b) is of the opinion that terms, conditions or limitations should be imposed on a certificate of registration of the applicant and the applicant does not consent to the imposition; or
- (c) proposes to refuse the application. 1991, c. 18, Sched. 2, s. 15 (2); 1993, c. 37, s. 6; 2009, c. 24, s. 33 (3).

Notice to applicant

(3) If the Registrar refers an application to the Registration Committee, he or she shall give the applicant notice of the statutory grounds for the referral and of the applicant's right to make written submissions under subsection 18 (1). 1991, c. 18, Sched. 2, s. 15 (3).

Terms, etc., attached on consent

(4) If the Registrar is of the opinion that a certificate of registration should be issued to an applicant with terms, conditions or limitations imposed and the applicant consents to the imposition, the Registrar may do so with the approval of a panel of the Registration Committee selected by the chair for the purpose. 1991, c. 18, Sched. 2, s. 15 (4).

Panels for consent

(5) Subsections 17 (2) and (3) apply with respect to the panel mentioned in subsection (4). 1991, c. 18, Sched. 2, s. 15 (5).

Section 18 of the *Code* reads, in part, as follows:

Orders by panel

(2) After considering the application and the submissions, the panel may make an order doing any one or more of the following: ...

- 4. Directing the Registrar to impose specified terms, conditions and limitations on a certificate of registration of the applicant and specifying a limitation on the applicant's right to apply under subsection 19 (1)....

Idem

(3) A panel, in making an order under subsection (2), may direct the Registrar to issue a certificate of registration to an applicant who does not meet a registration requirement unless the requirement is prescribed as a non-exemptible requirement.

Order on consent

(4) The panel may, with the consent of the applicant, direct the Registrar to issue a certificate of registration with the terms, conditions and limitations specified by the panel imposed. 1991, c. 18, Sched. 2, s. 18.

Section 1 of the registration regulation under the *Chiropractic Act* reads as follows:

Classes of certificate

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

1. General.
2. Temporary.
3. Inactive.
4. Retired. O. Reg. 137/11, s. 1.

Section 2 of the registration regulation reads as follows:

Application

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

Paragraph 3.4 of the registration regulation reads as follows:

Registration requirements, all classes

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

4. The applicant's past and present conduct must afford reasonable grounds for belief that the applicant,
 - i. is mentally and physically competent to practise chiropractic,
 - ii. will practise chiropractic with decency, integrity, honesty and in accordance with the law,
 - iii. has sufficient knowledge, skill and judgment to engage in chiropractic,
 - and
 - iv. will display professional behaviour. O. Reg. 137/11, s. 3.

Section 6 of the registration regulation reads, in part, as follows:

Additional requirements, general certificate

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

1. The applicant must have successfully completed the requirements for graduation from either a chiropractic education program that is accredited or recognized by the Council on Chiropractic Education (Canada) or a chiropractic education program considered equivalent by the Council to such a program. Subject to section 7, this requirement is non-exemptible.
2. Before applying for the certificate, the applicant must have passed,
 - i. a legislation examination set by the Council or set by another person or body and accepted by the Council as sufficiently testing the applicant's knowledge of relevant legislation, and
 - ii. the examinations set by the Canadian Chiropractic Examining Board or set by another person or association of persons and accepted by the Council as equivalent to the examinations set by the Board.
3. The applicant must complete a refresher course approved by the Registration Committee or otherwise satisfy the Registration Committee that he or she is currently competent to practise if the applicant applies for registration more than two years after completing the education program required under paragraph 1.

Paragraph 9.2 of the registration regulation reads as follows:

Additional requirements, temporary certificate

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

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

Paragraph 1.16 of the professional misconduct regulation defines the following as professional misconduct:

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

ITEM 1.4.2



CANADIAN CHIROPRACTIC EXAMINING BOARD
CONSEIL CANADIEN DES EXAMENS CHIROPRACTIQUES
230, 1209 – 59 Avenue SE
Calgary, AB T2H 2P6
Email: exams@cceb.ca Fax: (403) 230-3321

It is with great disappointment that we must announce that the spring administration of the CCEB examinations, scheduled for May 30 and 31, 2020, is cancelled.

The COVID-19 pandemic and related public health guidance continues to evolve and change daily. Unfortunately, it has reached the point where it is no longer possible, due to public health restrictions and facility closures, for the CCEB to host the Spring examination administration.

We recognize the significance of the CCEB examinations in the lives of candidates like you who are eager to seek licensure/registration in Canada, and we recognize you will have many questions.

You will find attached a comprehensive FAQ, which we hope addresses your unique concerns about this administration and future examination administrations. Please read it thoroughly and if you have additional questions please email exams@cceb.ca.

Full refunds will be processed in the coming weeks. Please have patience as we work through this process. If you have not received your refund by May 15, 2020 please contact the CCEB.

As always, please keep up to date about the situation and keep safe!

<https://www.canada.ca/en/public-health/services/diseases/coronavirus-disease-covid-19.html>

Nous nous voyons malheureusement dans l'obligation d'annoncer l'annulation de l'administration des examens du CCEB du printemps, prévue les 30 et 31 mai 2020.

La pandémie de COVID-19 et les conseils de santé publique qui en découlent évoluent quotidiennement. En raison des restrictions de santé publique et des fermetures d'établissements, il n'est malheureusement plus possible que le CCEB gère les examens de printemps.

Nous reconnaissons l'importance des examens du CCEB dans la vie des candidats comme vous, qui sont désireux d'obtenir un permis d'exercice / l'inscription au Canada, et nous reconnaissons que vous aurez de nombreuses questions.

Vous trouverez ci-jointe une FAQ complète qui, nous l'espérons, répondra à vos soucis particuliers concernant cette administration et les futures administrations d'examen. Veuillez la lire attentivement. Si vous avez des questions supplémentaires, veuillez envoyer un email à exams@cceb.ca.

Les remboursements complets seront traités dans les semaines à venir. Nous vous prions de patienter pendant que nous suivons ce processus. Si vous ne recevez pas votre remboursement avant le 15 mai 2020, veuillez contacter le CCEB.

Comme toujours, nous vous demandons de vous tenir au courant de la situation et rester en sécurité!

<https://www.canada.ca/fr/sante-publique/services/maladies/maladie-coronavirus-covid-19.html>



CANADIAN CHIROPRACTIC EXAMINING BOARD

230, 1209 – 59 Avenue SE

Calgary, AB T2H 2P6

Email: exams@cceb.ca Fax: (403) 230-3321

*****N.B. These frequently asked questions (FAQ) are based on the best and most current information available as of April 15, 2020*****

FAQ ~ COVID-19 impacts on the CCEB Examination

If, having read the FAQ, you have additional questions please email them to exams@cceb.ca.

1. Why did you cancel the Spring 2020 exam administration?

On April 7, 2020 Montreal, Quebec announced the cancellation of public gatherings on its territory until July 2, 2020. Additionally, on April 13, 2020 we were notified that the Hamilton Component C facility was cancelling all events until the end of June. These closures have made it impossible to proceed with the spring (May 30 - 31, 2020) examination administration.

2. Why did you wait so long to cancel the Spring 2020 exam administration?

The CCEB was committed to administering the spring examination, if at all possible, with the greatest attention to the safety of the staff and candidates. We continued to monitor the situation very closely and build contingency plans. However, with the extended closures and expanding public health measures that have continued to develop over the past several days, it has become clear that a path to the spring administration no longer exists.

3. Why are you providing refunds?

The CCEB does not defer payments or applications to future administrations. Refunding fees is the normal practice of the organization. Additionally, the CCEB recognizes that these are extraordinary times and that individual finances have been impacted; your money is best placed in your direct control.

4. Can I defer my application to the next administration, and do I need to reapply?

You must reapply for a future administration. Your existing application for the spring 2020 administration will be cancelled. All required documentation will need to be resubmitted when applications open later this year. <https://www.cceb.ca/upcoming-exams/>.

5. When will I get my money back?

Our goal is to return all spring administration applications fees no later than May 15, 2020. If you have not received your refund by May 15, 2020 please email exams@cceb.ca.

6. How will I get my money back?



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Your payment will be refunded through PayPal if you paid online. Be mindful that, in some cases, the candidate is not the payor. In these cases, check in with the payor to confirm the refund. If you paid by mail, you will receive a refund cheque by mail to the address we have on file. If you have changed your address, please email exams@cceb.ca immediately.

7. What about my flight and hotel bookings?

You will need to contact the airline and hotel directly to cancel your reservations.

8. Do I need to do anything to get my refund?

No. You will be automatically refunded and your application cancelled. You only need to contact the office if you do not receive the refund by May 15, 2020 or if your contact information has changed.

9. Will I need to reapply for the next examination administration?

Yes, the fall administration application will open as outlined on the website. You will need to fully reapply including all required documentation.

<https://www.cceb.ca/upcoming-exams/>.

10. Why don't you host the exam in a different location, with fewer restrictions, instead of cancelling?

A high-stakes, entry-to-practice, examination of this size requires human and facilities resources on a significant scale. The facilities that can be used to conduct an examination administration of this size and type are quite limited and are booked years in advance. Additionally, the examination administration leverages hundreds of trained staff, proctors, examiners, and standardized patients.

11. Why don't you host the examination at the chiropractic colleges?

We strive to provide the most secure and fair testing environment available, and select our facilities based on, among other things, these criteria. We test candidates from many different schools around the world and it would not be possible for us to securely provide an examination at each of these schools.

12. Will you be adding an examination in the summer to replace the spring exam?

Unfortunately, we were not able to secure required space for a summer administration. The window of time available over the summer was too small to ensure the release of examination results in time to permit candidates to apply for the fall administration. The facilities required to support and administer the examination were not available during that time.

13. When will the next examination administration be?



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The next examination administration will be this fall, as previously scheduled.

<https://www.cceb.ca/upcoming-exams/>.

14. Will the next exam have limited capacity?

No. We have built up contingency capacity for the fall administration to accommodate the combined candidates from both the spring and fall administration. As always, we suggest you register early for the examination. Individual site capacity will be limited, which means you will not be guaranteed your preferred examination site or day.

15. If I had applied for the spring examination administration, will I have priority in the next application process?

No. The spring administration has been cancelled and all applications will be cancelled and refunded.

16. Can I bring protective equipment (PPE) to the examination?

This will depend on the public health guidance and COVID-19 pandemic situation at the time. It is very difficult to predict how this will unfold. Should it be prudent, PPE such as masks, sanitizer and gloves may be permitted following our standard security procedure.

17. What if the fall examination administration must be cancelled?

Firstly, we recognize the frustration this uncertainty has caused and continues to cause. There is no way to be certain that the fall administration will go forward, as there are so many variables out of the CCEB's control. As with the spring administration we are committed to moving forward if it is safely possible to do so.

If, by administering our examination, we would be contravening the public health guidance of the day, we will not be able to move forward. This includes any social distancing requirements or gathering limitations, as they may functionally make the administration impossible. As we have seen, this situation is developing quickly and unpredictably.

We will proceed with applications as posted <https://www.cceb.ca/upcoming-exams/> and monitor the situation on an ongoing basis.

Please review all of our previous COVID-19 guidance <https://www.cceb.ca/home/> regarding refunds, screening practices etc.

18. What if I register for the fall but I am unable to get to the exam due to border restrictions, my health or any other reason related to COVID-19?



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Please review all of our previous COVID-19 guidance <https://www.cceb.ca/home/> regarding refunds, screening practices etc.

Full refunds will continue to be offered for the fall administration up to and including the day of the examination (prior to entering the exam) for any reason, with no penalty. Cancellation does NOT count as an attempt.

19. When will I be notified if the fall examination is being cancelled, how much notice will be provided?

We know you invest time and energy in preparing for your examinations and the uncertainty is frustrating. As with the spring administration, we will continue to monitor the COVID-19 situation and notify candidates as quickly as possible should public health guidance make the administration ill advised or impossible. It is important to understand that given the fluid nature of the situation the forced cancellation of the examination could happen at any time. This is beyond the control of the CCEB. The CCEB is unable to predict how the situation will unfold and accepts no liability for costs incurred by candidates above and beyond the examination application fee.

20. Why would the fall examination be cancelled?

Should public health restrictions anywhere in Canada restrict the ability of the CCEB to conduct the examination safely while adhering to test security and administration requirements, the exam will need to be cancelled. The following are provided as examples but do not represent an exhaustive list:

- Exam facilities are closed.
- Travel restrictions between provinces could restrict the ability of examiners and other exam staff to reach the examination, thus preventing the examination from proceeding.
- Social distancing and gathering limits could restrict the capacity of facilities making it impossible to accommodate candidates and exam staff as required to conduct the examination.

21. Will the CCEB eligibility requirements be changed or relaxed?

No, the Examination Eligibility Policy will remain in force and can be found here <https://www.cceb.ca/docs/Examination-Eligibility-Policy.pdf>. All timelines and requirements remain unchanged, including attempt limits and deadlines.

Candidates are cautioned to verify they will meet their graduation requirements. Confirm your anticipated graduation date with your chiropractic program prior to applying for the fall administration, in the event your graduation date has been impacted by COVID-19 restrictions.



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22. Will the format of the examination be changed?

No. The fall administration is intended to move forward using our existing standard testing conditions.

23. Will we need to be sequestered longer than expected?

There is the possibility of longer sequestering times. Increased candidate numbers may stipulate that additional sequestering is required to accommodate all candidates. If this is necessary, you will be made aware of this after applications close and once candidate numbers are finalized. Every effort will be made to minimize the impact on candidates.

24. Where will the next exam be held?

Please refer to <https://www.cceb.ca/upcoming-exams/> for upcoming exam information.

25. Will I be able to take my CCEB examination outside of Canada in case of border closures?

No. The CCEB administers the Canadian chiropractic examination for practice in Canada. We strive to provide the most secure and fair testing environment available and select our facilities based on, among other things, these criteria. We test candidates from many different schools around the world. It would not be possible for us to securely provide an examination local to all candidates globally.

26. Can you provide a letter so that I can cross the border into Canada?

No. The candidate is responsible for all aspects of attending the examination. Candidates are encouraged to fully investigate any barriers they may experience to attending the examination.

27. Will I need to self isolate for 2 weeks after crossing the border into Canada for the fall examination, or for any other reason?

Candidates are responsible for investigating and following any public health guidance or other restrictions that may impact their ability to participate in the examination administration.

Some links are provided to Canadian public health guidance on our website COVID-19 updates: <https://www.cceb.ca/home/> .

Candidates are reminded that municipal, provincial and federal guidance may vary, and thorough due diligence is encouraged.

28. Why can't I just write the examination at my chiropractic college? They could proctor my exam.



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We strive to provide the most secure and fair testing environment available, and select our facilities based on, among other things, these criteria. We test candidates from many different schools around the world and it would not be possible for us to securely provide an examination at each of these schools.

29. Why doesn't the CCEB use remote proctoring?

The CCEB can not embrace methods of testing that might, in any way, jeopardize the important role of the CCEB examinations in public protection. At this time, we are not able to embrace remote proctoring while being certain of the security, and fairness of the examination and the validity of the results. Remote proctoring can take many forms but relies on individual access to technology tools and resources that may not be universally or equally available to all candidates. At this time, we have not been able to satisfy the CCEB requirements while leveraging this technology.

30. Will the CCEB be using mannequins for the OSCE?

As you can see by reviewing the Component C (OSCE) study guide <https://www.cceb.ca/docs/Component-C-Study-Guide.pdf> there is far more to clinical testing than manipulating a mannequin.

At this time, the CCEB will not be replacing standardized patients with mannequins.

31. What if I am not able to participate because of the COVID-19 pandemic at the fall administration, either due to my local public health restrictions, border closures, my own health or concern for my health?

Please refer to <https://www.cceb.ca/home/> and review all our prior COVID-19 briefings which outline our approach to cancellations and refunds.

32. How will this impact when I can enter practice?

The CCEB does not make any decisions regarding entry to practice; licensure or registration. This is the exclusive jurisdiction of the provincial regulatory body. Please contact the regulatory body directly in the province you intend to practice.

33. Will we be provided with provisional licenses?

The CCEB does not make any decisions regarding entry to practice, licensure or registration. This is the exclusive jurisdiction of the provincial regulatory body. Please contact the regulatory body directly in the province you intend to practice.

34. I have a contract to start working/a work placement based on completing my CCEB examinations what should I do?

The CCEB is not involved in employment or work placements for candidates. You should contact your employer/placement/school directly to discuss the situation.

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Email: exams@cceb.ca Fax: (403) 230-3321**Sources:**<https://www.hamilton.ca/><https://montreal.ca/><https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection.html>



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Posted to cceb.ca on April 24, 2020

FAQ 2.0~ COVID-19 impacts on the CCEB Examination

If, having read **all** posted CCEB communications, you have additional questions please email them to exams@cceb.ca.

COVID-19 is a global crisis and the situation is fluid. The following is provided based on the best information available. We will continue to update the CCEB website if/when the situation changes.

Please monitor www.cceb.ca for examination related information.

1. Will the CCEB consider adapting the exam to an online platform in the event mass gatherings are restricted past the summer/fall?

The CCEB is continuously monitoring best practice in entry-to-practice testing and evaluating opportunities for improvement. Although online platforms for computer-based testing are used by many organizations, these examinations have been equally impacted, by the COVID-19 pandemic, due to proctoring centre closures.

Online platforms for remote proctoring (meaning testing in a location of your choosing under some varied form of proctoring program) have not been broadly adopted for high stakes entry-to-practice testing in any profession and less so in health professions. The CCEB can not embrace methods of testing that might, in any way, jeopardize the important role of the CCEB examinations in public protection. We continue to investigate, monitor, and review developments in the testing space.

The CCEB is thoughtfully reviewing the potential impacts of gathering size restrictions. These public health restrictions vary by jurisdiction and have changed significantly in the past few weeks. It is not possible to imagine what these restrictions might look like in the fall. Certainly, some restrictions would prohibit an in-person examination administration, as was the case with our spring administration. However, the CCEB is reviewing contingency plans to address some forms of social distancing requirements and gathering restrictions.

2. Will the CCEB consider hosting the exam at an earlier date, such as during the summer, at a different available facility (a chiropractic college for example)?

The CCEB explored a summer administration. There are several significant barriers to a summer administration.

The CCEB requires at least 70 simultaneously available OSCE stations in order to conduct an examination of this size. There are very few facilities that can provide the environment required to conduct this examination. At this time, the facilities that we rely on to conduct our OSCE examination are either not accepting bookings at all or not



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accepting 'confirmed' bookings into the summer, leaving to much uncertainty and too short a timeline.

There is a specified timeline to permit the CCEB to process results from an examination and deliver those results to candidates, such that the candidate can apply for the subsequent examination.

- Applications close for the fall administration on July 31, 2020.
- Any results received after July 31, 2020 would mean a candidate would have missed the fall application deadline.

The timeframe between the close of applications and the administration of the subsequent examination is spaced specifically to meet operational requirements (to ensure that final examination preparations can be completed). Significant portions of examination preparations rely on the candidate application data including: exam component(s), preferred location, language, academic accommodations etc.

Having an administration that could not support results being released in time for subsequent application would mean that a candidate would not be able to apply for the fall administration. Effectively, they would need to wait until February to complete their subsequent exam component or to retake the exam if they are unsuccessful.

Additionally, due to uncertainty in facilities booking noted above, an earlier administration in the summer could also need to be cancelled due to public health order(s). The timing of this could mean that any candidate who had applied for that earlier administration would not be able to write during the fall administration, having missed the application window.

We strive to provide the most secure and fair testing environment available, and select our facilities based on, among other things, these criteria. We test candidates from many different schools around the world. It would not be possible for us to securely provide an examination at each of these schools so that each candidate could be equally familiar with the testing environment.

3. I heard other examining boards are rescheduling their exams in the summer. Why isn't the CCEB?

Every organization has unique variables and constraints to consider. As such, the CCEB is not in a position to comment on, or confirm, the actions of specific organizations.

We do keep in contact with peers in high stakes testing and most have not yet rescheduled any cancelled administrations. Many organizations, like the CCEB, are seeking every avenue available to provide as much continuity to candidates as possible. The CCEB is fortunate to have three examination administrations annually and, as



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such, we have another available/secured date within approximately four months of the cancelled spring administration.

The CCEB exercised forethought in mid-March and expanded the space we had secured for the fall administration. At that time, the cancellation of the spring administration was not being considered but precautionary measures were taken. As such, we have sufficient space secured for our examinations in the fall; with many examinations being cancelled and moved to later dates, this is a fortunate position for the CCEB. As the situation develops, we continue to think strategically and create contingency plans.

4. If social distancing still applies in October, how will the OSCE be adapted?

The OSCE is designed to test clinical judgement/decision-making and, as such, it is structured to attempt to replicate (as closely as possible in a standardized environment) a clinical environment, which for most provinces remains a face-to-face patient interaction.

It is reasonable to presume that if public health restrictions remain such that chiropractors are not permitted to be in general practice, then our OSCE examination will not be permitted to proceed using the standard testing format.

We are preparing the fall CCEB Component C examinations with an eye to potential public gathering restrictions. We are prepared to permit PPE use and engage additional cleaning protocols if public health authorities deem it safe to do so. We cannot presume to know what level, or type, of public health guidance will be forming best practice in the fall. As mentioned, we continue to explore all available options that can reasonably meet the psychometric requirements of a high-stakes, entry-to-practice examination and our testing objectives. At all times, the CCEB is focused on adhering to public health guidance.

5. Will an online petition have an impact?

It is understandable that candidates are anxious, frustrated, and eager to begin practice in Canada. Candidates are advised to check with your chosen provincial regulatory body with respect to practice restrictions that may be in place in that province.

The CCEB is committed to following Canadian national, provincial, and related local public health guidance to ensure we are doing our part to help contain the spread of COVID-19 and support the safety of all involved in our exams, as well as the broader community. This crisis is not isolated to the CCEB examination administration; the local, national, and global impacts continue to unfold with remarkable speed, fluidity,



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and tragic loss of life. The administration of the CCEB examination will continue to be determined based on public health guidance and psychometrically valid administration principles.

Rose Bustria

From: Jo-Ann Willson
Sent: Wednesday, May 13, 2020 2:22 PM
To: Rose Bustria
Subject: Fwd: Video recording from May 8 townhall | Forum du 8 mai : Enregistrement vidéo
Attachments: image001.png; ATT00001.htm; Questions Members.Membres 8.5.2020 _ENFR.F0520.pdf; ATT00002.htm

Registration and Council.

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

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Begin forwarded message:

From: Suzette Martin-Johnson <admin1@cceb.ca>
Date: May 13, 2020 at 2:21:25 PM EDT
To: Suzette Martin-Johnson <admin1@cceb.ca>
Subject: Video recording from May 8 townhall | Forum du 8 mai : Enregistrement vidéo

Thank you to those who were able to attend the CCEB Member Town Hall on Friday May 8th, 2020. We know these are very busy and challenging times for every organization. In order to support continued communication and transparency, we are pleased to share a [video recording](#) of the Martek presentation.

Additionally, we are attaching the questions (and answers) that were raised during the call. We hope you find this information valuable.

If you or your council have any questions about the CCEB examination, our COVID response, or high-stakes testing in general, we are here to support you. Don't hesitate to contact me anytime at gbeierback@cceb.ca.

Merci à tous ceux qui ont pu assister au forum des membres du CCEB tenu le vendredi 8 mai 2020. Nous vivons tous des jours difficiles et nous savons que vous

êtes très occupés. Pour renforcer la communication et la transparence, nous sommes heureux de partager un [enregistrement vidéo](#) de la présentation effectuée par Martek.

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Nous incluons d'ailleurs en p.j. les questions qui ont été soulevées pendant l'appel et les réponses y afférant. Nous espérons que ces informations vous seront utiles.

Si vous ou votre conseil avez des questions concernant l'examen du CCEB, notre réponse à la COVID ou les tests à enjeux élevés en général, nous sommes là pour vous aider. N'hésitez pas à me contacter à gbeierback@cceb.ca.

Sincerely | Bien cordialement,



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CCEB townhall questions May 8, 2020 |

Questions du forum des membres tenu le 8 mai 2020

1. What are the cost considerations with remote proctoring? | 1. Quelles sont les répercussions sur les coûts si l'on considère la surveillance à distance?

The cost of remote proctoring is varied based on the specific third-party product/tier selected. The most secure level of service, which would be the most appropriate choice in a high-stakes testing environment, would result in increased Component A and B administration costs.

The in-person multiple choice written exam, our current format, benefits from economies of scale, whereas remote proctoring is a per candidate cost.

Using the actual candidate numbers and costs from our most recent winter examination, the cost to administer that exam using remote proctoring would have been 30% higher than the actual cost.

When considering the estimated larger scale of the fall administration and the anticipated costs to administer that examination, we anticipate remote proctoring would result in approximately 50% increase in cost.

Le coût de la surveillance à distance varie en fonction du produit / niveau sélectionné parmi les services offerts par les tiers. Le niveau de service le plus sûr, qui serait l'option la plus appropriée dans un environnement de test à enjeux élevés, entraînerait une augmentation des coûts d'administration des Composantes A et B.

L'examen écrit à choix multiples en personne, notre format actuel, bénéficie d'économies d'échelle, tandis que la surveillance à distance implique un coût par candidat.

Si on parle des effectifs et des coûts réels de notre dernier examen hivernal, le coût d'administration de cet examen aurait augmenté de 30% avec la surveillance à distance.

Lorsque nous considérons les coûts de l'administration de l'automne, qui aura potentiellement davantage de candidats, nous prévoyons que la surveillance à distance entraînerait une augmentation d'environ 50% des coûts.

2. What would need to happen for the CCEB to adopt remote proctoring (what are the 'conditions')? | Quelles sont les « conditions » pour que le CCEB adopte la surveillance à distance?

As Dr. Marini indicated, the best course of action is to maintain our current administration practices. We have performed the due diligence required to be prepared to move to secure remote proctoring for Components A and B, should the ongoing COVID-19 pandemic continue to impact our ability to administer an examination using typical testing conditions.

The CCEB continues to prepare, and create contingency, for an in-person examination administration, including contemplating various social distancing and maximum gathering size restrictions. This is the preferred course of action at this time.

Tout comme le Dr. Marini l'a indiqué, la meilleure solution consiste à maintenir nos pratiques administratives actuelles. Nous avons exercé la diligence raisonnable requise pour nous préparer à passer à la surveillance à distance sécurisée pour les Composantes A et B, si la pandémie de COVID-19 continue d'avoir un impact sur notre capacité à administrer un examen dans les conditions de test typiques.

Le CCEB prépare et crée des contingences pour une administration d'examen en personne, y compris en envisageant des restrictions d'éloignement sanitaire et de taille maximale de rassemblement. C'est l'option préférée en ce moment.

3. What alternatives to the OSCE are being considered? What about screens and hazmat suits? | Quelles alternatives à l'ECOS sont envisagées? Qu'en est-il des écrans protecteurs et des combinaisons contre des matières dangereuses?

The Objective Structured Clinical Examination (OSCE) is designed specifically to evaluate clinical judgement in a standardized environment. The intent is to replicate as closely as possible the practice environment, including patient interactions. This is achieved by using professional standardized patients (SPs). These individuals are highly trained, which is very important to enhance the standardization of the examination administration. As such, the requirements of the OSCE with respect to psychometric requirements create a significant barrier to remote proctoring. There is a critical need for the candidate to interact with various SP's and be examined by diverse examiners.

The CCEB is preparing contingency with respect to facilities, in the event the medical centres we use for the OSCE testing are not open.

The CCEB is preparing for reasonable PPE requirements and will be permitting candidates to bring their own PPE as well as providing PPE to our staff, contractors and volunteers.

The CCEB is monitoring the COVID-related practice requirements being released by regulators so that we may ensure that our own standards in our testing environment are a close match to the expectations of regulators for their existing registrants.

L'examen clinique objectif structuré (ECOS) est conçu spécifiquement pour évaluer le jugement clinique dans un environnement normalisé. L'objectif est de reproduire le plus fidèlement possible l'environnement de pratique, y compris les interactions avec les patients. Ceci est réalisé en utilisant des patients standardisés professionnels (les PS). Ces personnes sont hautement qualifiées, ce qui est très important pour améliorer la standardisation de l'administration des examens. Donc, les exigences de l'OSCE en ce qui concerne les exigences psychométriques créent un obstacle important au contrôle à distance. Le candidat doit interagir avec divers PS et être examiné par divers examinateurs.

Le CCEB prépare des mesures d'urgence en ce qui concerne les installations, dans le cas où les centres médicaux que nous utilisons pour les tests de l'OSCE ne sont pas ouverts.

Le CCEB se prépare à des exigences raisonnables en matière d'EPI. Nous permettrons aux candidats d'apporter leur propre EPI et nous fournirons de l'EPI à notre personnel, nos sous-traitants et nos bénévoles.

Le CCEB se tient au courant des exigences de pratique liées à la COVID publiées par les organismes réglementaires. Ceci assure que les normes dans notre environnement de test satisfont aux attentes des organismes réglementaires pour leurs inscrits existants.

4. Is there a desire to have other CCEB Member Town Hall meetings? | Veut-on organiser d'autres forums de membres du CCEB?

CCEB Chair Dr. Elli Morton asked members to share their feedback with us regarding this Town Hall format or any additional ways we can improve. If members find value in the Town Hall sessions, we will happily continue to host them. Please email gbeierback@cceb.ca with your thoughts.

Dre Elli Morton, Présidente du CCEB, a demandé aux membres de nous communiquer leurs commentaires au sujet de ce forum ou de toute autre façon que nous pourrions nous améliorer. Si les membres apprécient le format des forums, nous continuerons volontiers à les accueillir. Veuillez envoyer un email à gbeierback@cceb.ca pour partager votre opinion.

**College of Chiropractors of Ontario
Executive Committee Report to Council (Virtual)
June 17, 2020**

- Members:** Dr. Dennis Mizel, *President*
Mr. Rob MacKay, *Vice-President*
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

- Let me start my report by reminding all Council members that Ontario continues to be under an Emergency Order of government until at least June 30, 2020. We are all trying our best to prioritize CCO core functions while maintaining the health and safety of everyone, including all staff who continue to work remotely to the extent possible. I very much appreciate everyone's efforts during a very difficult time, and I appreciate your ongoing support as we navigate through uncharted waters.
- There are two agendas for June 17, 2020. One agenda relates to the high priority business matters to be addressed by Council (marked Council Meeting Agenda (Business Meeting)). I trust and hope that we can proceed through the business agenda efficiently. If there is something requiring a great deal of discussion and debate, it should be moved to a future agenda, or referred to the appropriate committee to do a further work up of the issue.
- My understanding is that there will be many guests at the June 17, 2020 meeting. I am hoping we can finish the approval of the minutes, adoption of consent and main agenda, review of the camera matters from 8:30 a.m. to 9:00 a.m. Following that, Mr. Joel Friedman will grant access to join the meeting from the many guests who have expressed a desire to attend. Thank you to the Discipline Committee for reviewing a draft undertaking for observers at discipline hearings. There is a similar document for guests at CCO's virtual Council meetings that guests will be asked to sign and return before being provided with the link to the meeting.

- If we can move through the business portion of the meeting efficiently, I would like to take a brief break from approximately 10:15 a.m. – 10:30 a.m., following which Ms Willson will conduct the internal elections. The material for that portion of the meeting is reflected in the second agenda for June 17, 2020, marked Council Meeting Agenda (Elections) – June 17, 2020.
- Since the last meeting of Council, the Executive Committee (“Committee”) has met virtually on May 12, 2020. The draft, confidential minutes are included in the Council information package, and are subject to review and approval. This report highlights the Committee’s efforts and actions over the past several weeks.

III Communications/Strategic Planning

- A major priority since the last report to Council, has been ongoing communications to stakeholders, including members, providing updates on CCO activities, and guidance on how to comply with and practise chiropractic consistent with the various government orders and directives. I know Ms Willson has participated in many virtual meetings with the Ministry of Health and other health regulators as matters have evolved. The five President's Messages that have been distributed to stakeholders since the last report to Council are included in the Council information package. A great deal of work has gone into keeping the messages concise, consistent with direction from government, informative, and reflective of CCO's commitment to doing business differently during a world health crisis. There has been helpful feedback about these messages (overwhelmingly positive), and from a communications perspective, it appears shorter more frequent communications done electronically may best facilitate CCO's strategic objectives.
- Council members should know that the colleges received only a couple of hours' notice that Directive # 2 would be changing to permit health professionals to return to work. Fortunately, CCO had already communicated back to work guidance to members. CCO had also prepared and distributed the two graphics to accompany the guidance, one for members, and one for patients, to put into simple visual form, what the requirements were. When we received the go ahead from government, we only had to make minor amendments to what had already been communicated.
- The Committee has considered many appropriate topics for the next strategic planning session when it is safe to meet in person. The in-person meetings previously scheduled at the White Oaks in September 2020 have been cancelled. We don't know at this time when the hotels will be reopening to accommodate corporate functions. Some of the topics being considered include emergency preparedness and policy, CCO position Statement/Guideline on Chiropractic and the Immune System, Core Competencies for Council members and Evaluation.

- I encourage all Council members who have ideas about strategic planning or other training topics to forward them to Ms Willson and me on an ongoing basis. What may be more appropriate at this time is for Council members to forward any suggestions for training sessions which would be done virtually over the next several weeks.

IV Ministry of Health

- There has been and will be some transition in CCO's public members. I'd like to thank Ms Sheryn Posen whose term has concluded. Ms Posen has requested in lieu of a gift, that we make a donation to the Royal College of Chiropractic Sports Sciences, and we would be pleased to do so. I would also like to thank Ms Karoline Bourdeau who has served on many committees during her tenure including the Executive Committee, Patient Relations Committee and Discipline Committee. Ms Bourdeau chaired the virtually hearings which took place at CCO on May 14, 2020. These hearings were the first hearings held virtually by any health regulatory college in Ontario during the pandemic, involved very serious allegations of sexual abuse, and were attended by the complainants in each case, as well as over 100 members of the public (many of whom were CMCC students). Thank you, Karoline! We have learned a great deal from you and wish you every success moving forward.
- I previously welcomed Mr. Gagan Singh, and very much look forward to meeting him in person at the earliest opportunity. CCO has another public member who was with us briefly before advising that he would be unable to serve on the Council because of a family emergency requiring his full time and attention. The Ministry has been advised. In the interim, CCO is properly constituted.
- Council members will recall that in determining CCO's key audiences and stakeholders, we need to be mindful of both interest in and influence over the CCO in categorizing stakeholders. One of the stakeholders with a high level of interest and influence in the Ministry of Health. The Ministry will be soon ramping up its efforts to develop a framework for the evaluation of the performance of colleges. Mr. Thomas Custers addressed Council in April 2019 about this.

- In view of the high level of interest in and influence over CCO by the Ministry, some public members have expressed concern about one or more patient advocates, who may be distracting CCO from other public protection work. Although there may not be enough time to fully discuss this issue, time permitting, I'd like the public members who have expressed concern to briefly outline their concerns. Any further action plan will be carefully considered by the Committee.

V By-laws/Policy Review and Recommendations

- At the May 12, 2020 Committee meeting, the Committee had the opportunity to review some matters of long standing, which should be prioritized. The Committee has the following recommendations for Council's consideration:

Recommendation 1

That Council approve the by-law amendments reflected in the proposed by-law amendment chart.

- Please note, that these amendments reflect best practices from other colleges, are consistent with past Council decisions and have been reviewed by Richard Steinecke who confirms these amendments do not require circulation. At the April 15, 2020 meeting there was a discussion about the requirement to change auditors every five years. Council members will note from the information in the Council information package that this is not considered a best practice for many reasons, including that it tends to increase costs without increasing accountability. Accordingly, the Committee is recommending revocation of the five-year change of auditors requirement.
- With that change, the Committee has the following recommendation which was deferred from the April 15, 2020 meeting;

Recommendation 2

That Council approve the appointment of Tator, Rose and Leong for the 2021 fiscal year.

- To be consistent with changes to the By-law amounts reflected in By-law 4: Banking and Finance, the Committee has the following recommendation:

Recommendation 3

That Council approve amendments to I-017: Procurement of Goods and/or Services.

- The Committee also reviewed CCO's Rules of Order, and has the following recommendation:

Recommendation 4

That Council approve the Rules of Order as amended.

VI CCO Committees

- At various times Council has reviewed and considered the need for and appropriate mandate of the Advertising Committee, which is a nonstatutory committee which reports under the terms of reference to the Executive Committee. The Committee was of the view that it would be most efficient if the terms of reference reflected the committee's role in reviewing proposed advertisements to ensure overall consistency with CCO's Advertising provisions, and that policy work, such as the review of the relevant standards, policies and procedures, be done by the Executive Committee. The Committee has the following recommendations for Council:

Recommendation 5

That Council approve the revised terms of reference for the Advertising Committee.

Recommendation 6

That Council approve the revised terms of reference for the Executive Committee.

- I am aware of the extraordinary efforts of many of CCO's committees over the course of the past several weeks. Thank you to the Inquiries, Complaints and Reports Committee which has efficiently addressed an unprecedented number of complaints. The Discipline Committee has continued to hold hearings on serious public interest matters and has led the way in terms of determining how to maximize the use of technology to ensure discipline matters continue to be addressed in an open, transparent and fair manner. The Registration Committee is grappling with what may be one of the most important policy decisions to be made by CCO Council over the past several years. The committee is exercising due diligence by seeking feedback from stakeholders and engaging an expert to ensure its policy recommendations are based on best available evidence and are focused on public interest. Thank you to those committees as well who decided it made sense to defer any meetings at this time until there is some easing of the global pandemic.
- Given the unanticipated and challenging times we have all faced, I think it would be prudent for all committee chairs to carefully review their budgets, priorities, and work plans in light of different pressures and priorities arising from the pandemic. If you think there will be significant changes in your financial requirements either because of workload or the need to have business done differently, please forward that information to Ms Willson and me at the earliest opportunity. I anticipate the Committee will be reviewing the implications of the pandemic on CCO's approved budget at the upcoming meeting on August 14, 2020.

VII Chiropractic/Health Related Stakeholders

- During the pandemic, CCO has communicated on an ongoing basis with many stakeholders and has participated in many virtual meetings. Council members will note the following:
 - The Ontario Chiropractic Association is requesting feedback on their opioid clinical tool; time permitting, Council should have a discussion to facilitate feedback on June 17, 2020;
 - The Canadian Chiropractic Association is recommending that the various provisions relating to tele practise continue after the pandemic; it may be most appropriate for this matter to be deferred to the Quality Assurance Committee for review and recommendation to Council; and

- The Canadian Chiropractic Examining Board has had several Town Hall Meetings to discuss its action plans arising from the cancellation of the Spring 2020 examinations.

VIII Conclusion

This has been a challenging and rewarding term as President. I don't think any of us predicted the enormous challenges that would be facing CCO, Ontario and in fact the entire world. I thank each of you for your ongoing commitment to CCO, for your flexibility in learning to do things differently, and your patience as we all try our best to monitor the action being taken by government while maintaining CCO's core functions. It has been an honour and a privilege to serve as CCO President over the last term. I give a special shout out to the CCO staff who have kept the operations going and have supported me and all of you over the past year including the past many difficult weeks. It does appear there is room for cautious optimism, and I look forward to supporting CCO Council over the next several months. Thank you.

Respectfully submitted by,

Dr. Dennis Mizel,
President

From: College of Chiropractors of Ontario <cco.info@cco.on.ca>
Sent: Tuesday, June 9, 2020 2:31 PM
To: Joel Friedman
Subject: President's Message #10 re: COVID-19 - June 9, 2020



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

President's Message #10 re: COVID-19 - Tuesday, June 9, 2020

There have been many important turning points throughout the province's response to the unprecedented COVID-19 pandemic, perhaps none as significant for Ontario chiropractors as the May 26, 2020 Ministry of Health announcement that amended its previous [Directive #2](#) to allow for all deferred and "non-essential" and elective services offered by health care practitioners to be gradually restarted.

We were well positioned to meet the [stringent ministerial requirements](#) for the gradual resumption of full service, as CCO had earlier provided to members comprehensive and authoritative guidelines for a safe and compliant return to practice. (**Please note:** these guidelines have now been updated to further reinforce Ontario health ministry directives and can be [found here](#). Members are advised to review these guidelines again and to implement the updated measures as required.)

In the wake of the May 26 announcement, licensed practitioners across Ontario have begun providing the full range of chiropractic services to the public - while following strict COVID-19 protocols to ensure public and workplace safety. Members must adhere to these protocols and remain vigilant in mitigating the risk of transmission as they re-open their practices.

Optimizing technology in support of openness and accountability

One of CCO's strategic objectives is to optimize the use of technology to facilitate regulatory functions and communications. I am proud to say that the College has demonstrated its commitment to this objective

through its adaptive and accountable response to managing remotely CCO's core business during the pandemic.

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The CCO Discipline Committee's virtual hearings held on May 14, 2020 are but one example. As a result of the temporary suspension of in-house hearings due to pandemic concerns, the Committee held two virtual hearings, respecting the values of openness, transparency, accountability and fairness. Conducted over a videoconferencing platform, the hearings were attended by more than 100 members of the public, while the confidentiality of the complainants was maintained by orders from the Committee panel that prohibited the sharing of any identifying information during the hearing.

In an article titled [*Leading the way forward: Modernizing access to justice*](#) Colin Stevenson, Independent Legal Counsel to the Discipline Committee, wrote recently that:

"Administrative tribunals have already conducted videoconference hearings. The College of Chiropractors of Ontario was the first regulated health profession to hold discipline hearings using Zoom videoconferencing."

This was indeed a first, but it will definitely not be the last instance of CCO striving to be at the forefront of using technology wisely to support its core business - pandemic or not. (In fact, CCO is scheduled to have the its first *virtual* internal elections on June 17, 2020.)

Flexibility and scrutiny in licensing new registrants

The CCO Registration Committee met on June 2, 2020 to consider the best way to ensure a transparent, fair and impartial registration of applicants who are unable to complete the Canadian Chiropractic Examining Board (CCEB) examinations cancelled because of COVID-19. The Committee expects to have a recommendation for CCO Council shortly about addressing the impact of the cancellation. I should point out, though, that the situation is not unique to the CCO, and we have had discussions with other health regulators in Ontario and other chiropractic regulators across Canada to consider and share best practices.

The Registration Committee understands that there are compelling public interest reasons for accommodating applicants for registration who cannot attempt the examinations. At the same time, it recognizes that exempting applicants from having to successfully pass the examinations, even temporarily, is a major concession that requires adequate alternative safeguards. As soon as is practical, applicants who have been temporarily exempted will have to complete the examinations. Moreover, holders of provisional licenses will only be able to practise under a

stringent set of terms, conditions and limitations designed to ensure the safety and well-being of the public.

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I look forward to being able, along with my fellow members of CCO Council, to evaluate the Registration Committee's proposed recommendations and communicate the Council's decision in the future.

And let me thank once again all members who have closely followed and adhered to Ministry of Health and CCO directives over the past few weeks and who continue to maintain the highest standards of practice in serving the public interest. COVID-19 remains a persistent concern and we are reminded daily by the province that we must all continue to work to minimize its spread.

But before I close - a bit of good news. CCO would like to thank Dr. Colleen Patrick, CCO member since 1975, and artist, for her painting entitled *Sustenance*, which was unveiled on March 10, 2020 and will be hung in the CCO's Members' Lounge for everyone to enjoy when CCO reopens its premises.



Sincerely,

Dennis N. Mizel DC

Dr. Dennis Mizel, President

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COVID-19**Directive #2 for Health Care Providers (Regulated Health Professionals or Persons who operate a Group Practice of Regulated Health Professionals)****Issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7**

THIS DIRECTIVE REPLACES THE DIRECTIVE #2 ISSUED ON MARCH 19th, 2020. THE DIRECTIVE #2 ISSUED ON MARCH 19th, 2020 IS REVOKED AND THE FOLLOWING SUBSTITUTED:

WHEREAS under section 77.7(1) of the HPPA, if the Chief Medical Officer of Health (CMOH) is of the opinion that there exists or there may exist an immediate risk to the health of persons anywhere in Ontario, he or she may issue a directive to any health care provider or health care entity respecting precautions and procedures to be followed to protect the health of persons anywhere in Ontario;

AND WHEREAS, On March 17th, 2020 an emergency was declared in Ontario due to the outbreak of COVID-19, pursuant to Order-in-Council 518/2020 under the *Emergency Management and Civil Protection Act*;

AND HAVING REGARD TO, the emerging evidence about the ways this virus transmits between people as well as the potential severity of illness it causes in addition to the declaration by the World Health Organization (WHO) on March 11th, 2020 that COVID-19 is a pandemic virus and the spread of COVID-19 in Ontario;

AND HAVING REGARD TO the potential impact of COVID-19 on the work of regulated health professionals, the need to protect regulated health professionals in their workplaces, and the need to prioritize patients who have or may have COVID-19 in the work that regulated health professionals and certain health care entities undertake;

AND HAVING REGARD TO the need to gradually restart health services for the people of Ontario, based on a reduction of COVID-19 activity;

I AM THEREFORE OF THE OPINION that there exists or may exist an immediate risk to the health of persons anywhere in Ontario from COVID-19;

AND DIRECT pursuant to the provisions of section 77.7 of the HPPA that:

Directive #2 for Health Care Providers dated March 19th, 2020 is revoked and replaced with this Directive.

COVID-19

Directive #2 for Health Care Providers (Regulated Health Professionals or Persons who operate a Group Practice of Regulated Health Professionals)

Date of Issuance: May 26, 2020

Effective Date of Implementation: May 26, 2020

Issued To:

- **Health Care Providers** (Regulated Health Professionals or persons who operate a Group Practice of Regulated Health Professionals, defined in section 77.7(6), paragraph 1 of the *Health Protection and Promotion Act*)

Health Care Providers must provide a copy of this directive to the co-chairs of the Joint Health & Safety Committee or the Health & Safety Representative (if any).

Introduction

Coronaviruses (CoV) are a large family of viruses that cause illness ranging from the common cold to more severe diseases such as Middle East Respiratory Syndrome (MERS-CoV), Severe Acute Respiratory Syndrome (SARS-CoV), and COVID-19. A novel coronavirus is a new strain that has not been previously identified in humans.

On December 31st, 2019, the World Health Organization (WHO) was informed of cases of pneumonia of unknown etiology in Wuhan City, Hubei Province in China. A novel coronavirus (COVID-19) was identified as the causative agent by Chinese authorities on January 7th, 2020.

On March 11th, 2020 the WHO announced that COVID-19 is classified as a pandemic virus. This is the first pandemic caused by a coronavirus.

On March 17th, 2020 the Premier declared an emergency in Ontario under the *Emergency Management and Civil Protection Act* due to the outbreak of COVID-19 in Ontario and Cabinet made emergency orders to implement my recommendations of March 16th, 2020.

On March 19th, 2020, I issued a Directive to Health Care Providers requiring all non-essential and elective services to be ceased or reduced to minimal levels, subject to allowable exceptions, until further notice. That Directive is now replaced by this Directive.

Approach

This Directive reflects a gradual restart of deferred services. Where possible, health care providers are encouraged to limit the number of in-person visits for the safety of health care providers and their patients.

It remains important for Health Care Providers to continue to monitor COVID-19 spread in their community and to carefully and gradually restart services. Examples of sources of data to use in monitoring local COVID-19 spread include, but are not limited to: [Ontario.ca](https://www.ontario.ca), [Public Health Ontario](https://www.ontario.ca/public-health), and local public health unit data dashboards.

The gradual restart of services should be carried out in coordination with, and adherence to guidance from, applicable health regulatory colleges. If appropriate, coordination should also be undertaken with local and regional Health Care Providers and Health Care Entities.

In collaboration with health system partners and technical experts from Public Health Ontario and the broader health system, emerging evidence will be continually reviewed to understand the most appropriate measures to take to protect Health Care Providers and patients.

Symptoms of COVID-19

For signs and symptoms of COVID-19 please refer to the latest [COVID-19 Reference Document for Symptoms](#) on the Ministry of Health's [COVID-19 Guidance for the Health Sector Website](#).

Complications from COVID-19 can include serious conditions, like pneumonia or kidney failure, and in some cases, death.

There are no specific treatments for COVID-19, and there is no vaccine that protects against coronaviruses. Most people with COVID-19 illnesses will recover on their own.

Requirements for Health Care Providers (Regulated Health Professionals or Persons who operate a Group Practice of Regulated Health Professionals)

The following steps are required by Health Care Providers:

- All deferred and non-essential and elective services carried out by Health Care Providers may be gradually restarted, subject to the requirements of this Directive.
- In the gradual restart of services, Health Care Providers must comply with the requirements as set out in [COVID-19 Operational Requirements: Health Sector Restart \(May 26, 2020 or as current\)](#), including, but not limited to, the hierarchy of hazard controls.
- Health Care Providers must consider which services should continue to be provided remotely and which services can safely resume in-person with appropriate hazard controls and sufficient PPE.
- Health Care Providers should be sourcing PPE through their regular supply chain. PPE allocations from the provincial pandemic stockpile will continue. PPE can also be accessed, within available supply, on an emergency basis through the established escalation process through the Ontario Health Regions.
- Subject to the requirements of this Directive, Health Care Providers are in the best position to determine which services should continue to be provided remotely (online, by telephone or other virtual means) and which should be provided in-person. This should be guided by best clinical evidence. Health Care Providers must also adhere to the guidance provided by their applicable health regulatory college, and the following principles:
 - **Proportionality.** Decision to restart services should be proportionate to the real or anticipated capacities to provide those services.
 - **Minimizing Harm to Patients.** Decisions should strive to limit harm to patients wherever possible. Activities that have higher implications for morbidity/mortality if delayed too long should be prioritized over those with fewer implications for morbidity/mortality if delayed too long. This requires considering the differential benefits and burdens to patients and patient populations as well as available alternatives to relieve pain and suffering.

- **Equity.** Equity requires that all persons with the same clinical needs should be treated in the same way unless relevant differences exist (e.g., different levels of clinical urgency), and that special attention is paid to actions that might further disadvantage the already disadvantaged or vulnerable.
- **Reciprocity.** Certain patients and patient populations will be particularly burdened as a result of our health system's limited capacity to restart services. Consequently, our health system has a reciprocal obligation to ensure that those who continue to be burdened have their health monitored, receive appropriate care, and be re-evaluated for emergent activities should they require them.

Decisions regarding the gradual restart of services should be made using processes that are fair to all patients.

Questions

Health Care Providers subject to this Directive may contact the ministry's Health Care Provider Hotline at 1-866-212-2272 or by email at emergencymanagement.moh@ontario.ca with questions or concerns about this Directive.

Health Care Providers are also required to comply with applicable provisions of the [Occupational Health and Safety Act](#) and its Regulations.



David C. Williams, MD, MHSc, FRCPC
Chief Medical Officer of Health

Ministry of Health

COVID-19 Operational Requirements: Health Sector Restart

Version 1.0 – May 26, 2020

This document provides operational details and requirements as referenced in Directive #2 dated May 26, 2020. It is not intended to take the place of medical advice, diagnosis, treatment, or legal advice.

- Please check the [Ministry of Health \(MOH\) COVID-19 website](#) regularly for updates to this document, case definition, testing guidance, the latest 'COVID-19 Reference Document for Symptoms', 'COVID-19 Patient Screening Guidance Document', other guidance documents, mental health resources, and other COVID-19 related information.
- Please check the [Directives, Memorandums and Other Resources](#) page regularly for the most up to date Directives issued by the Chief Medical Officer of Health.
- Additional information regarding emergency orders can be found [here](#).

This document is intended for Health Care Providers (Regulated Health Professionals or persons who operate a Group Practice of Regulated Health Professionals, defined in section 77.7(6), paragraph 1 of the [Health Protection and Promotion Act](#)).

Context

On March 19, 2020, the Chief Medical Officer of Health issued Directive #2 for Health Care Providers (Regulated Health Professionals or Persons who operate a Group Practice of Regulated Health Professionals) as part of the response to the COVID-19 pandemic. This Directive required that all non-essential and elective services be ceased or reduced to minimal levels, subject to allowable exceptions, until further notice.

On May 26, 2020, Directive #2 was amended to support the gradual restart of all deferred and non-essential and elective services carried out by Health Care Providers (HCPs). Where possible, HCPs are encouraged to limit the number of in-person visits for the safety of health care providers and their patients.

As part of the gradual restart of services, HCPs are in the best position to determine which services can continue to be offered remotely (virtually) and which services can safely resume in-person, assuming the necessary preconditions as set out in this Operational Requirements document are met.

The gradual restart of services should be carried out in coordination with, and adherence to guidance from, applicable health regulatory colleges. If possible, coordination should also be undertaken with local and regional Health Care Providers and Health Care Entities.

HCPs should also adhere to the guidance of their regulatory colleges when determining when and how to resume service delivery, and all decisions around service resumption should be guided by the four foundational principles in Directive #2 (included in [Appendix A](#)). Regulatory colleges should provide additional guidance to their members regarding the gradual restart of services that are essential to be provided in person, and those that can be provided virtually (e.g., phone consultations, virtual assessments, etc.).

All HCPs are encouraged to implement a system for virtual and/or telephone consultations when and where possible. HCPs should conduct an initial consultation over the phone, video, or secure messaging to determine if a virtual/telephone consultation is appropriate or whether an in-person appointment is necessary. The purpose of this is to support physical distancing and minimize contact of persons who may have COVID-19 with health care settings (i.e. other HCPs and patients) as much as possible.

HCPs are also encouraged to seek opportunities to modify the delivery of services. Modifications could include the use of services that reduce patient time spent in health care settings, use of virtual care (e-consults, virtual medical assessments, etc.), home care, and post-operative remote monitoring programs.

This document outlines measures that must be in place in order to meet public health guidelines and promote a safe environment for the provision of in-person health services by HCPs.

Recommended Risk Assessments

Organizational Risk Assessment

Each Health Care Entity should conduct an organizational risk assessment (ORA) as a precondition to restarting services. An ORA is a systematic approach to assessing the efficacy of control measures that are in place to mitigate the transmission of infections in a health care setting.

Organizations that employ HCPs have a responsibility to provide education and training to HCPs regarding the organization's ORA.

Point of Care Risk Assessment

A Point of Care Risk Assessment (PCRA) assesses the task, the patient, and the environment. A PCRA should be completed by the HCP before every patient interaction to determine whether there is a risk to the provider or other individuals of being exposed to an infection, including COVID-19.

A PCRA is the first step in routine practices, which are to be used with all patients, for all care and all interactions.

Hierarchy of Hazard Controls

The application of the following hierarchy of hazard controls is a recognized approach to containment of hazards, including health hazards, and is fundamental to occupational health and safety.

1. Elimination and Substitution

Elimination and substitution are considered to be the most effective means in the hierarchy of controls. However, they are often not feasible to implement within all health care settings.

- Examples include: not having patients physically come into the office/clinic, telemedicine, etc.

2. Engineering and Systems Control Measures

These measures help reduce the risk of exposure to a pathogen or infected source hazard by implementing methods of isolation or ventilation. These measures work to reduce exposure by isolating the hazard from the worker and by physically distancing actions to reduce the opportunity for transmission.

- Examples include: physical barriers like plexiglass barriers for administrative staff. A plexiglass barrier can protect reception staff from sneezing/coughing patients.

3. Administrative Control Measures

Administrative control measures aim to reduce the risk of transmission of infection to staff and patients through implementing policies, procedures, training, and education with respect to infection prevention and control.

- Examples include: [active screening](#), [passive screening](#) (signage), and restricted visitor policies.

4. Personal Protective Equipment (PPE)

PPE controls are the last tier in the hierarchy of hazards controls and should not be relied on as a stand-alone primary prevention program. An employer of an HCP plays a critical role in ensuring staff have access to appropriate PPE for the task to be performed, and the necessary education/training to ensure competency on the appropriate selection, use, maintenance, and disposal of PPE.

- Examples of PPE include: gloves, gowns, facial protection (including surgical/procedure masks and N95 respirators), and/or eye protection (including safety glasses, face shields, goggles, or masks with visor attachments).

Screening

Active Screening

- Patients and [essential visitors](#) should be screened over the phone for symptoms of COVID-19 before coming for their appointments. The latest [COVID-19 Patient Screening Guidance Document](#) on the [MOH COVID-19 website](#) should be used and may be adapted as needed and appropriate for screening purposes. If a patient or essential visitor screen positive over the phone, the appointment should be deferred if possible and the individual referred for testing.
- Staff should conduct screening of patients and essential visitors on site. Staff should ideally be behind a barrier to protect from contact/droplet spread. A plexiglass barrier can protect reception staff from sneezing/coughing patients. If a plexiglass barrier is not available, staff should maintain a 2-metre distance from the patient. Screeners who do not have a barrier and cannot maintain a 2-metre distance should use contact/droplet precautions. This includes the following PPE: gloves, isolation gown, a surgical/procedure mask, and eye protection (goggles or face shield).
 - If a patient or an essential visitor screens positive, the appointment should be deferred if possible and the individual referred for testing.
- For reference, a full list of common COVID-19 symptoms is available in the [COVID-19 Reference Document for Symptoms](#) on the [MOH COVID-19 website](#). Atypical symptoms and signs of COVID-19 are also included in this document and should be considered, particularly in children, older persons, and people living with a developmental disability.

Passive Screening

- Signage should be posted at the entrance to the office/clinic and at reception areas requiring all patients/essential visitors to wear a face covering (if available and tolerated), perform hand hygiene, and then report to reception to self-identify. Sample signage is available on the [MOH COVID-19 website](#) (scroll to the bottom of the page). Fact sheets on how to wear a mask and how to perform hand hygiene are available on the Public Health Ontario (PHO) website.

- Signage should be accessible and accommodating to patients and essential visitors (e.g., plain language, pictures, symbols, languages other than English and French).

Positive Screening: Providing Care

- HCPs may offer clinical assessment and examination to patients who screen positive **only if** they are able to follow Droplet and Contact precautions and are knowledgeable on how to properly don and doff PPE. This includes the following PPE: gloves, isolation gown, a surgical/procedure mask, and eye protection (goggles or face shield).
- If HCPs are not able to follow Droplet and Contact precautions and/or are not knowledgeable on how to properly don and doff PPE, they should divert the care of the patient as appropriate. This includes: to the emergency department, for testing and patient care, if the reason for the medical visit is urgent; or to an assessment centre, for testing, if the medical reason for the medical visit can be deferred.
- Patients who screen positive should be given a surgical/procedure mask and be advised to [perform hand hygiene](#). Ensure patients do not leave their masks in waiting areas. The patient should be immediately placed in a room with the door closed (do not cohort with other patients), where possible, to avoid contact with other patients in common areas of the office/clinic (e.g., waiting rooms). If it is not possible to move a patient from the waiting room to an available exam room, the patient can be instructed to return outside (e.g., vehicle or parking lot, if available and appropriate) and informed that they will be texted or called when a room becomes available.
- Patients should be provided with hand sanitizer (if available), access to tissues, and a hands-free waste receptacle for their used tissues and used masks. All patients should be instructed to cover their nose and mouth with a tissue when coughing and sneezing, dispose of the tissue in the receptacle and to use the hand sanitizer right afterwards. Patients may also be instructed to take their surgical/procedure mask home with them with instructions for doffing masks.

Testing

- Testing for COVID-19 should be undertaken for all patients as per below. The exception being runny nose or nasal congestion related to an underlying condition such as seasonal allergies or post-nasal drip. In the event a patient tests positive for COVID-19 and requires health services, the HCP should determine if services can be deferred until the patient is cleared (see [Quick Reference Public Health Guidance on Testing and Clearance](#)).
 - Symptomatic testing:
 - **All patients with at least one symptom** of COVID-19, even for mild symptoms. Please refer to the [Testing Guidance](#) for details about these symptoms.
 - Asymptomatic, risk-based testing:
 - **Patients who are concerned that they have been exposed to COVID-19.** This includes people who are contacts of or may have been exposed to a confirmed or suspected case.
 - **Patients who are at risk of exposure to COVID-19 through their employment,** including essential workers (e.g., health care workers, grocery store employees, food processing plants).
- If the HCP is properly equipped and trained to conduct testing, then testing can be conducted onsite. All other cases should be referred elsewhere for testing (Assessment Centre, Telehealth (1-866-787-0000), Primary Care Provider, etc.).
- HCPs should refer to the latest [Testing Guidance](#) and take into account the nature of the service being provided when determining whether a COVID-19 test is required prior to delivering services.

Physical Capacity/Environment

- Ensure that there is sufficient space to follow physical distancing guidelines of maintaining at least 2 metres from other people.
 - Redesign physical settings and interactions to minimize contact between individuals where possible (e.g., space out chairs in the waiting room, consider traffic flow for common spaces, limit the number of people in an elevator, place markings in hallways, install plexiglass barrier at reception, establish an alternate service delivery site).

- Minimize the need for patients/visitors to wait in the waiting room (e.g., spread out appointments, have patients stay outside office/clinic until the examination room is ready for them).
- Provide face coverings when physical distancing is not possible, and if a patient is not wearing their own face covering. Ensure that patients do not leave their masks in waiting areas.
- Provide tissues and lined garbage bins for use by staff and patients. No-touch garbage cans (such as garbage cans with a foot pedal) are preferred.
- Ensure there are enough supplies on hand for proper hand hygiene, including pump liquid soap in a dispenser, running water, and paper towels or hot air dryers. If possible and appropriate, consider adding alcohol-based hand rub (ABHR) stations throughout the setting. Use ABHRs with 60% - 90% alcohol.
- Post [signage](#) throughout the building/office reminding staff and patients about the [signs and symptoms of COVID-19](#), and the importance of proper hand hygiene, physical distancing, and respiratory etiquette.
- Ensure there is designated space to isolate staff who develop COVID-19 symptoms and immediately send them home if possible.
- If a patient has or develops COVID-19 symptoms, the HCP should provide assessment and care to the patient if possible/appropriate and feasible following OHS requirements. When it is not possible/appropriate or feasible to provide assessment and care, patients should be referred for further assessment and support for COVID-19 (referral to Primary Care Physician, Telehealth (1-866-787-0000), [Self-Assessment Tool](#), etc.).

Critical Supplies and Equipment

- To support safe service delivery, HCPs and employers must ensure a stable supply of drugs, PPE, and other essential supplies and must review the supply in place considering local and regional sector inter-dependencies.
- Appropriate stewardship of PPE is required to reduce negative impacts on other parts of the health system. Employers remain responsible for sourcing and providing PPE to their frontline workers in accordance with their responsibilities to ensure workplace safety under the [Occupational Health and Safety Act](#). The provincial government has created a [PPE Supplier Directory website](#) to assist workplaces in sourcing PPE.

- Different services require different levels of PPE. HCPs should reference [Ministry of Health guidance](#) to ensure adherence to guidance on appropriate PPE levels based on the type of interaction with the patient and the type of health care setting.
- HCPs and employers should be sourcing PPE through their regular supply chain. PPE allocations from the provincial pandemic stockpile will continue. PPE can also be accessed, within available supply, on an emergency basis through the established escalation process through the Ontario Health Regions.
- HCPs will need to conserve the use of PPE in their settings through the application of the hierarchy of controls as noted above.
- Additional information on [Occupational Health and Safety](#) is available below.

Health Human Resources (HHR)

- Employers and HCPs must ensure adequate staffing to provide services, including ensuring there is adequate PPE for staff members in the health setting based on the organizational risk assessment and application of the hierarchy of controls. Consideration should also be given to preserving HHR capacity where possible as part of planning for future surges/outbreaks.
- Minimize staff in the health care setting. Consider what tasks can be done from home or outside of regular hours to minimize staff interactions with each other and patients.
- All staff and HCPs should [self-monitor](#) for COVID-19 symptoms at home and not come to work if feeling ill.
- HCPs who have returned from travel outside of Ontario in the last 14 days and/or have had a confirmed, unprotected exposure to a person with COVID-19 may continue to work with specific precautions if they are critical to operations. Refer to the [How to Self-isolate while Working fact sheet](#) and the [Quick Reference Sheet Public Health Guidance on Testing and Clearance](#) available on the [MOH COVID-19 website](#).

Sector Inter-dependencies and Collaboration

- Employers and HCPs must ensure that the restart of services aligns with the restart of related services. For example, with the resumption of scheduled surgeries, related diagnostic, primary care, and rehabilitation services must also be able to resume service delivery.

- Employers and HCPs should plan collaboratively within their regions and communities to ensure a coordinated gradual resumption of services, ensuring a holistic approach across the health system. HCPs and employers must ensure that the gradual restart of services takes into consideration health system and community capacity.

Infection Prevention and Control

- Employers should have written measures and procedures for staff safety including for infection prevention and control. These should be easily accessible to staff and opportunities/resources for education should be provided.
- After every patient visit, whether the patient is symptomatic or not, patient-contact surfaces (i.e., areas within 2 metres of the patient) should be disinfected as soon as possible, and before another patient is seen. Treatment areas, including all horizontal surfaces, and equipment used on the patient (e.g., exam table, thermometer, BP cuff) should be cleaned and disinfected before another patient is brought into the treatment area or used on another patient. Refer to Provincial Infectious Diseases Advisory Committee's [Best Practices for Environmental Cleaning for Prevention and Control in All Health Care Settings](#) for more information about environmental cleaning.
- All common areas should be regularly cleaned (e.g., daily) following PHO's [guidance on cleaning and disinfection for public settings](#). In addition:
 - Plexiglass barriers are to be included in routine cleaning (e.g. daily) using a cleaning product that will not affect the integrity or function of the barrier.
 - Non-essential items are recommended to be removed from patient care areas to minimize the potential for these to be contaminated and become a potential vehicle for transmission (e.g., magazines and toys).
- If a patient was in the health care setting and later tests positive for COVID-19, HCPs, if aware, are encouraged to call their [local public health unit](#) for advice on their potential exposure and implications for continuation of work.

Essential Visitors

In order to reduce the risk of COVID-19 transmission, visitors should be limited to those who are essential.

- HCPs and employers should determine what visitors are considered 'essential' based on the COVID-19 data in their local community.
- Considerations of which visitors are considered essential should include: those who are visiting/accompanying a patient who is dying or very ill, a parent/guardian of a child or youth who is a patient, visitors of patients who require physical assistance (e.g., who need to be driven home following a procedure), and individuals providing essential support to a patient.
- Essential visitors must be actively screened prior to entering a health care setting to visit or as a support to a patient. In the event an essential visitor screens positive, they should be referred for further assessment and testing (Assessment Centre, Telehealth (1-866-787-0000), Primary Care Provider, [Self-Assessment Tool](#)) and should not be permitted to attend with the patient pending test results. Where possible, services should be deferred until symptoms have resolved.

Occupational Health & Safety

HCPs must comply with [Directives](#) as applicable.

Personal Protective Equipment (PPE)

Summary of required precautions are displayed in the table below

Activity	HCP Precautions
Before every patient interaction	HCP must conduct a point-of-care risk assessment to determine the level of precautions required
All interactions with and within 2 metres of patients who screen positive	Droplet and Contact precautions: <ul style="list-style-type: none"> • Surgical/procedure mask* • Isolation gown • Gloves • Eye protection (goggles or face shield) • Perform hand hygiene before and after contact with the patient and the patient environment and after the removal of PPE
All interactions with and within 2 metres of patients who screen negative	<ul style="list-style-type: none"> • Surgical/procedure mask required • Use of eye protection (goggles or a face shield) should be considered • Perform hand hygiene before and after contact with the patient and the patient environment and after the removal of PPE

*N95 respirator must be worn for Aerosol-Generating Medical Procedures (AGMPs)

- Given community spread of COVID-19 within Ontario and evidence that transmission may occur from those who have few or no symptoms, masking (surgical/procedure mask) for the full duration of shifts for HCPs and other staff working in direct patient care areas is recommended.
- The use of a surgical/procedure mask is also recommended for all staff working outside of direct patient care areas when interacting with other HCPs and staff and physical distancing cannot be maintained. The rationale for full-shift masking is to reduce the risk of transmitting COVID-19 infection from HCPs to patients or other facility staff. This is a form of source control. Use of eye protection (e.g., goggles or a face shield) for the duration of shifts should be strongly considered in order to protect staff when there is COVID-19 infection occurring in the community.
- Detailed precautions for HCPs by activity and procedure are listed in PHO's [Technical Brief on Updated IPAC Recommendations for Use of PPE for Care of Individuals with Suspect or Confirmed COVID-19](#).
- HCPs should assess the availability of PPE and other infection prevention and control supplies that are used for the safe management of suspected and confirmed COVID-19 cases.
- HCPs who are required to wear PPE must be trained in the use, care, and limitations of PPE, including the proper sequence of donning and doffing PPE. Visual factsheets for '[Putting on PPE](#)' and '[Taking off PPE](#)' are available on [PHO's website](#). Videos are also available on [PHO's website](#).

Staff Illness

- Where a case involves staff considered likely to have been infected as a result of a workplace exposure, employers are reminded of their duty to notify the Ministry of Labour, Training and Skills Development for occupational illnesses.
- Staff, including HCPs, who test positive for COVID-19 should report their illness to their manager/supervisor or to Employee Health/Occupational Health and Safety as per usual practice.
- In accordance with the [Occupational Health and Safety Act](#) and its regulations, an employer must provide written notice within four days of being advised that a worker has an occupational illness, including an occupationally-acquired infection, or if a claim has been made to the Workplace Safety and Insurance Board (WSIB) by or on behalf of, the worker with respect to an occupational illness or infection, to the:

- Ministry of Labour, Training and Skills Development,
- Joint Health and Safety Committee (or health and safety representative),
and
- Trade union, if any.
- Occupationally-acquired infections and illnesses are reportable to the WSIB.
Work Restrictions for HCPs
- For guidance regarding work restrictions and when to return to work, HCPs should refer to the COVID-19 Quick Reference Public Health Guidance on Testing and Clearance document. The recommendations in the document take into account the HCW's symptoms or lack thereof, test results, and the staffing capacity of the facility.
- HCPs should also report to their Employee Health/Occupational Health and Safety department before returning to work.

Resources

Public Health Ontario:

- [Infection Prevention and Control \(IPAC\) On-Line Learning](#)
- [Infection Prevention and Control Fundamentals](#)

Ontario Government:

- [Workplace PPE Supplier Directory](#)

Appendix A

Decisions related to the gradual restart of services should be made using fair, inclusive and transparent processes for all patients following the principles articulated in Directive #2 (May 26, 2020):

- **Proportionality.** Decision to restart services should be proportionate to the real or anticipated capacities to provide those services.
- **Minimizing Harm to Patients.** Decisions should strive to limit harm to patients wherever possible. Activities that have higher implications for morbidity/mortality if delayed too long should be prioritized over those with fewer implications for morbidity/mortality if delayed too long. This requires considering the differential benefits and burdens to patients and patient populations as well as available alternatives to relieve pain and suffering.
- **Equity.** Equity requires that all persons with the same clinical needs should be treated in the same way unless relevant differences exist (e.g., different levels of clinical urgency), and that special attention is paid to actions that might further disadvantage the already disadvantaged or vulnerable.
- **Reciprocity.** Certain patients and patient populations will be particularly burdened as a result of our health system's limited capacity to restart services. Consequently, our health system has a reciprocal obligation to ensure that those who continue to be burdened have their health monitored, receive appropriate care, and be re-evaluated for emergent activities should they require them.

GUIDANCE FOR RETURN TO PRACTICE FOR CCO MEMBERS WHEN AUTHORIZED BY GOVERNMENT (DURING COVID-19 PANDEMIC)



Approved: May 15, 2020

Came into Force when the Ontario Government Announced Effective Date for Return to Work for Chiropractors: May 26, 2020

Amended: June 9, 2020

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

Introduction

The intent of this document is to provide guidance to members in returning to work as the Ontario Government allows for businesses to reopen and for chiropractic care to be delivered to all patients.

The Government of Ontario has outlined a framework for reopening businesses in Ontario that takes a gradual, staged approach. Through all stages, public health and safety will be the number one concern, while balancing the needs of patients and businesses.

On May 26, 2020, the Ministry of Health amended [Directive #2 for Health Care Providers \(Regulated Health Professionals or Persons who operate Group Practice of Regulated Health Professionals\)](#) to restart non-essential and elective services and released the [COVID-19 Operational Requirements: Health Sector Restart Document](#). Please review these documents for directives and operational details and requirements for all regulated health professionals.

As regulated health professionals, members are required to review and follow the directives and guidance from the Ministry of Health, Public Health Ontario, the Chief Medical Officer of Health and other authoritative bodies regarding practices during COVID-19. In implementing office policies, members should continuously assess the organizational and point of care risks for infection control. In addition, members are responsible for and expected to prioritize the safety of their patients, staff, colleagues and others visiting their practice. CCO publications, including this document, provide authoritative guidance on how to achieve this overarching duty. Of course, chiropractors are expected to use professional judgment. Some of the guidance may not apply in some circumstances (e.g., the spacing of chairs in the waiting area may not be necessary if patients are required to wait outside (perhaps in their cars) before being called in) and in other circumstances the guidance may be insufficient to meet your duty of safety (e.g., for patients with concurrent conditions that require additional safeguards).

This guidance document is current as of the date of publication and amendment and will continue to be updated as directives from the Ontario Government change. To the extent that directives and guidance from the Ministry of Health, Public Health Ontario, the Chief Medical Officer of Health and other authoritative bodies regarding practices during COVID-19 and this guidance document differ, chiropractors should apply the higher standard. It is the responsibility of the member to ensure staff working at a chiropractic office are appropriately trained in proper practices related to patient

interactions, hygiene and cleaning and disinfection. As well, members should ensure they have protocols in place to ensure there are enough supplies on hand and that supplies are replenished.

Decisions related to practice should be made using fair, inclusive and transparent processes for all patients, applying the following principles, identified by the Ministry of Health and Chief Medical Officer of Health:

- **Proportionality:** Decision to restart services should be proportionate to the real or anticipated capacities to provide those services.
- **Minimizing Harm to Patients:** Decision should strive to limit harm to patients wherever possible. Activities that have higher implications for morbidity/mortality if delayed too long should be prioritized over those with fewer implications for morbidity/mortality if delayed too long. This requires considering the differential benefits and burdens to patients and patient populations as well as available alternatives to relieve pain and suffering.
- **Equity:** Equity requires that all persons with the same clinical needs should be treated in the same way unless relevant differences exist (e.g. different levels of clinical urgency), and that special attention is paid to actions that might further disadvantage the already disadvantaged or vulnerable.
- **Reciprocity:** Certain patients and populations will be particularly burdened as a result of our health system's limited capacity to restart services. Consequently, our health system has a reciprocal obligation to ensure that those who continue to be burdened have their health monitored, receive appropriate care, and be re-evaluated for emergent activities should they require them.

Please see the Appendix of this document for links to additional resources from authoritative bodies regarding COVID-19.

Overview of Interactions with Patients

1. Initial Screening Procedures
 - a. Active Screening
 - b. Passive Screening
 - c. Keeping a register for contact tracing
2. Conducting In-person Appointments
 - a. Physical Distancing
 - b. Hygiene
 - c. Use of Personal Protective Equipment (PPE)
 - d. Cleaning and Disinfection
3. Monitoring for Symptoms for Members and Staff

1. Initial Screening Procedures

All members must undertake active and passive screening before any in-person interactions with patients and essential visitors. Ideally, screening should take place over the phone or through a secure teleportal (e.g. via an online screening questionnaire). A member should also conduct this screening with staff prior to attending the office in person. Any in office screening should maintain physical distancing of at least 2 metres.

It is expected that members are using their best clinical judgment when conducting screening procedures, reviewing all relevant clinical information and screening results in the context of the patient's overall presentation and general history. It would also be reasonable to expect members are conducting the screening process, taking into account geographical locations of patient's homes, workplaces and the clinical setting. For example, when communities may be divided by a provincial border that would otherwise be considered one community, it is likely there is no greater risk to a health care provider on one side of the border over the other. Alternatively, if a patient recently returned from a community with high COVID-19 rates to their community which may have very low rates, there might be a higher risk to health care providers, patients and staff even when no border was crossed.

Active Screening

- Conducted over the phone or through teleportal before patient/essential visitor interaction.
- When possible, upon entry at office.

Passive Screening

- Appropriate signage at points of entry of the office and at reception in a location that is visible before entering the clinic:
(Examples of signage for visitors for health care settings provided by Ministry of Health – members should use signs appropriate to their setting of care)
 - [English](#)
 - [French](#)
- Screening messages communicated on office websites and voicemail.

Members should follow the patient [screening guidance document](#) from the Ontario Ministry of Health (please refer to the Ministry of Health screening document if there are any inconsistencies with this document, as the Ministry of Health screening document continues to be updated). Regular screening questions are as follows:

1. Did the person have close contact with anyone with acute respiratory illness or travelled outside of Ontario in the past 14 days?
2. Does the person have a confirmed case of COVID-19 or had close contact with a confirmed case of COVID-19?
3. Does the person have any of the following symptoms: fever, new onset of cough, worsening chronic cough, shortness of breath, difficulty breathing, sore throat, difficulty swallowing, decrease or loss of sense of taste or smell, chills, headaches, unexplained fatigue/malaise/muscle aches (myalgias), nausea/vomiting, diarrhea, abdominal pain, pink eye (conjunctivitis), runny nose/nasal congestion without other known cause?
4. If the person is 70 years of age or older, are they experiencing any of the following symptoms: delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions?

If a patient has answered yes to any of these questions, they should be advised to:

- not attend in person at the member's office for at least 14 days, unless the member is able to follow strict Droplet and Contact Precautions (see further description below);
- get tested for COVID-19;
- complete the [Ontario Government's self-assessment](#); and
- contact an appropriate authority such as their family physician, [local medical officer of health](#) or [Telehealth Ontario](#).

Members must document the screening of patients as part of the record of personal health information as well as keep documentation of screening of staff.

Please note: patients who have screened positive is not equivalent to a confirmed diagnosis of COVID-19.

A member who forms the opinion that a person has or may have COVID-19 is required to report this to the medical officer of health of the health unit in which the professional services are provided, in accordance with section 25(1) of the [Health Protection and Promotion Act, 1990](#) and [Standard of Practice S-004: Reporting of Designated Diseases](#).

In conducting screening, a member should consider whether in-person treatment is the most advisable one taking into consideration the patient's other conditions and whether they fall into a high-risk group. When appropriate a member is encouraged to consider telecare¹ as an option.

If a member encounters a patient or staff who exhibits signs and symptoms consistent with the COVID-19, the member must:

- Establish and maintain a safe distance or two metres;
- Have the patient complete hand hygiene;
- Provide a new mask for the patient to don;
- Separate the patient from others in the clinic;
- Explain the concern to the patient that they are symptomatic, discontinue treatment and reschedule the appointment;
- Advise the patient to self-isolate for at least 14 days, complete the online self-assessment and contact their local medical officer of health;
- Clean and disinfect the practice area immediately; and
- Keep a record of all close contacts of the symptomatic patient and other visitors and staff in the clinic at the time of the visit. This information will be necessary for contact tracing if the patient later tests positive for COVID-19.

Members must not attempt a differential diagnosis of patients who present signs and symptoms of COVID-19.

¹ Please see [President's Message](#) from Friday, April 17, 2020

Members may offer clinical assessment and examination to patients who screen positively **only** if they are able to follow Droplet and Contact precautions and are knowledgeable on how to properly don and doff PPE. This includes the following PPE: gloves, isolation gown, surgical/procedural mask and eye protection (goggles or face shield). Please see the [COVID-19 Operational Requirements: Health Sector Restart Document](#) sections on Positive Screening: Providing Care and Occupational Health & Safety sections for further details. Members must take enhanced measures for PPE, infection control, physical separation and cleaning and disinfection of such patients.

If a patient was in the office and later tests positive for COVID-19, the member should contact their [local public health unit](#) upon learning of this positive result, for advice on their potential exposure and implications for continuation of work

Keeping a Register for Contact Tracing

A register of all people entering the setting should be kept to help in contact tracing, if required. This would include people in the clinic aside from patients/clients (e.g. couriers, guardians accompanying a patient/client, etc). The register should include name and telephone number. This is not an open sign-in book and should be kept and managed privately by the clinic. This registry should be kept until further notice. Explain to visitors that this information will be used for contact tracing only, should someone who visited the setting later be diagnosed with COVID-19.

2. Conducting In-Person Appointments

Physical Distancing

Members, office staff, patients and other individuals should remain **two metres** away from each other within the office whenever possible, including in:

- waiting areas,
- transition areas and hallways,
- reception and payment areas, and
- treatment areas.

It is recommended that a suitable barrier (e.g. plexiglass) be used to protect staff and the reception area. This is required if physical distancing will be less than 2 metres. Outside of a barricaded reception area, facemasks must be worn when staff interact with patients, essential visitors and other staff within a 2 metre distance.

Member should take practical measures to ensure physical distancing, such as reconfiguring clinical spaces and waiting rooms, having patients wait outside until their appointment time, removing waiting room chairs, adjusting staff and patient schedules to reduce the number of patients in the office, restricting access to practice environments to those who must be present (including patients, patient chaperones, staff) and consideration of off hour appointments for high-risk populations (e.g. for those patients who may have answered “yes” to any screening questions and/or may be front line/essential workers and/or at-risk populations). Special considerations to accommodate appropriate physical distancing should be put in place (e.g. one patient at a time) when providing care in an open concept treatment space.

Patients should be encouraged to use credit card or debit cards for payment. Limit contact by allowing patients to scan/tap/swipe their own credits cards and limit the exchange of paper whenever possible (e.g., use email receipts).

Please note: Due to the number of variables related to possible transmission, cleaning and disinfecting, PPE, exposure to other individuals and geographical location, member must be aware of the possible increased risks involved with providing home care. As such, it may be difficult to account for all safety measures when providing home care. Members may consider the suitability of providing home care, while considering all applicable risks, when appropriate safety measures can be put in place.

Hygiene

Hand hygiene is the most effective way of preventing the transmission of infections to patients and staff in clinics. Members and staff should be educated in proper hand hygiene practices. Members, staff and patients should wash their hands with soap and water or hand sanitizer when appropriate, including:

- after arriving and entering the clinic
- before and after each patient interaction
- before and after use of diagnostic or therapeutic equipment
- before and after changing a mask or other Personal Protective Equipment
- before and after processing any payments wens contactless payment is not possible
- before and after leaving the clinic
- when hands are visibly soiled
- before and after cleaning/disinfection procedures

Members, staff and patients should avoid touching their faces and practice respiratory etiquette by coughing or sneezing into their elbow or covering coughs and sneezes with a facial tissue and disposing of the tissue immediately. The use of lined garbage cans and those with no-touch lids (e.g. cans with a foot pedal) are preferred. When contact with the face or a tissue is made, hand hygiene must occur before resuming any activities in the clinic environment.

Please see the [following resources](#) for hand washing directives from Public Health Ontario.

Use of Personal Protective Equipment (PPE)

Despite screening procedures, it is important to remember that individuals may carry COVID-19 and not demonstrate symptoms. Therefore, for proper contact/droplet precautions, members must be familiar with and implement the use of appropriate PPE for both health care practitioners and staff when in close contact with patients, especially during manual procedures, consistent with the protocols of the Ministry of Health and Public Health Ontario and the [COVID-19 Operational Requirements: Health Sector Restart Document](#). This would include the requirement to use a surgical/procedural mask (cloth masks not appropriate for health care practitioners) when treating patients within a physical distance of two metres. Members should avoid touching or adjusting masks while they are being worn. Members may also want to consider the use of eye protection, such as goggles or face shield for practitioners and staff when in close contact with patients. N95 respirators are unlikely to be required for chiropractic offices, as typical chiropractic procedures do not involve aerosol generating medical procedures. Enhanced PPE (Droplet and Contact procedures and PPE including gloves, isolation gown, surgical/procedural mask and

eye protection (goggles or face shield)) are required to be used when treating patients who may have provided positive responses in their screening process, such as front-line workers.

As part of the progressive opening plan, Government has communicated that members of the public wear face coverings when going out in public and physical distancing of 2 metres cannot be maintained. Therefore, members must remind patients to wear a face covering (cloth face coverings are acceptable for patients) for appointments that involve examination and treatment where physical distancing of 2 metres cannot be maintained. If a patient cannot wear a face covering (e.g. due to a health condition or difficulty breathing), the member must use their professional judgment to assess the risk of providing examination or treatment to that patient. In accordance with the [COVID-19 Operational Requirements: Health Sector Restart Document](#), members must provide a face covering to a patient when physical distancing is not possible, and if the patient is not wearing their own face covering. Members must educate patients in the proper donning and doffing of masks when providing a face covering to a patient. Members should ensure that patients do not leave their masks in the waiting area.

Single use gloves may be used but are not required for most chiropractic services, unless the member is using Droplet and Contact precautions to provide care to a patient who has answered yes to an active screening question. If gloves are used, members should not touch their face when wearing gloves, gloves should be changed in between each patient encounter and be accompanied by proper hand hygiene between every glove change.

Please see pages 11-12 of the [COVID-19 Operational Requirements: Health Sector Restart Document](#) for further required precautions for the use of PPE in different scenarios. Please see the [Ontario Government's PPE Supplier Directory Website](#) to assist in sourcing PPE.

The following procedures should be followed for donning and doffing masks:

Donning mask:

1. Perform hand hygiene.
2. Put on mask. Secure ties to head or elastic loops behind ears. Mould the flexible band to the bridge of nose (if applicable). Ensure snug fit to face and below chin with no gaping or venting.

Doffing mask:

1. Perform hand hygiene.
2. Carefully remove mask by bending forward slightly, touching only the ties or elastic loops. Undo the bottom tie first and then undo the top tie. Discard the mask in the garbage.
3. Perform hand hygiene.

Members, staff and patients should be aware of and follow the proper donning, doffing and use of PPE, specifically masks. Members should review and apply the resources from the Ministry of Health and Public Health Ontario related to the use of masks. One mask may be used for multiple patients (possibly an entire shift), but must be discarded and replaced when wet, damaged or soiled, exposed to bodily fluids, when taking a break and at the end of the day. The use of PPE must be precise and ordered to limit the spread of COVID-19.

Members and staff should practice in clean clothes that have not been worn in public places or with exposure to other individuals.

Please see the following resources for use of PPE from Public Health Ontario:

- [COVID-19 Operational Requirements: Health Sector Restart Document](#)
- [Public Health Ontario Resources](#)
- [Public Ontario Guide for PPE](#)
- [Public Ontario Guide for Universal Mask Use](#)
- [Public Services Health & Safety Association: Health and Safety Guidance During COVID-19 for Physician and Primary Care Provider Employers](#)

Cleaning and Disinfection

Cleaning refers to the removal of visible soil. Cleaning does not kill germs but is highly effective at removing them from a surface. Disinfecting refers to using a chemical to kill germs on a surface. Disinfecting is only effective after surfaces have been cleaned. Use a “wipe-twice” method to clean and disinfect. Wipe surfaces with a cleaning agent to clean off soil and wipe again with a disinfectant.

Regular household cleaning and disinfecting products are effective against COVID-19 when used according to the directions on the label. Use a disinfectant that has a Drug Identification Number (DIN) and a virucidal claim (efficacy against viruses). Alternatively, use a bleach-water solution with 100 ml of bleach to 900 ml water. Health Canada has approved several [hard-surface disinfectants](#) and [hand sanitizers](#) for use against COVID-19. Use these lists to look up the DIN number of the product you are using or to find an approved product. Make sure to follow instructions on the product label to disinfect effectively.

Members should schedule patient appointments to allow for a suitable time for proper cleaning and disinfection in the office. The frequency of cleaning and disinfection is dependent on the nature of use/contact of the surface/item in question. Members should follow the cleaning and disinfection protocols from Public Health Ontario. For example, after every patient visit, whether the patient is symptomatic or not, patient-contact surfaces (i.e. areas within 2 metres of the patient) should be disinfected as soon as possible, before another patient is seen.

The following is a list (not exhaustive) of areas that will need to be addressed as part of the cleaning and disinfection protocols, conducted at least daily:

- Chiropractic adjusting tables
- Diagnostic and therapeutic tools and devices
- Diagnostic and therapeutic surfaces such as any exercise or rehabilitation equipment
- All surfaces in treatment rooms
- Computers, telephone and other devices in reception area
- Entry, reception, waiting, washroom and transition areas such as hallways, doorways etc. as well as any furniture in those areas
- Staff rooms and furniture in those areas
- Other touch surfaces as identified in the clinic, such as light switches, doorknobs, toilets, taps, handrails, countertops, touch screens, mobile devices, phones, keyboards, payment machines, clipboards, pens.

Cleaning and disinfecting protocols:

- Clinical contact surfaces should be cleaned and disinfected after each patient encounter.
- Any materials on clinical contact surfaces that cannot be properly disinfected shall not be used.
- Patient contact items such as payment machines, reception counter, seating areas, door and handrails should be cleaned and disinfected after each patient encounter.
- Books, magazines, toys, etc. should be removed from patient areas.
- A regular schedule for periodic environmental cleaning should be established and documented.
- Members should use single-use equipment instead of shared high touch equipment whenever possible.
- Any areas or equipment that patients occupy should be regularly cleaned and disinfected, particularly high touch surfaces.
- Any cloth items, such as towels, sheets, and headrest coverings that are used in the clinic, must be laundered in hot water (above 60 degrees Celsius). Staff that are handling these items should be gloved for both dirty and clean laundry processing. Staff must always use new gloves when handling clean laundry.

Please see the [following resources](#) from Public Health Ontario for further guidance on cleaning and disinfection.

3. Monitoring for Symptoms for Members and Staff

Guidance for employers

Employers have a legal duty under Ontario's *Occupational Health and Safety Act* to take every reasonable action to protect the health and safety of workers. This duty is particularly important in the context of COVID-19, where there is a need to protect workers and the public from contracting the virus.

Employers should carefully review the sector specific guidelines highlighted below and make reasonable efforts to implement the recommended actions. Otherwise, they could face charges and prosecution under the *Occupational Health and Safety Act*, and employees have the right to refuse work if employers do not take the recommended precautions.

The guidance documents currently available are listed below, by sector or practice setting. Keep in mind that guidance is likely to evolve as the pandemic evolves. It is important to refer back to the links below regularly:

- [Ministry of Health guidance for the healthcare sector](#)
- [Ministry of Health COVID-19: Operational Requirements: Health Sector Restart](#)
- [Sector-specific guidance for employers from the Public Services Health and Safety Association](#)
- [Sector-specific guidance from the Ministry of Labour](#)

Members and staff must self-screen for COVID-19 before attending in person at the clinic, using the same screening questions used for patients.

If member or staff screens positive and/or exhibits any symptoms of COVID-19, they must stay home or be sent home and should follow the advice of public health officials before returning to work, including getting tested for COVID-19. Please see the [Ministry of Health COVID-19 Provincial Testing Guidance Update](#) for further details around testing.

When employees go home sick, their work areas must be cleaned and disinfected. Upon recommendation by public health officials, the member or staff may return to work at the clinic. The advice of Public Health officials shall be followed regarding impact on clinic operations during these periods. There may also be reporting requirements to the Ministry of Labour and others in these circumstances.

Appendix: Resources and Links Related to COVID-19

Directive #2 for Health Care Providers (Regulated Health Professionals or Persons who operate a Group Practice of Regulated Health Professionals)

- http://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/directives/RHPA_professionals.pdf

How Ontario is Responding to COVID-19

- <https://www.ontario.ca/page/how-ontario-is-responding-covid-19#section-0>

Ontario Government: Health and Safety Association Guidance Documents for Workplaces During the COVID-19 Outbreak

- https://www.news.ontario.ca/opo/en/2020/04/health-and-safety-association-guidance-documents-for-workplaces-during-the-covid-19-outbreak.html?_ga=2.201752599.76004541.1588429546-1834799787.1584580203
- https://www.ontario.ca/page/resources-prevent-covid-19-workplace?_ga=2.258073421.652386584.1589286222-295529957.1588594081

Ontario Ministry of Health COVID-19 Guidance for the Health Sector

- MOH COVID-19 Operational Requirements – Health Sector Restart – May 26, 2020
http://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/operational_requirements_health_sector.pdf
- MOH COVID-19 Guidance for Health Sector
http://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/2019_guidance.aspx
- MOH COVID-19 Provincial Testing Guidance
http://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/2019_covid_testing_guidance.pdf

Ontario Ministry of Health COVID-19 Reference Documents for Symptoms, Patient Screening and Self Assessment

- MOH COVID-19 Reference Document for Symptoms
http://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/2019_reference_doc_symptoms.pdf
- MOH COVID-19 Patient Screening Document
http://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/2019_patient_screening_guidance.pdf
- Ontario Government COVID-19 Self-Assessment <https://covid-19.ontario.ca/self-assessment/>

Public Health Ontario COVID-19 Health Care Resources

- Public Health Ontario COVID-19 Health Care Resources
<https://www.publichealthontario.ca/en/diseases-and-conditions/infectious-diseases/respiratory-diseases/novel-coronavirus/health-care-resources>
- Public Health Ontario Recommended Steps for Putting on Personal Protective Equipment
<https://www.publichealthontario.ca/-/media/documents/ncov/ipac/ppe-recommended-steps.pdf?la=en>

Public Health and Services Safety Association: Health and Safety Guidance During COVID-19 for Physician and Primary Care Provider Employers and Acute Care

- <https://www.pshsa.ca/resources/health-and-safety-guidance-during-covid-19-for-physician-and-primary-care-provider-employers>



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

ITEM 4.1.19

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President's Message #9 re: COVID-19 - Tuesday, May 26, 2020

The Ministry of Health today announced that, after approximately 2 1/2 months in which health professionals were limited to providing urgent/emergency and telehealth services only to patients, it has amended [Directive #2](#) to allow for "all deferred and non-essential and elective services carried out by Health Care Providers" *to be gradually restarted*, subject to a number of requirements contained in the amended Directive.

In other words, Ontario chiropractors can, under certain conditions, start the process of getting back to our work and our driving passion - providing the highest quality care for all our patients!

But, and this is a very important 'but', CCO members must review in detail the re-opening requirements outlined in the documents '[Ministry of Health COVID-19 Operational Requirements: Health Sector Restart](#)' and '[Requirements for Health Care Providers \(Regulated Health Professionals or Persons who operate a Group Practice of Regulated Health Professionals\)](#)' which can be found here.

The documents detail what all health care professionals MUST consider in deciding which services can safely resume in-person, guided by the best clinical evidence and with appropriate hazard controls and sufficient PPE for practitioners and staff alike - and which services should continue to be provided remotely.

The amended directive also makes clear that all health care professionals must follow the restart guidance provided by their health regulatory college. As a reminder, in my previous message I recommended that you prepare for today's announcement by reviewing CCO's '[Guidance for Return to Practice for CCO Members when Authorized by Government](#)', which details the actions to be followed when the go-ahead is given to restart your practices.

You also received two infographics summarizing these guidelines: one for [members](#) and the other for [patients](#). As I wrote then, "This information provides authoritative direction and support for Ontario's chiropractors in prioritizing the safety of their patients, staff, colleagues and others visiting their practice."

The guidance provided by these documents, combined with the comprehensive prerequisites set out in the '[Ministry of Health COVID-19 Operational Requirements: Health Sector Restart](#)' document and '[Requirements for Health Care Providers \(Regulated Health](#)

Professionals or Persons who operate a Group Practice of Regulated Health Professionals'), will ensure the safe resumption of patient care for those who need it in your clinics and workplaces. (If there is any perceived inconsistency between the CCO's guidance and that of the Ministry of Health, the Ministry's requirements certainly take precedence).

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I will stress, though, that the CCO will be looking into any concerns about a practice not following any of these requirements, including, for example, the use of appropriate hazard controls and availability of sufficient PPE.

As we begin a cautious, careful and steady restart process, I know I can count on all of you to adhere to the highest standards of professional conduct in your practices and in your service to your patients and the public.

And let me close by thanking you for your efforts and sacrifices so far. Your commitment to the health and safety of your patients, staff, and the public of Ontario has helped us get to this point where we can begin again to practise our profession in safe and caring clinics and workplaces. Thank you!

Sincerely,

Dr. Dennis Mizel, President

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

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ITEM 4.1.20

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President's Message #8 re: COVID-19 - Friday, May 15, 2020

As you are no doubt aware, on May 14, 2020 the province of Ontario announced an additional [easing of restrictions](#) on [certain workplaces and services](#) as part of the phased approach outlined previously in its framework for re-opening.

There are no immediate changes to the previous directives and guidelines provided by CCO to members as a result of the Ontario government's announcement.

However, this measured approach to reopening allows time for health service providers and business owners to prepare for an eventual reopening, and to ensure that their clinics and workplaces are safe for staff, patients, practitioners and the general public alike.

In keeping with this approach, CCO has prepared the [Guidance for Return to Practice for CCO Members when Authorized by Government \(During COVID-19 Pandemic\)](#) to be followed when, and only when, the provincial government authorizes a return to full, or non-urgent, in-person chiropractic services. Until that authorization is granted, members must continue to follow the previously announced [Ministry of Health Directive #2](#), and previous CCO messages governing the provisions for telecare and provision of urgent/emergency care only.

In addition to the included guidance, CCO has prepared two infographics summarizing the guidance: one for [members](#) and the other for [patients](#). Taken together, this information provides authoritative direction and support for Ontario's chiropractors in prioritizing the safety of their patients, staff, colleagues and others visiting their practice. The documents are meant to ensure you are ready and able to practice as soon as the Ontario government makes the announcement that health professionals may reopen their practices.

CCO continues to work diligently with other Canadian chiropractic regulators, and other health regulators in Ontario, to ensure it is adhering to best practices in its guidance to members and the public about how to safely return to practice.

But let me stress again that these guidelines do not supersede directives from Ministry of Health, Public Health Ontario, or the Chief Medical Officer of Health for Ontario and other authoritative bodies with respect to required measures in response to COVID-19. As regulated health professionals, members are required to review and comply with all these directives and to adhere to the highest standards of professional conduct in their practices and in their service to the public.

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I would ask you to continue to monitor the CCO website for further updates and announcements as we work together to ensure CCO members are ready and able to return to full practice as soon as they are authorized to do so by the provincial government. Please use this time, and the attached guidance, to prepare yourselves and your practices accordingly.

And, again, thank you for your ongoing commitment to the health and safety of your patients, staff, and the public of Ontario.

Sincerely,

Dr. Dennis Mizel, President

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

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Returning to Work for CCO Members

Guidelines for Return to Practice for CCO Members

To Come into Force when the Ontario Government Announces Effective Date for Return to Work for Chiropractors

Review and comply with all government directives and orders to maximize the health and safety of patients and all office staff.

1 Preparation for Before Patient Arrives



All members must undertake and document **Active** and **Passive** screening before any in-person interactions with patients or staff.

Active Screening

- Conducted over the phone or through teleportal before in-person patient visit and/or when the patient arrives at the office

Passive Screening

- Appropriate signage at all points of entry to the office
- Screening messages on office website and voicemail

If a patient answers **yes** to any of the questions on the screening guidance document from the Ontario Ministry of Health, the patient should be advised to:

- Not attend in person at the member's office for at least 14 days
- Complete the Ontario Government's self-assessment
- Contact an appropriate medical authority to report their condition and seek treatment if necessary
- A member who forms the opinion that a person has or may have COVID-19 is required to report this to the medical officer of health of the local health unit

Check List:

- Install signage, rearrange office layout and flow for safe two metre distancing; plexiglass barriers are recommended
- Remove all soft materials (magazines, toys etc.)
- Office cleaning and disinfection
- Minimize staffing
- Appropriate PPE supplies for all staff; consistent with protocols of the Ministry of Health and Public Health Ontario
- Safe patient flow schedule
- Ensure all staff understand new return to work practices and requirements



2 Patient Visits



Physical Distancing

Everyone should remain two metres away from each other when in the office. Appropriate PPE (e.g. surgical/procedural mask) will be used when conducting examinations or treatments within two metres.

Hygiene

Hand hygiene is the most effective way of preventing the transmission of infections to patients and staff. Members should wash their hands frequently, including when entering the clinic, before and after each patient interaction and when changing their PPE.

PPE (members and staff)

- The use of surgical/procedural masks when treating patients within a two metre distance must be consistent with protocols of the Ministry of Health and Public Health Ontario
- Have specific work clothes and home clothes and clean work clothes every day
- Follow appropriate procedures when changing PPE

Cleaning

The frequency of cleaning and disinfection is dependent on the nature of use/contact of the surface/item in question. Members should follow the cleaning and disinfection protocols from Public Health Ontario. This would include cleaning of all diagnostic and treatment tools and treatment surfaces.

Check List:

- Prominent signage for hand hygiene
- Clean and disinfect all surfaces after each patient following the protocols of Public Health Ontario
- Regular periodic environment cleaning
- Access to hand sanitizer for patients and staff
- Contact-less payment process and limiting the exchange of paper wherever possible is encouraged



3 Monitoring for Symptoms



Conducting ongoing regular active and passive screening of patients and staff.

If a patient or member of staff exhibits symptoms of COVID-19, they must stay home or be sent home and the member is required to report this to the medical officer of health of the local health unit.

Check List:

Common Symptoms

- Fever (temperature of 37.8°C or greater)
- New or worsening cough
- Shortness of breath (dyspnea)

Other symptoms can include:

- Sore throat
- Hoarse voice
- Difficulty swallowing
- New olfactory or taste disorder(s)
- Nausea/vomiting, diarrhea, abdominal pain
- Runny nose. Sneezing or nasal congestion



Returning for Treatment – A Patient Guide

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Guidelines for Returning for Treatment With Your Chiropractor

To Come into Force when the Ontario Government Announces Effective Date for Return to Work for Chiropractors

Your Chiropractor will review and comply with all government directives and orders to maximize your health and safety.

1 Preparation Before Your Appointment



To return to treatment, there are some guidelines that you, your Chiropractor and their office staff must follow for everyone's safety.

Active Screening

- Will be conducted over the phone or through teleportal before your in-person visit and/or upon your arrival at the office

Passive Screening

- Please read and adhere to the instructions on the screening signage within your Chiropractor's office

Your Chiropractor will have:

- Installed signage and rearranged their office layout and flow for safe two metre distancing
- Removed all soft materials (magazines, toys etc.)
- Regularly cleaned and disinfected the office
- Minimized staffing
- Has appropriate PPE supplies for all staff
- Has created a safe patient flow schedule
- Has educated all staff with new return to work practices and requirements

Check List:

Before you arrive, **do you have a fever?**

If **No**, then contact your Chiropractor to book an appointment

If **Yes**, please do the following:

- Not attend in person at your Chiropractor's office for at least 14 days
- Complete the Ontario Government's Self-assessment
- Contact an appropriate medical authority to report your condition and seek treatment if necessary
- Your Chiropractor is required to report any suspected or confirmed cases



2 Your Visit



Physical Distancing

Everyone should remain two metres away from each other when in the office. Appropriate PPE (e.g. surgical/procedural mask) will be used when having your examination or treatment within two metres.

Hygiene

Hand hygiene is the most effective way of preventing the transmission of infections to patients and staff. Hands should be washed or hand sanitizer used when entering the clinic, and after leaving the clinic.

Your Chiropractor will:

- Follow the protocols of the Ministry of Health and Public Health Ontario for the use of PPE
- Have specific work clothes and home clothes and clean work clothes every day
- Wash their hands between each patient visit

Cleaning

Your Chiropractor will follow the cleaning and disinfection protocols from Public Health Ontario. This would include cleaning of all diagnostic and treatment tools and treatment surfaces between each patient visit.



Check List:

When at the office **you will:**

- Maintain physical distancing whenever possible - two metres
- Wash or sanitize your hands upon entering the clinic and as you leave. It is highly recommended to wash your hands again as soon as you get to your home
- Use contact-less payment and limit the exchange of paper (i.e. emailed receipt)

3 Monitoring for Symptoms



Continue to conduct ongoing regular screening of your health.

If you exhibit symptoms of COVID-19, please follow the advice of public health officials before infecting others. Your Chiropractor is required to report any suspected or confirmed cases.

Check List:

Common Symptoms

- Fever (temperature of 37.8°C or greater)
- New or worsening cough
- Shortness of breath (dyspnea)

Other symptoms can include:

- Sore throat
- Hoarse voice
- Difficulty swallowing
- New olfactory or taste disorder(s)
- Nausea/vomiting, diarrhea, abdominal pain
- Runny nose. Sneezing or nasal congestion



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

ITEM 4.1.21

President's Message #7 re: COVID-19 - Monday, April 27, 2020

I heard it said recently that the extraordinary nature of this past month has made it feel more like a year. I can certainly appreciate the sentiment. There have been at least a year's worth of challenges and changes as a result of the COVID-19 pandemic, and it remains an evolving situation with no immediate end in sight.

One thing that will not change, however, is the expectation that members adhere to the highest standards of professional conduct in their practices and in their service to the public. CCO has both the statutory obligation - and the complaints reporting, investigation and discipline processes - to ensure compliance with these standards and to regulate in the public interest.

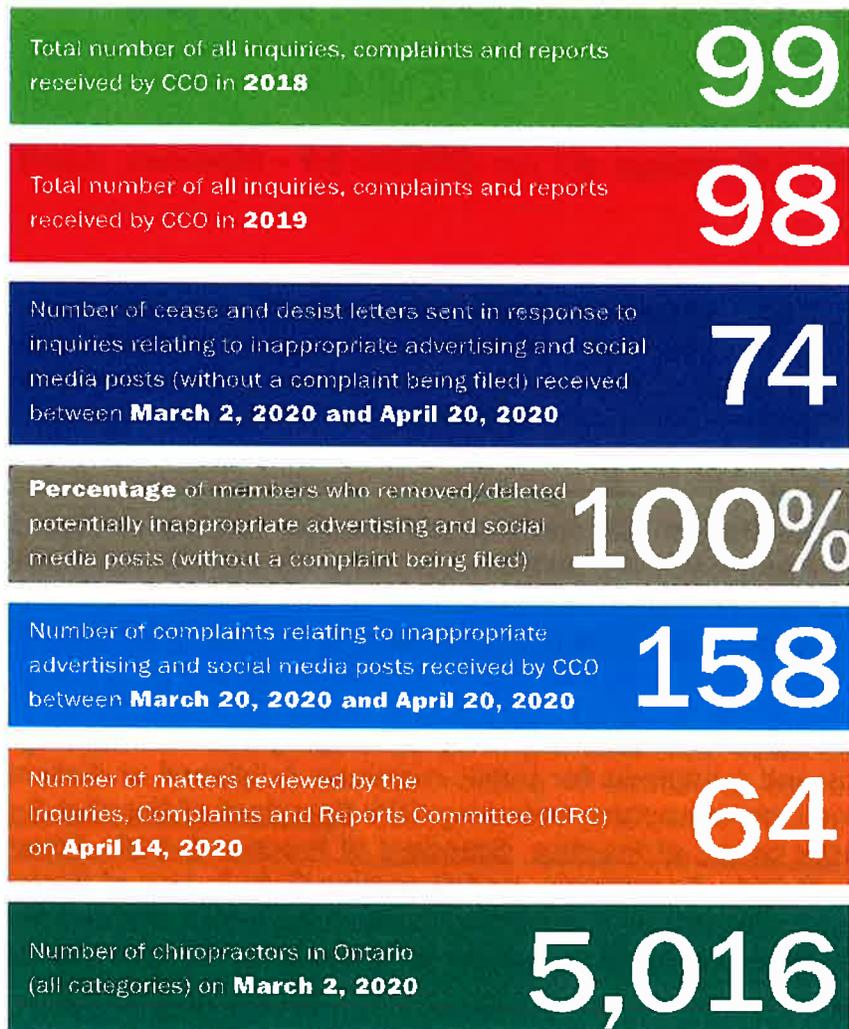
One of the ways CCO does this is by developing and maintaining relevant standards and guidelines for public materials published or disseminated by Ontario's chiropractors, including CCO [Standard of Practice S-001: Chiropractic Scope of Practice](#), [Standard of Practice S-016: Advertising](#), [Guideline G-016: Advertising](#), and [Guideline G-012: Use of Social Media](#). The College also has an Advertising Committee which reviews members' proposed advertisements to ensure compliance with these standards and guidelines.

The CCO acts quickly and decisively when it becomes aware of advertising or social media posts that are not in compliance with the standards identified above. In fact, beginning March 2, 2020 without any complaint having been filed, CCO delivered 74 cease and desist letters in response to inquiries relating to inappropriate advertising and social media posts. These letters resulted in *all identified website, advertisements and social media posts being subsequently removed*.

Of course, the CCO's central compliance assurance process is the work of the Inquiries Complaints and Reports Committee (ICRC), whose recent deliberations I would like to highlight here.

As you can see in the accompanying table, in the past month alone (or more accurately in the period from March 20 to April 20, 2020) the ICRC received 158 complaints pertaining to inappropriate advertising and social media posts. As you will also note, that is considerably more than were received throughout the entire year in either 2019 or 2018. To what should we attribute this increase, and in such short a time span?

INQUIRIES, COMPLAINTS AND REPORTS RECEIVED BY CCO



At the risk of oversimplification, I believe a few factors were in play. First, during this global health crisis there is a heightened sense of awareness regarding any claims made in advertising or social media in conjunction with COVID-19. Given the seriousness of the pandemic, this increased scrutiny is without question both appropriate and welcome.

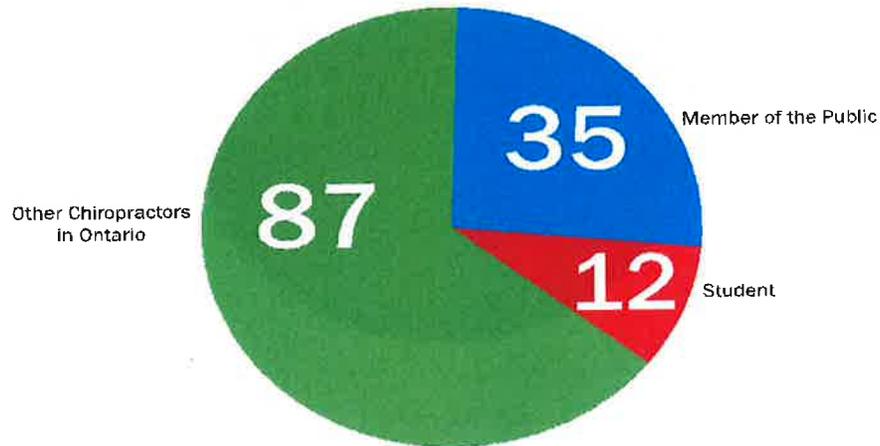
The overwhelming majority of recent complaints pertain to claims made for chiropractic's benefits for the immune system, and by extension, as a deterrent to contracting or managing the coronavirus. As I stated clearly in my messages of on March 16th and 22nd, "members should not make any unsubstantiated claims concerning chiropractic care and COVID-19."

Second, it is helpful to consider from where the complaints are originating*. Two-thirds came from CCO member chiropractors, who expressed a concern about claims made by a fellow College member. The remaining third was made up of complaints from the public (26% of total) and one student (8% of total). Of the 35 complaints received from the public, all were submitted by one individual, who has indicated that they do not use chiropractic services.

Significantly, not one complaint was received from a chiropractic patient in Ontario during this period.

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ORIGIN OF COMPLAINTS
RELATING TO INAPPROPRIATE ADVERTISING AND SOCIAL MEDIA POSTS
RECEIVED BY CCO BETWEEN MARCH 20, 2020 AND APRIL 20, 2020
TOTAL: 134

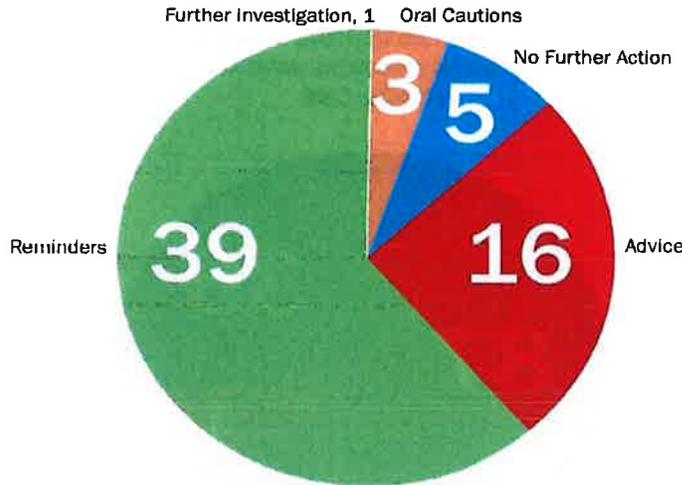


But let me be clear: CCO takes every complaint very seriously, regardless of where - or from whom - it originates. The work of the ICRC is completely agnostic as to origin and focused only on the matter of the complaint before it. Each complaint is subject to an exacting review and due diligence process by a committee comprised of two public members, one non-Council CCO member and two elected members, and is also supported by legal counsel. The ICRC is empowered to make decisions concerning the appropriate action to take regarding a complaint. The ICRC may refer to the Discipline Committee specified allegations of professional misconduct, require the member to appear before the ICRC to be cautioned or take other remedial action, or take no further action. Its work is legal in nature and is undertaken accordingly, including providing an opportunity for the referenced chiropractor to reply to the complaint.

The ICRC meets monthly. As you can see in the accompanying pie chart, on April 14, 2020 the Committee managed to review and render decisions on 64 investigations arising from the complaints received. Again, this number of decisions is equivalent to two-thirds of the complaints received annually over the last two years, and they were received and rendered in just over three weeks. My sincere thanks to the members of the ICRC, for tackling the urgency and volume of these complaints head on in the time available and given the restrictions of working remotely. It remains a top priority for the CCO to deal with these complaints thoroughly, and as expeditiously as possible. The outstanding complaints will be addressed in subsequent sittings of the Committee.

DISPOSITIONS OF THE INQUIRIES, COMPLAINTS AND REPORTS COMMITTEE MEETING
APRIL 14, 2020
TOTAL: 64

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Of the 64 dispositions rendered, 39 resulted in 'reminders', 16 resulted in 'advice', three resulted in an 'oral caution', five were deemed not to require any further action, and one was sent back for further investigation.

'Reminders' and 'advice' are written notices to members whose actions were the subject of the complaint, issued when the ICRC is of the view there has been a breach of the applicable standards but the Committee believes the member in question will remediate their practice and not commit a similar breach in the future. They are instructive and educational measures that differ in degree. 'Oral cautions' are another form of instructive measure, but are recorded on the public register. As implied, an oral caution is one the ICRC communicates to the member by discussing the finding with him or her directly.

In making its determinations, the ICRC looks at a number of factors including how false or misleading the content was, how likely it was to put the public at risk, whether the member could recognize the breach, had a history of breaching the advertising or scope of practice standards in the past, was co-operative, and/or took down the posting or remediated the content; and whether the member could demonstrate they were taking steps to ensure it would not happen in the future.

In a number of cases, the investigations were complicated by the fact that the social media postings in questions were taken down before the complaints were addressed, the complaints didn't include the entire content of the post, or the content was illegible or partially legible, and /or it was difficult to obtain the original post.

Again, I thank the ICRC, especially its public members, for its diligence and timely work to ensure the public interest in Ontario is protected from

inappropriate advertising, or from claims for the health benefits of chiropractic that are inconsistent with [Standard of Practice S-001: Chiropractic Scope of Practice](#), [Standard of Practice S-016: Advertising, Guideline G-016: Advertising](#), and [Guideline G-012: Use of Social Media](#).

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In closing, I urge all members to carefully review their own social media posts and advertising materials to ensure there are no breaches of the relevant CCO standards and guidelines I've just specified. If you have any questions about the suitability of any post or advertising, ask the Advertising Committee to review them prior to publishing. And I remind members not to rely on third parties for social media or advertising content, especially as those parties may not be familiar with CCO legislation, standards, policies and guidelines to which all members are required to adhere. Please continue to be safe, remain healthy, and watch for further announcements as CCO provides guidance on members' safe and gradual return to practice to coincide and be consistent with directives from the provincial government.

Sincerely,

Dr. Dennis Mizel, President

*while 158 complaints were received in total, for the purposes of understanding where these complaints originated the total number depicted on this pie chart is 134, as some complainants may have complained about more than one chiropractor, or different people may have complained about the same chiropractor.

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ITEM 4.1.22

President's Message #6 re: COVID-19 - Friday, April 17, 2020

On Tuesday, April 14, 2020 the Ontario legislature extended its [emergency order](#) until May 12, 2020 as it attempts to manage the impact of COVID-19. While this action may not have come as a surprise to any of you, it nonetheless means that the extraordinary conditions under which we have all been living and working will continue for several more weeks at the very least.

I recognize how challenging this period is for all CCO members, and I thank you for your commitment to adhering to the highest standards of professional conduct in serving the public, and in maintaining the health of your patients and well-being of your communities. I would also like to acknowledge the resilience and tireless efforts of CCO staff and committee members as we continue to confront what has become a global health crisis.

Changes at Council

In my last message, I welcomed three newly elected members to CCO's Council. This week I am pleased to welcome CCO's newest public member, Gagandeep Dhanda, who was appointed by Ontario Order in Council. Public members play a vital role in the deliberations and functioning of provincial health care regulatory bodies like CCO. Mr. Dhanda joins the College at an unusual time, and we very much look forward to his insights and contributions to the business of Council.

At the same time, I wish to thank the outgoing members of the CCO Executive and Council. Dr. Cliff Hardick has served the College in many capacities over the years including as President, Vice President and most recently as Treasurer. He was also Chair of the Office Development Project, which was instrumental in CCO's acquisition of its new permanent office headquarters at 59 Hayden Street in Toronto, and he has agreed to stay on in that capacity.

Likewise, Dr. Peter Amlinger leaves Council after years of leadership and service, most recently as a member of the Executive and Inquiries, Complaints and Reports Committees, and as former Chair of the Advertising Committee and former member of the Quality Assurance Committee. Dr. Amlinger had also served as President and Vice President during his previous term on CCO. Thank you also to outgoing public member Ms. Sheryn Posen, who has left us to take up residence in another province. Please note that during the March 29 meeting of the CCO Executive (convened via teleconference), a motion to defer the scheduled April 16, 2020 internal Council elections and appointment of

non-Council committee members was approved, until such time that they can be safely held in person or conducted on a virtual platform, consistent with CCO's by-laws. If you are interested in participating as a non-Council committee member on CCO's committees, please forward your expression of interest to CCO at the earliest opportunity. Any new information will be posted on CCO's website.

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Guidance on Telecare

In my [March 24, 2020 message](#) in response to the Ontario emergency order shutting down non-essential workplaces, I provided a series of protocols for CCO members to follow in contemplating or providing remote services (via telecare or tele-portal), as permitted under the order. The [updated Ontario emergency order](#) which listed essential services advised health care providers that only urgent care can be provided in-person but that telecare is not impacted.

The Ontario emergency order is to be read in concert with the recent [Directive from the Chief Medical Officer of Health](#). As you recall, the Directive required all health care providers to stop or reduce all non-essential or elective services subject to certain exceptions (i.e. time sensitive situations or to avoid adverse patient outcomes). We are seeking clarification about the impact of the Directive from the Chief Medical Officer of Health on provision of non-urgent telecare. Pending that clarification, telecare should be restricted to what is essential care as outlined in the protocols below. We also recognize that new patients may require urgent care and the following provides guidance until further notice.

I want to remind members, as I did then, that they must comply with all CCO regulations, standards of practice, policies and guidelines - regardless of whether care is provided through telecare or in person.

Today, in addition to the earlier guidance, CCO issues the following detailed directives with respect to the provision of remote chiropractic services, or telecare.

As of April 17, 2020, CCO members may provide telecare services to new patients - meaning an individual who does not have a pre-existing, in-person doctor/patient relationship with the member - as this is deemed to be essential. Without obtaining initial information from the patient, members cannot be in a position to advise if the patient requires urgent/emergency in-person treatment.

To be very clear, these protocols governing telecare are temporary (during the period of the Ontario emergency order). CCO will review and provide further guidance following the lifting of this order.

CCO members may use an initial telecare screening consultation to determine:

- If the new patient is in need of urgent/emergency care that requires in-person chiropractic treatment.
- If it is determined that in-person treatment is required, members must comply with the [screening, practice, hygiene and protective](#)

equipment protocols for in-person urgent/emergency care.

- If the new patient requires urgent/emergency care that is outside the chiropractic scope of practice, the member must make a referral to the appropriate health professional.

If, however, it is determined that the new patient does not require urgent/emergency in-person care but is in need of essential chiropractic services that could be offered remotely through telecare (i.e. time sensitive situation or to avoid adverse patient outcomes as per the Chief Medical Officer Directive), CCO members may now provide telecare services to that patient with the following protocols:

- The member must be registered in the General class of registration and ensure they have appropriate malpractice insurance or protection for telecare services.
- Both the member and patient must reside in the province of Ontario.
- The member must ensure they have achieved, maintain and can demonstrate clinical competency in providing telecare (as required of CCO members for every diagnostic and therapeutic procedure).
- The member must ensure a safe, secure and confidential platform is being used for telecare, and is used with the patient's authorization.
- The member is required to maintain the privacy of personal health information in accordance with the *Personal Health Information Protection Act, 2004* and CCO standards of practice, policies and guidelines, including the use of technological safeguards, such as secure transmission systems and storage mechanisms, password protection for any devices used for telecare services, and physical safeguards to prevent unauthorized use.
- The member must communicate to the patient, in advance, if any fee is to be charged for telecare services.
- The member must maintain records and billing practices consistent with CCO standards of practice, policies and guidelines that explicitly indicate that the services provided are telecare in nature.

In addition, members must use their professional judgement to determine whether:

- Telecare is appropriate for that patient without an in-person examination;
- The patient has the physical, cognitive, language and technological capabilities to be able to participate in telecare services; and
- There are risks, contra-indications or limitations to performing telecare services that outweigh the benefits for that patient.

To summarize - CCO members may now offer consultation, obtain informed consent, conduct modified assessment/examination, and provide diagnosis/clinical impression, plan of care recommendations, and other telecare services within the chiropractic scope of practice to new patients via telecare. These services include recommending and monitoring of appropriate exercises, recommending appropriate devices or supports, advice on ergonomics, nutrition, hot/cold therapies, lifestyle and home care.

In providing telecare services members must understand and acknowledge the limitations of telecare, specifically with respect to: care and communication with patients, including limitations to the performance of certain orthopedic, neurological and chiropractic assessments; limitations to providing a definitive diagnosis (in which case a clinical impression may be more appropriate), and recognition that no hands-on assessment or care will be provided through telecare.

Consistent with CCO requirements for periodic assessment and treatment review, members providing telecare must evaluate the new patient's progress no later than two-weeks after the onset of treatment (and thereafter according to CCO guidelines on assessment/reassessment).

If, after the initial two-week period the patient's condition worsens or does not improve, the member must take the appropriate next steps either to refer the patient to another qualified healthcare professional, to terminate care, or if it is established that the patient is now in need of urgent/emergency care, to follow CCO protocols for the provision of urgent/emergency in-person care under the Ontario legislature's emergency order.

In these extraordinary times, and for the duration of the Ontario emergency order, CCO has provided these enhanced protocols for telecare in the public interest; to allow individual Ontarians to receive ethical and competent chiropractic care that could forestall an escalation of their condition to that requiring urgent/emergency care, and through these measures to divert additional strain on front line health resources in our province in support of the Ministry's effort to ensure we have the necessary capacity to successfully manage the impacts of COVID-19.

Please note that the situation remains very fluid and that further practice directives may be necessary as events require. I thank you for your patience and understanding.

Concluding Comments

I would like to conclude by thanking all former Presidents who have helped to steer CCO and the former Board of Directors over many years. I particularly would like to acknowledge the efforts of recently passed Dr. Leo Rosenberg who will be sadly missed at our annual Presidents' luncheons. We are all sharing fond memories about Leo and we express condolences to his family during what is already a challenging time. We are all reminded of the importance of celebrating life and health, and of remembering the importance of family, friends, and colleagues.



Presidents' Luncheon and Tour of New Premises - June 2019

Sincerely,

Dr. Dennis Mizel, President

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

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



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From: Jo-Ann Willson
Sent: Thursday, May 28, 2020 2:50 PM
To: Rose Bustria
Subject: Fwd: Today's Inquiry

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
Fax: (416) 925-9610
E-mail: jpwilson@cco.on.ca
Web Site: www.cco.on.ca

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Begin forwarded message:

From: "Macdonell, Beth" <Beth.Macdonell@bellmedia.ca>
Date: May 28, 2020 at 2:49:14 PM EDT
To: Jo-Ann Willson <jpwilson@cco.on.ca>
Subject: RE: Today's Inquiry

Appreciate it thank you

Beth Macdonell | Videojournalist
CTV Toronto | m [647-389-9921](tel:647-389-9921) | Beth.Macdonell@bellmedia.ca
9 Channel Nine Court
[Toronto, Ontario](#)
M1S 4B5

@BethCTV on Twitter

On May 28, 2020, at 2:05 PM, Jo-Ann Willson <jpwilson@cco.on.ca> wrote:

Dear Beth,

Thank you for reaching out to us for your news story. We are unable to meet your deadline for an interview by 3:00 p.m. today, but share the following with you.

Many chiropractors will not begin fully opening their practices until at least next week, and it is much too early for us to comment on how the Ministry of Health's and our own guidelines are being implemented, and what effect they are having on the resumption of in-office clinical services.

In anticipation of the government's announcement, less than two weeks ago the CCO recommended that all chiropractors in Ontario prepare for an announcement that they could resume practice by reviewing our [Guidelines for Return to Practice for CCO Members](#). This document details all the steps that should be taken for safely restarting a practice under the current pandemic conditions. We also created two infographics summarizing these guidelines: one for [members](#) and the other for [patients](#). (I have linked to these documents for your consideration.)

After reviewing the Ontario government guidelines released on May 26, we are gratified that our earlier guideline materials sent to all Ontario chiropractors are consistent with the Ontario government's own expectations.

We are confident that in re-opening their practices Ontario's chiropractors will prioritize the safety of their patients, staff, colleagues and others visiting their practice, and will in fact not re-open until they can do so.

College of Chiropractors of Ontario

59 Hayden St., Suite 800

Toronto, ON M4Y 0E7

Tel: (416) 922-6355 ext. 111

Fax: (416) 925-9610

E-mail: jpwillson@cco.on.caWeb Site: www.cco.on.ca

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On May 28, 2020, at 12:56 PM, Macdonell, Beth
<Beth.Macdonell@bellmedia.ca> wrote:

Thank you

It would be great up speak with someone via Skype
around 3 if that could work

Beth Macdonell | Videojournalist
CTV Toronto | m [647-389-9921](tel:647-389-9921) | Beth.Macdonell@bellmedia.ca
9 Channel Nine Court
[Toronto, Ontario](#)
M1S 4B5

@BethCTV on Twitter

On May 28, 2020, at 12:15 PM, Jo-Ann
Willson <jpwillson@cco.on.ca> wrote:

Good afternoon - your request has just
been forwarded to me, and we will take
a look at it and see what we can do for
your deadline. In the meantime, please
feel free to forward any communication
to me directly. Thank you.

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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Web Site: www.cco.on.ca

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***External Email:** Please use caution when opening links and attachments / **Courriel externe:** Soyez prudent avec les liens et documents joints*

From: Jo-Ann Willson
Sent: Tuesday, June 2, 2020 8:50 PM
To: Rose Bustria
Cc: Joel Friedman
Subject: Fwd: Ontario Extends Declaration of Emergency until June 30

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: Ontario News <newsroom@ontario.ca>
Date: June 2, 2020 at 8:40:07 PM EDT
To: Jo-Ann Willson <jpwillson@cco.on.ca>
Subject: Ontario Extends Declaration of Emergency until June 30

Ontario 

Newsroom

News Release

Ontario Extends Declaration of Emergency until June 30

June 2, 2020

Extension Key to Protecting Ontarians as Province Safely Reopens

TORONTO — In consultation with the Chief Medical Officer of Health, Ontario is extending the provincial Declaration of Emergency to June 30. The decision supports the government's efforts to respond to the COVID-19 outbreak and protect the health and safety of Ontarians as the province reopens in a measured and responsible way. The extension, under s.7.0.7 of the *Emergency Management and Civil Protection Act*, was approved by the Ontario legislature earlier today.

"Extending the provincial Declaration of Emergency will allow us to safely and gradually reopen the province, while we continue to use every resource at our disposal to battle this deadly virus," said Premier Doug Ford. "We are not out of the woods yet, so it is critical that we exercise caution to keep everyone safe, including protecting our most vulnerable citizens in long-term care homes, retirement homes and group homes."

As Ontario charts a path to recovery, the Declaration will support the continued enforcement of emergency orders that give hospitals and long-term care homes the necessary flexibility to respond to COVID-19 and protect vulnerable populations and the public as the province reopens.

Current emergency orders include allowing frontline care providers to redeploy staff where they are needed most, enabling public health units to redeploy or hire staff to support case management and contact tracing, limiting long-term care and retirement home staff to working at one home, and preventing unfair pricing of necessary goods.

The Declaration of Emergency may be further extended with the approval of the legislature, as set out in the *Emergency Management and Civil Protection Act*.

A full list of emergency orders can be found on the [e-Laws website](#) under the *Emergency Management and Civil Protection Act* and at [Ontario.ca/alert](https://ontario.ca/alert).

ADDITIONAL RESOURCES

- [Ontario's Action Plan: Responding to COVID-19](#)
- Visit [Ontario's website](#) to learn more about how the province continues to protect Ontarians from COVID-19.
- For public inquiries call the ServiceOntario INFOline at 1-866-532-3161 (Toll-free in Ontario only).

CONTACTS

ITEM 4.1.29

Ministry of Health

Office of the Deputy Premier
and Minister of Health

777 Bay Street, 5th Floor
Toronto ON M7A 1N3
Telephone: 416 327-4300
Facsimile: 416 326-1571
www.ontario.ca/health

Ministère de la Santé

Bureau du vice-premier ministre
et du ministre de la Santé

777, rue Bay, 5^e étage
Toronto ON M7A 1N3
Téléphone: 416 327-4300
Télécopieur: 416 326-1571
www.ontario.ca/sante



April 21, 2020

Mrs. Karoline Bourdeau

Dear Mrs. Bourdeau:

I would like to take this opportunity to thank you for the time and effort you have given while serving on the Council of the College of Chiropractors of Ontario.

Your current appointment will come to an end on July 10, 2020. Your commitment as a member of the council has been invaluable and the work you have done has left a lasting impact on all Ontarians. I truly appreciate your contribution and I hope you have found your tenure both challenging and rewarding.

Please accept my best wishes. I hope that you will continue to offer your time and talent in serving the people of Ontario.

Sincerely,

A handwritten signature in cursive script that reads "Christine Elliott".

Christine Elliott
Deputy Premier and Minister of Health

c: Registrar

Ministry of Health

Office of the Deputy Premier
and Minister of Health

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Toronto ON M7A 1N3
Téléphone: 416 327-4300
Télécopieur: 416 326-1571
www.ontario.ca/sante



April 23, 2020

Mr. Gagandeep Dhanda

Dear Mr. Dhanda:

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

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

I have enclosed a copy of the Order in Council which was approved on April 9, 2020, appointing you for the period April 9, 2020 until April 8, 2021.

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

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

Sincerely,

A handwritten signature in cursive script that reads "Christine Elliott".

Christine Elliott
Deputy Premier and Minister of Health

Enclosure

c: Registrar
Deepak Anand, MPP



Ontario

**Executive Council of Ontario
Order in Council**

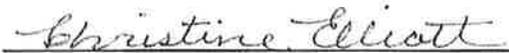
On the recommendation of the undersigned, the Lieutenant Governor of Ontario, by and with the advice and concurrence of the Executive Council of Ontario, orders that:

**Conseil exécutif de l'Ontario
Décret**

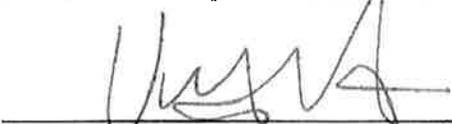
Sur la recommandation de la personne soussignée, le lieutenant-gouverneur de l'Ontario, sur l'avis et avec le consentement du Conseil exécutif de l'Ontario, décrète ce qui suit :

PURSUANT TO clause 6(1)(b) of the *Chiropractic Act, 1991*, **Gagandeep Dhanda** of Mississauga, be appointed as a part-time member of the Council of the College of Chiropractors of Ontario to serve at the pleasure of the Lieutenant Governor in Council for a period not exceeding one year, effective the date this Order in Council is made.

EN VERTU DE l'alinéa 6 (1) b) de la *Loi de 1991 sur les chiropraticiens*, **Gagandeep Dhanda** de Mississauga, est nommé au poste de membre à temps partiel du Conseil de l'Ordre des chiropraticiens de l'Ontario pour exercer son mandat à titre amovible à la discrétion du lieutenant-gouverneur en conseil, pour une période maximale d'un an à compter du jour de la prise du présent décret.



Recommended: Minister of Health
Recommandé par : La ministre de la Santé



Concurred: Chair of Cabinet
Appuyé par : Le président | la présidente du Conseil des ministres

Approved and Ordered: APR 09 2020
Approuvé et décrété le :



**Lieutenant Governor
La lieutenant-gouverneure**

O.C. | Décret : 623 / 2020

Ministry of Health

Office of the Deputy Premier
and Minister of Health

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Ministère de la Santé

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et du ministre de la Santé

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Toronto ON M7A 1N3
Téléphone: 416 327-4300
Télécopieur: 416 326-1571
www.ontario.ca/sante



May 20, 2020

Ms. Sheryn Posen

☺

Dear Ms. Posen:

I would like to take this opportunity to thank you for the time and effort you have given while serving on the Council of the College of Chiropractors of Ontario.

Your commitment as a member of the council has been invaluable and the work you have done has left a lasting impact on all Ontarians. I truly appreciate your contribution and I hope you have found your tenure both challenging and rewarding.

Please accept my best wishes.

Sincerely,

A handwritten signature in cursive script that reads "Christine Elliott".

Christine Elliott
Deputy Premier and Minister of Health

Enclosure

c: Registrar



Ontario

**Executive Council of Ontario
Order in Council**

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

**Conseil exécutif de l'Ontario
Décret**

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

Order in Council numbered O.C. 1279/2018 dated November 28, 2018 that appointed **Sheryn Posen** of Toronto as a part-time member of the Council of the College of Chiropractors of Ontario under the *Chiropractic Act, 1991*, be revoked effective the date this Order in Council is made.

Le décret 1279/2018 daté du 28 novembre 2018 qui nommait **Sheryn Posen** de Toronto au poste de membre à temps partiel du Conseil de l'Ordre des chiropraticiens de l'Ontario en vertu de la *Loi de 1991 sur les chiropraticiens*, est révoqué à compter du jour de la prise du présent décret.

Recommended: Minister of Health
Recommandé par : La ministre de la Santé

Concurred: Chair of Cabinet
Appuyé par : Le président | la présidente du Conseil des ministres

Approved and Ordered:
Approuvé et décrété le : MAY 13 2020

**Lieutenant Governor
La lieutenant-gouverneure**

O.C. | Décret : 768 / 2020

**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.

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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.

ITEM 4.1.38

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ADVERTISING COMMITTEE

TERMS OF REFERENCE

1. The Advertising Committee is a non-statutory committee pursuant to the by-law in accordance with S. 94 (1)(i) of the *Health Professions Procedural Code*, Schedule 2 to the *Regulated Health Professions Act, 1991*.
2. The Committee is composed of one elected member, one public member, one alternate public member, and one non-Council member.
3. The Committee reports to the governing Council via the Executive Committee.
4. Areas of responsibility:
 - Develop, establish and maintain standards of advertising for chiropractors.
 - Advise CCO members of the Committee's procedures to determine if an advertisement falls within the advertising standard of practice. The advertisement is a proposed advertisement by a member sent to the Committee for approval prior to publication.
 - Encourage members to submit proposed advertisements to the Committee for review before publication.
 - Review proposed advertisements and provide feedback to members within a reasonable timeframe (approximately 10 business days).
 - Keep current with advertising/marketing trends in the contemporary environment.
5. Proposed advertisement by a member sent to the Committee for preapproval:
 - Member sends his/her proposed advertisement to CCO, which is forwarded to the Committee for review (preferably via e-mail).
 - Committee members review the advertisement and provide feedback to CCO staff (preferably via e-mail).
 - CCO staff aggregates the feedback and, on behalf of the chair, advises the member in writing (letter, facsimile and/or e-mail) within approximately 10 business days. The response includes the following information:

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- The advertisement complies or does not comply with the advertising standard of practice.
 - If the advertisement does not comply, why it does not comply and some suggestions on how it may be made to comply.
 - Approval of an advertisement by the Committee does not guarantee that a complaint will not come forward.
- If the member disagrees with the Committee's decision, the Committee will consider the member's comments, provided in writing, and take one the following actions:
 - advise the member that the Committee stands by its original decision;
 - advise the member that the Committee will revise its original decision; or
 - advise the member that the Committee will forward the member's letter to the Executive Committee for additional review/consideration.
6. The Committee will not review published advertisements sent to CCO by a concerned member of the public (including another chiropractors).

POLICY P-004

Advertising Committee Protocol

ITEM 4.1.39

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Advertising Committee
Approved by Council: November 25, 1994
Amended: April 20, 2002, September 24, 2009, April 24, 2012

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

INTENT

To advise members of the Advertising Committee's procedure to determine if an advertisement falls within Standard of Practice S-016: Advertising.

The advertisement is a proposed advertisement by a member sent to the Committee for preapproval prior to publication.

DESCRIPTION OF POLICY

1. A member considering advertising is encouraged to forward his/her advertisements to CCO for review, prior to publication.
2. CCO forwards the advertisement to the Advertising Committee for review (via e-mail).
3. The members of the Advertising Committee review the advertisement and provide feedback to CCO (via e-mail).
4. CCO aggregates the feedback and, on behalf of the Committee Chair, advises the member in writing (letter, facsimile and/or e-mail) if the advertisement complies with the advertising standard of practice. CCO provides a response within approximately **10 business days**.
5. If the member disagrees with the Advertising Committee's decision, the committee will consider the member's comments, provided in writing, and take the following actions:
 - advise the member that the committee stands by its original decision;
 - advise the member that the committee will revise its original decision; or
 - advise the member that the committee will forward the member's letter to the Executive Committee for additional review and consideration.

**EXECUTIVE COMMITTEE
TERMS OF REFERENCE**

ITEM 4.1.40

The Executive Committee (“Committee”) is a statutory committee pursuant to S. 10 of the Health Professions Procedural Code, Schedule 2 to the *Regulated Health Professions Act*, (“Code”).

1. Composition

The composition of the Committee is set out in By-law 11: Committee Composition as follows:

- four members of the Council who are members of the College; and
- three members of the Council appointed to the Council by the Lieutenant Governor in Council.

2. Duties and Objects of the College for which the Committee has primary responsibility (with reference to specific sections of section 3(1) of the Health Professions Procedural Code)

- 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.
- 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.
- To promote and enhance relations between the College and its members, other health profession colleges, key stakeholders, and the public.
- To promote inter-professional collaboration with other health profession colleges.

3. 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.

4. Accountability and Reporting

The Executive Committee reports to Council.

5. Duties under the *Regulated Health Professions Act, 1991*

- The Committee has the powers and duties authorized to it pursuant to the *Regulated Health Professions Act, 1991 (RHPA)*, including those outlined in section 12 of the *Code*, which provides:
 - Between the meetings of the Council, the Executive Committee has all the powers of the Council with respect to any matter that, in the Committee's opinion, requires immediate attention, other than the power to make, amend or revoke a regulation or by-law.
 - If the Executive Committee exercises a power of the Council under subsection (1), it shall report on its actions to the Council at the Council's next meeting."
- The Executive Committee will develop, establish and maintain standards, guidelines and policies of advertising for chiropractors;

6. Meetings

The Executive Committee typically meets five times per year, between meetings of Council, and more often in-person or by teleconference, as required.

From: Jo-Ann Willson
Sent: Monday, April 6, 2020 3:50 PM
To: Rose Bustria
Subject: Fwd: 9:00 a.m. - April 6, 2020 - Presentation to CMCC students re: CCO discipline

Council.

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

College of Chiropractors of Ontario
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Web Site: www.cco.on.ca

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Begin forwarded message:

From: Dominic Giuliano <DGiuliano@cmcc.ca>
Date: April 6, 2020 at 3:49:02 PM EDT
To: Brian Gleberzon <BGleberzon@cmcc.ca>, Jo-Ann Willson <jpwillson@cco.on.ca>, "Karen.Jones@paliareroland.com" <Karen.Jones@paliareroland.com>, "Chris.Paliare@paliareroland.com" <Chris.Paliare@paliareroland.com>, "cstevenson@stevensonlaw.net" <cstevenson@stevensonlaw.net>
Cc: David Starmer <DStarmer@cmcc.ca>
Subject: Re: 9:00 a.m. - April 6, 2020 - Presentation to CMCC students re: CCO discipline

Hello Everyone,

Much appreciate to the group of you for sharing your knowledge and expertise with our students. You being as flexible and accommodating in these difficult times is very appreciated.

Health and safety to you and your families,
Dom

Dr. Dominic Giuliano B.Sc. (Kin), D.C.
Director, Education Year III
Canadian Memorial Chiropractic College,
6100 Leslie Street
Toronto, ON
Tel. 416.482.2340 ext. 163

515

From: Brian Gleberzon <BGleberzon@cmcc.ca>
Sent: April 6, 2020 3:46 PM
To: Jo-Ann Willson <jpwillson@cco.on.ca>; Karen.Jones@paliareroland.com
<Karen.Jones@paliareroland.com>; Chris.Paliare@paliareroland.com
<Chris.Paliare@paliareroland.com>; cstevenson@stevensonlaw.net
<cstevenson@stevensonlaw.net>
Cc: David Starmer <DStarmer@cmcc.ca>; Dominic Giuliano <DGiuliano@cmcc.ca>
Subject: Re: 9:00 a.m. - April 6, 2020 - Presentation to CMCC students re: CCO discipline

Good afternoon-

I wanted to thank all of you for providing an excellent learning opportunity for the students this morning. I certainly appreciate how difficult it must be for each of you to set aside time to participate in this kind of session.

The students have already emailed me and some of their other instructors saying what a valuable experience it was.

I would very much like to send you each a token of my appreciation for doing this for the students. Please send me a mailing address at your earliest convenience.

Stay safe and speak to you soon,
Brian

Dr. Brian J. Gleberzon BA, MHSc, DC, PhD (student)
Professor, Chair, Department of Chiropractic Therapeutics,
Canadian Memorial Chiropractic College,
President, CUPE Local 4773
Vice President, Ontario Chiropractic Association
& Private Practitioner

*"The credit belongs to the man who is actually in the arena...
who at the best knows in the end the triumph of high achievement,
and who at the worst, if he fails, at least fails while daring greatly,
so that his place shall never be with those cold and timid souls
who neither know victory nor defeat". Theodore Roosevelt c1910*

From: Jo-Ann Willson <jpwillson@cco.on.ca>
Sent: April 6, 2020 9:04 AM
To: Karen.Jones@paliareroland.com <Karen.Jones@paliareroland.com>;
Chris.Paliare@paliareroland.com <Chris.Paliare@paliareroland.com>;
cstevenson@stevensonlaw.net <cstevenson@stevensonlaw.net>
Cc: Brian Gleberzon <BGleberzon@cmcc.ca>; David Starmer <drstarmer@gmail.com>
Subject: Re: 9:00 a.m. April 6, 2020 - Presentation to CMCC students re: CCO discipline

Hi Brian - I think we thought it was 9 - 10:30 a.m. but I just noticed on the zoom information that it says 9:30, so I take it we have a 9:30 start? Also, I trust cmcc is initiating the meeting? Thanks.

forwarded message:

From: CCPA <admin@ccpaonline.ca>
Date: March 25, 2020 at 7:06:37 AM EDT
To: drmizel@stcatharineschiropractic.com
Subject: Virtual/remote chiropractic services during COVID-19
Reply-To: admin@ccpaonline.ca



Dear Dr. Mizel,

After reviewing the recent President's Message from the College of Chiropractors of Ontario (CCO), you may be wondering about your CCPA malpractice protection for providing virtual or remote services.

CCPA protection is based upon what services or care the provincial regulator, in this case CCO, mandates as within your scope of practice. So CCPA can provide protection to members who undertake virtual or remote services in accordance with the CCO's protocols, as outlined in the Presidents Message. It is important for CCPA members to ensure they abide by the appropriate standards of practice when undertaking such services.

Our team wishes you well during this time. Should you have any concerns or questions, please know we are available if you need us.

All the Best,

Dr. Dean J Wright
CEO, Canadian Chiropractic Protective Association

CCPA: 802 The Queensway, Etobicoke, ON M8Z 1N5
Email: admin@ccpaonline.ca, Phone: 416-781-5656 (Toll-free) 800-668-2076

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From: Jo-Ann Willson
Sent: Friday, April 24, 2020 2:17 PM
To: Rose Bustria
Subject: Fwd: COVID-19 Updates

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: "Dr. Mizel" <drmizel@stcatharineschiropractic.com>
Date: April 24, 2020 at 2:15:20 PM EDT
To: Jo-Ann Willson <jpwillson@cco.on.ca>
Cc: Rob MacKay <mackayrob@tbaytel.net>
Subject: FW: COVID-19 Updates

FYI

From: CCPA <admin@ccpaonline.ca>
Sent: Friday, April 24, 2020 1:54 PM
To: drmizel@stcatharineschiropractic.com
Subject: COVID-19 Updates

April 24, 2020

Dear Dr. Mizel,

I know it is not business as usual for the chiropractic community – far from it, in fact. As measures to flatten the curve continue to evolve, we must all be on alert and pay attention to guideline and protocol changes and how they apply to our unique situation. However, while these are unprecedented times, the core principles that guide us in providing care to patients and conducting ourselves and our clinics have not changed.

- **Pay attention to communications from your regulatory body, the organization that gives you a licence to practice.** If you are unsure about their directives or advice, reach out to them to clarify. The standards of practice and guidance put out by the regulator determine what you can and cannot do as a chiropractor.
- **CCPA protection is based on what your regulator allows.** For example, if your regulator has advised you may provide telehealth or virtual services, then CCPA will protect you for that care.
- **Pause** before making a decision, sending an email or text, or posting on your website or social media. Always consider the risks, benefits and alternatives to what you are about to do. If you need help, please call us. We are always happy to talk through a problem and be your sounding board.
- **If you are allowed to see patients on an emergent basis in your province, ensure you are up to date on the rules and screening requirements for COVID-19.** These can be difficult decisions. Take your time to think through the situation in front of you and make a reasonable choice that you can stand behind. If you're having difficulty, read through the regulator's directives governing the issue. If you are still unsure, contact us and we will assist you in your analysis.
- **Regarding sanitization protocols and PPE use, take the safest approach.** Ensure you are abiding by your regulator's recommendations, where available. It is important that you take the greatest measures possible to protect your and your patient's health, and ensure you have mitigated your risks. When in doubt, use the highest level of sanitization and PPE protocol possible.
- **Most importantly, record keeping, informed consent and communication are vital, and the Roadmap to Care should continue to be your guide.** If you're offering telehealth or virtual visits, ensure you note in your file any discussion that takes place. If you make recommendations, give warnings, or educate the patient about something, note it in your file. Ensure your records provide a clear picture about what occurs during your interactions with your patients.

Please do not hesitate to call us with questions or concerns, especially during this challenging time. We can be reached by phone at 416-781-5656 or toll-free 800-668-2076 or email at admin@ccpaonline.ca. We will be there for you.

At the best,
Dean



CANADIAN
CHIROPRACTIC
PROTECTIVE
ASSOCIATION

Dr. Dean J. Wright | Chief Executive Officer
T: 416.781.5656 ext 228 TF: 1.800.668.2076
E: dwright@ccpaonline.ca

You can find past COVID-19 Updates from CCPA by [clicking here](#) and entering your regular email and password for the Member Portal.

Our records indicate you prefer receiving correspondence in English. To update your communication preferences please contact us at admin@ccpaonline.ca.

CCPA: 802 The Queensway, Etobicoke, ON M8Z 1N5
Email: admin@ccpaonline.ca, Phone: 416-781-5656 (Toll-free) 800-668-2076

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May 20, 2020

BY EMAIL

Ms. Tina Yuan
Policy Advisory, MOHLTC
Legislative Building, Queen's Park
Toronto, ON M7A 1A1

Dear Ms. Yuan,

On behalf of chiropractors across Ontario, we congratulate the work of Premier Ford, the Honourable Christine Elliott, Deputy, Premier and Minister of Health, Public Health officers and the Ministry of Health, for working tirelessly to contain the COVID-19 pandemic in Ontario and protect Ontarians.

The OCA represents 80 per cent of Ontario's chiropractors, over 3,800 members. Since early March, we have been the definitive voice in communicating with chiropractors to ensure compliance with the directives declared by the Ontario government on COVID-19. You have our unwavering support for your diligent efforts.

The Ontario government recognized chiropractic as an essential service; and chiropractors across Ontario have been providing safe, 'urgent' in-person care to patients, demonstrating a proven, responsible approach to protecting Ontarians and mitigating the spread of COVID-19.

On Friday, May 15, the College of Chiropractors of Ontario (CCO) released its directives to allow chiropractors to be prepared to re-open safely once the Ontario government declares chiropractors and other regulated health professionals can re-open clinics to care for patients. The OCA is completely aligned with CCO re-opening directives.

To support our members returning to practice safely, and in accordance with CCO directives, the OCA is producing a *Return to Practice Playbook*. We are also supporting our members with access to personal protective equipment (PPE) supplies and cleaning necessities, as well as detailed screening and social distancing support tools.



Chiropractors will protect the health of their patients, their staff, colleagues and themselves by following all directives regarding PPEs, screening, cleaning and social distancing practices that keep Ontarians safe and support our collective efforts to stop COVID-19 from spreading.

We understand that you and some MPPs may have received letters from a few chiropractors asking the Ontario government to remove the requirement for practitioners to wear masks. The OCA does not support this request. The few letters you received do not represent the overwhelming majority of chiropractors working in Ontario. Our members are prepared to re-open and follow all requirements established by the regulatory college.

If you have any questions or concerns, I welcome your reply email or call to 416-346-3288.

Sincerely,

A handwritten signature in black ink, appearing to read "Caroline Brereton".

Caroline Brereton, CEO
Ontario Chiropractic Association

CC: Jo-Ann Willson, Registrar and General Counsel, CCO



ITEM 4.1.46

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ALLIANCE FOR CHIROPRACTIC

INTEGRITY - ACCOUNTABILITY - LEADERSHIP

The Alliance For Chiropractic has joined a consortium of national and international chiropractic organizations who collectively reject the recent statements of several organizations including the American Chiropractic Association (ACA), Parker University, and the World Federation of Chiropractic (WFC) denying scientific evidence of the connection between chiropractic care and immunity.

The perceived eminence of these institutions should not be exclusively relied upon without careful consideration of all available evidence.

[Read the Full Statement Here](#)

Dr. 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: drmizel@stcatharineschiropractic.com

[Unsubscribe](#)

Alliance For Chiropractic, 17A-218 Silvercreek Pwy N, Suite 126, Guelph, Ontario
N1H 8E8, Canada

From: Jo-Ann Willson
Sent: Tuesday, March 31, 2020 12:24 PM
To: Rose Bustria
Subject: Fwd: Stakeholder Report
Attachments: Stakeholder Report Recent_March 2020_ English_LV.docx;
ATT00001.htm

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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Web Site: www.cco.on.ca

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Begin forwarded message:

From: Lisa Pelletier <Lisa.Pelletier@uoit.ca>
Date: March 31, 2020 at 12:12:05 PM EDT
To: Jo-Ann Willson <jpwillson@cco.on.ca>, "cco.info" <cco.info@cco.on.ca>
Cc: "ldp.rhcc@sasktel.net" <ldp.rhcc@sasktel.net>, Carolina Cancelliere <Carolina.Cancelliere@uoit.ca>
Subject: Stakeholder Report

Dear Dr. Mizel and Ms. Wilson,

We hope that you are all well during this challenging time.

Please find attached our bi-annual stakeholder report (March 2020 report).

Please do not hesitate to contact me or Carol if you have any questions, or require further information.

Yours sincerely,

Dr. David Peeace, DC
Chair, Guideline Steering Committee

Canadian Chiropractic Guideline Initiative (CCGI)

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Dr. Carol Cancelliere, DC, PhD

CCGI Project Lead

CCRF Research Chair in Knowledge Translation

Faculty of Health Sciences

Ontario Tech University

Centre for Disability Prevention and Rehabilitation at CMCC and Ontario Tech University

Lisa Pelletier

Administrative Assistant

Faculty of Health Sciences

Centre for Disability Prevention and Rehabilitation | www.cdpr-research.org

Tel: 416.482.2340 Ext 233



Ontario Tech University is proud to acknowledge the lands and people of the Mississaugas of Scugog Island First Nation, which is covered under the Williams Treaties. We are situated on the Traditional Territory of the Mississaugas, a branch of the greater Anishinaabeg Nation, which includes Algonquin, Ojibway, Odawa and Pottawatomi.

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Canadian Chiropractic Guideline Initiative

ADVANCING EXCELLENCE IN CHIROPRACTIC CARE

March
2020

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Canadian Chiropractic Guideline Initiative Bi-Annual Stakeholder Report

Enhancing the health of Canadians by fostering
excellence in chiropractic care



A message from the Chair & Project Lead

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We know that back and neck pain are leading causes of disability globally. Recent evidence from the Journal of the American Medical Association (doi:10.1001/jama.2020.0734) also demonstrates that back and neck pain have a financial impact on our economy. The public and healthcare systems globally are in dire need of effective and efficient solutions. With patient-centered and evidence-based care, our profession is very well-positioned to help!

Please visit our homepage <https://www.ccgi-research.com/> to keep updated regarding our current projects and upcoming products, which include new guidelines, guideline summaries, care pathways, systematic reviews and evidence summaries, patient resources, and continuing education.



We highlighted some of our work in this report. Please do not hesitate to contact us if you require further information. Thank you for your ongoing support! We are looking forward to continue working toward improving public health and the delivery of healthcare.

Yours Truly,

David Peeace, DC
Chair, Guidelines Steering Committee

Carol Cancelliere, DC, PhD
Project Lead
CCRF Research Chair in Knowledge Translation in the Faculty
of Health Sciences, Ontario Tech University



CCGI Research Team

570



Hainan Yu MBBS, MSc
Research Project Manager –
Guidelines



Leslie Verville MSc
Research Project Manager –
Knowledge Translation



Heather Shearer DC, MSc, FCCS(C)
PhD student (Clinical Epidemiology)
Research Associate



Jessica Wong BSc, DC, MPH,
FCCS(C)
PhD student (Epidemiology)
Research Associate



Gaelan Connell BHK, DC
MRSc (student)
Knowledge Broker



Anne Taylor-Vaisey
Research Associate,
Health Sciences Librarian



Poonam Cardoso BHSc, PMP
Finance Officer



Daphne To
BSc, DC, Clinical Sciences Resident
Research Associate



Darrin Germann, BSc(Hons), DC,
RCCSS(C) Sports Sciences Resident
Research Associate



Lisa Pelletier, M. Psy (Candidate)
Administrative Assistant



Headache Care Pathway

Our newest care pathways are here! We have developed a series of care pathways for the management of persistent headaches, which includes cervicogenic headaches, episodic tension-type headaches, and chronic tension-type headaches.

Care pathways comprise of a series of **actionable, evidence-based steps** intended to have the **largest impact on patient-centered care**. Appropriately tailored care pathways for chiropractors can **reduce the variability in clinical practice; improve the quality of care; reduce costs; improve patient outcomes, satisfaction and teamwork; and ease the cognitive burden on providers and patients**. We are working on developing a care pathway for the management of neck pain, which will be available in the summer of 2020.

Patient Resources

Self-management tools enable patients to take ownership of their health. We are creating a series of one-page evidence-based patient handouts, providing patients with key information about their condition, treatment options, when they need to seek healthcare, and self-management strategies. Topics include back and neck pain, headaches, shoulder pain, knee impairments, osteoarthritis, concussion, and physical activity throughout pregnancy. Additionally, we have organized a series of self-management tools for patients including online resources for stress, depression and anxiety as well as managing pain.

Shoulder Pain

The following information is for individuals experiencing shoulder pain for 6 months or less.

<p>What can cause shoulder pain?</p> <ul style="list-style-type: none"> • Injury to a ligament (sprains) • Injury to a muscle or tendon (sprains) • Inflammation of a tendon (tendinitis) • Inflammation of the small fluid filled sacs near your joint (bursitis) • Irritation or degeneration of the tendons caused by repetitive overhead motions (impingement syndrome) 	<p>Will my pain go away?</p> <ul style="list-style-type: none"> • Shoulder pain will typically resolve on its own within a few months of onset • Treatment can speed up recovery while reducing pain and improving function 	<p>What can I do?</p> <ul style="list-style-type: none"> • To help speed up your recovery time: • Participate in your care with your healthcare provider • Continue with your day-to-day activities even if you experience some pain (within reason)
---	--	--

Sleep and Pain

We know that a number of lifestyle factors, including sleep quality, are associated with musculoskeletal pain. We have systematically reviewed the literature regarding the effectiveness of non-pharmacological sleep interventions for sleep difficulties in adults with musculoskeletal pain. We are preparing our manuscript for publication and will present the evidence summary at ACC-RAC, March 2020. We will add tools to our website (such as this infographic on sleep hygiene) to help you assess and manage/co-manage adults with co-morbid sleep and musculoskeletal conditions.

Outcome Measurements

Visit this section of our website to select outcome measurements appropriate for your patients.

Sleep Hygiene

- Establish a relaxing bedtime routine that is early enough for you to get at least 7 hours of sleep.
- Turn off electronics 30 minutes before bedtime.
- Keep a consistent schedule. Get up and go to sleep at the same time every day even on weekends.
- Beats are for sleeping, not working or studying. Leave electronics in another room.
- Use a sleep diary.
- Avoid alcohol, caffeine, and nicotine too close to bedtime.
- Avoid eating large meals before bedtime. If you are hungry at night, eat a light, healthy snack.
- Exercise regularly and maintain a healthy diet.

www.acc-research.org



CCGI Podcast: Neck Pain and Headaches

In a recent podcast episode, we interviewed Dr. Gwendolen Jull. Dr. Jull has published over 300 articles, 40 book chapters as well as three text books, including the recently published 2019 text 'Management of neck pain disorders: A research informed approach'. In this episode, we learn about the assessment and management of neck pain and headaches in the adult and older adult populations.



Website Translated to French

Our website is now translated in French! Access to this feature can be found on the top left-hand corner of the webpage. Additionally, all care pathways will be translated to French by Fall 2020. Also, a special thank you to Dre. Catherine Aubé for her time and help with reviewing the translated website.

Our YouTube videos now have more than 230,000 views!



1,200+
YouTube
subscribers



750+
Twitter
followers



900+
Facebook
members

For more information about the CCGI and any of our initiatives, please contact us at contactccgi@chiropractic.ca

From: Jo-Ann Willson
Sent: Thursday, June 11, 2020 9:46 AM
To: Rose Bustria
Subject: FW: CNAC Introduction
Attachments: CNAC Introduction Letter.pdf

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
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Tel: (416) 922-6355 ext. 111
Fax: (416) 925-9610
E-mail: jwillson@cco.on.ca
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From: drchad@mycnac.ca <drchad@mycnac.ca>
Sent: Thursday, June 11, 2020 9:40 AM
To: Jo-Ann Willson <jwillson@cco.on.ca>
Subject: CNAC Introduction

Dear Ms. Willson,

RE: Canadian National Alliance for Chiropractic

I hope this message finds you well. As you are likely aware, a new national chiropractic association, the Canadian National Alliance for Chiropractic (CNAC), was launched on October 26th, 2019. We have a rapidly growing membership base, representing Chiropractors from every province in Canada.

We have recently formed our first full board of directors and are making formal introductions to all relevant Canadian stakeholders. The CNAC board is committed to working alongside regulators in a collaborative approach, respecting the role of public protection as we promote the full scope of chiropractic practice in Canada. Please find attached for your reference a copy of the introduction letter we are distributing to Canadian Chiropractors; this letter may answer some questions your board has on the direction and focus of CNAC.

Please respond to confirm your receipt of our notice at your earliest convenience; my personal contact information is listed below. If your regulatory board has any other initial questions regarding CNAC I would be happy to provide clarification and/or have a discussion.

Thank you in advance for your attention; we look forward to working together in future endeavours!

Sincerely,

Chad Mykietiuk, DC

President

Canadian National Alliance for Chiropractic

myCNAC.ca

e: drchad@mycnac.ca p: (902) 401-9903 w: myCNAC.ca

574



Dear Friends and Colleagues:

By now, we expect you may have heard the news: We have a new national organization in Canada for chiropractors, The Canadian National Alliance for Chiropractic. While some of you may already be members (and we thank you!), we want our colleagues to know who we are and what we stand for, because if we are going to make a difference in this profession, we need YOU. **Your voice matters.**

We know there are questions you may have, so we have included a few answers here. We welcome your comments, especially as we build this organization to ensure it represents those of us who want to keep our freedom to practice in a neurologically-based, all-ages style of practice.

At the CNAC, our intention is to have a voice for chiropractic in Canada for those practitioners who choose to practice in a neuromusculoskeletal, salutogenic model of care, while being inclusive of musculoskeletal, symptomatic models; to promote chiropractic care for all ages; to advocate for neurophysiologically-based research; to build relationships with stakeholders; and create public education that encompasses a broader view of the profession.

The intention of the CNAC is to be inclusive, not divisive. However, the challenge has long existed that there are differing opinions in the chiropractic profession. At the CNAC we believe that chiropractors have more similarities than differences and we choose to embrace the diversity in our profession, as we acknowledge that different applications of chiropractic care can be of great benefit to the public to meet the varying needs and goals.

- We consider that some of the aligning factors in our profession are the desire to:
 - improve patient outcomes and experience through caring, effective and ethical care
 - improve function and performance through chiropractic care, including symptomatic, pain-based and biomechanical outcomes, as well as neurophysiological outcomes.
 - improve the function of the neuromusculoskeletal system through spinal adjustments, which include a wide variety of techniques and approaches, and which may include other modalities that are not exclusive to chiropractic.
 - provide a natural, drugless and surgery-free option for patients

Who formed the CNAC?

CNAC was formed by a group of chiropractors from almost every province in Canada, with the intention to represent each province with its unique challenges, while collectively having a voice in Canada for the chiropractic profession. (You can find a list of our Board Executive [here](#) and Founding Members [here](#))



Why is there a need for another national association?

Historically, the only national association has been the CCA. Many practicing chiropractors have felt for decades that the focus on chiropractic in Canada needs to encompass more than MSK, pain-focused chiropractic care, which is the main communication tool, PR strategy and focus of research and education provided by the CCA. As such, a significant portion of chiropractors have not felt represented by the national association and out of that need, the CNAC was formed.

How is the CNAC different from the CCA?

- CNAC embraces that chiropractic can be used in both a symptom-based, acute-care environment AND in a salutogenic, proactive health care model and that BOTH provide valuable services to the public.
- CNAC considers the neurological impact of chiropractic adjustments to be the foundational piece and is committed to supporting research and education to expand our understanding to better serve the public.
- CNAC acknowledges that adjustments are the unique, defining tool of chiropractic care, which can encompass many different techniques, and may be used with or without other modalities that are not exclusive to chiropractic.
- CNAC acknowledges that the body's innate ability to self-regulate and self-organize is more easily expressed when tension and pressure from vertebral subluxation within the neurospinal system is reduced or removed.
- CNAC endorses the use of the term subluxation, with an updated definition relevant to current scientific understanding (our position paper can be found [here](#))
- CNAC encourages chiropractic care for all ages from newborn to elderly.
- CNAC stands by chiropractic remaining a drug-free, surgery-free health care option.

We hope that our vision for this profession resonates with yours.

As we embark on this new endeavour, we invite you to add your voice to ours.

Join us!

www.mycnac.ca

Sincerely,

The CNAC Board of Directors

College of Chiropractors of Ontario
Discipline Committee Report to Council
June 17, 2020

607

Core Members: Ms Karoline Bourdeau, *Chair*
Dr. Colin Goudreau
Dr. Paul Groulx
Dr. Steven Lester
Mr. Rob MacKay
Dr. Daniela Arciero, *non-Council member*
Dr. Liz Gabison, *non-Council member*
Dr. Colleen Patrick, *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*

As a core function of CCO, discipline matters have continued to be prioritized during the pandemic. Prehearing conferences have been held virtually. In addition, since the last meeting of Council, the Discipline Committee has met once virtually on June 3, 2020.

Two virtual hearings have been held since the last Council meeting.

- Dr. Dirk Keenan – May 14, 2020
Panel: Ms Karoline Bourdeau, Chair, Mr. Rob MacKay,
Dr. Daniela Arciero, Dr. Steven Lester and Dr. Murray Townsend
- Dr. Randell Ricohermoso – May 14, 2020
Panel: Ms Karoline Bourdeau, Chair, Mr. Rob MacKay,
Dr. Daniela Arciero, Dr. Steven Lester and Dr. Murray Townsend

Recommendation

That Council approve:

- ***The Notice to the Chiropractic Profession and Members of the Public, Re: Remote Hearings of the Discipline Committee***
- ***Undertaking, Re: Accessing the Public Portion of Discipline Committee Hearings held via videoconferencing during the COVID-19 Crisis***
- ***Email from CCO, Re: Access to Public Discipline Hearings Held Via Videoconferencing***

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

**NOTICE TO THE CHIROPRACTIC PROFESSION
AND MEMBERS OF THE PUBLIC**

RE REMOTE HEARINGS OF THE DISCIPLINE COMMITTEE

(Recommended to Council: June 17, 2020)

1. CCO is committed to openness, transparency, accountability and fairness as well as safety during these extraordinary times involving COVID-19. Accordingly, although all in-house hearings of the Discipline Committee including prehearings are suspended until further notice from the Registrar, this notice provides the framework for virtual hearings in appropriate circumstances.
2. During this temporary suspension of in-house hearings or at the discretion of the Discipline Committee, the Discipline Committee will hear all hearings (including prehearings, emergency orders any other motions) by virtual means except where the Chair is satisfied the party opposing same will suffer undue prejudice.
3. Counsel and Members are expected to move hearings forward by remote or virtual processes.
4. During the suspension of in-office operations hearings may be heard in writing or by telephone or videoconference. Counsel and Members will be advised by the Registrar's office or independent legal counsel how to connect to telephone and videoconference hearings.
5. Hearing participants should have an appropriate technical setup and observe etiquette and best practices appropriate to remote hearings. Some guidance on these points can be found at https://www.oba.org/2020_COVID_19/News-Updates/Up-to-date-Justice-Sector-Information/News-update/Best-Practices-for-Remote-Hearings.
6. The Discipline Committee virtual hearings remain open to the public throughout the Covid19 pandemic in accordance with ss. 45 and 46 of the *Health Professions Procedural Code*.
7. Any member of the media or the public who wishes to hear/observe a remote proceeding may email their request to the Registrar's office (Rose Bustria RBustria@cco.on.ca) in advance of the hearing. The person requesting access should advise of the hearing they wish to hear/observe and their contact information. They will be expected to sign the undertaking **attached** as Schedule 'A'.

8. Every effort will be made to provide the requestor with information on how to hear/observe the proceeding unless the proceedings are closed to the media and public by order of the Discipline Committee. The number of observers may be limited by the technology of the virtual platform.
9. The Registrar's office posts hearings to be scheduled to be heard by the Discipline Committee at their website <https://www.cco.on.ca/about-cco/discipline-hearings-and-decisions/>.
10. Proceedings of the Discipline Committee are recorded in accordance with s. 48 of the *Health Professions Procedural Code*. They must not be recorded by anyone else.
11. If affidavits are to be filed the CCO adopts the position of the Law Society of Ontario which has interpreted s. 9 of the *Commissioners for Taking Affidavits Act* as not requiring the commissioner to be in the physical presence of the client. Rather, alternative means of commissioning, such as commissioning by videoconference will be sufficient. The affidavit should state that it was commissioned by videoconference. For more details see the Law Society website (<https://lso.ca/lawyers/practice-supports-and-resources/topics/the-lawyer-client-relationship/commissioner-for-taking-affidavits-and-notary-publ/virtual-commissioning>).
12. In accordance with Rule 5.2 of the *Rules of Procedure of the Discipline Committee* the Chair of the Discipline Committee directs that unless the parties agree otherwise all documents should be filed in continuous accessible PDF format by email with the Registrar's office (Rose Bustria RBustria@cco.on.ca) or if the documents exceed accessible capacity, then by means of a secure drop box or similar facility arranged by counsel or, if necessary, coordinated through the Registrar's office or Independent Legal Counsel for the hearing.
13. Self-represented Members who are unable to file materials by email should contact the Registrar's office to make alternative arrangements. Please note that the Registrar's office will only accept email filings for hearings that can proceed during the suspension period.
14. Caselaw and other source materials to be relied on in written argument by counsel or Members should be hyperlinked. Where hyperlinks are provided it will not be necessary to file a book of authorities.

COLLEGE OF CHIROPRACTORS OF ONTARIO

Recommended to Council: June 17, 2020

610

UNDERTAKING

Re: Accessing the public portion of meetings of Discipline Committee hearings held via videoconferencing during the COVID-19 crisis

I agree to the following in order to be granted access to the public portion of hearings of the Discipline Committee held via videoconferencing:

- I will not share or distribute the videoconferencing links that will be provided to me.
- I will ensure my microphone is muted at all times and that I will join and observe the meeting without my video image being displayed.
- I will not use the chat, reaction or any other communication or other functions.
- I agree not to make audio recordings of the meetings.
- I will not record or capture from the videoconference, by any photographic, video-recording or other such methods, nor distribute, any visual images of the hearings.

By typing your full name in the signature field below you are signing this Undertaking electronically and are thereby agreeing to be bound by its terms and conditions.

Signature: _____

Date: _____

Email from College of Chiropractors of Ontario (Recommended to Council: June 17, 2020)

Subject: Access to public Discipline hearings held via videoconferencing

Good morning [or afternoon],

Hearings of the Discipline Committee of the College of Chiropractors of Ontario (CCO) are now being held via videoconferencing to ensure the continuation of CCO operations while complying with public health measures.

While we are unable to grant broad access to the Discipline Committee hearings with this technology, we have developed the following process to give access to the public portions of the hearings to media, members of the public and other stakeholders, where appropriate.

If you are interested in having access to these hearings held via videoconferencing:

1. Review, sign and return the attached form.
2. Those who return the form will receive an email a few days ahead of each hearing with a request to respond if you still intend to view the upcoming hearing.
3. The day before the hearing you will receive an email with the videoconferencing link, if you indicated an interest in viewing.

We have put this process in place to ensure we are able to accommodate everyone who wishes to view the hearings as there are limits to the number of people able to access a videoconference.

We will address any questions you may have.

DISCIPLINE COMMITTEE OF THE
COLLEGE OF CHIROPRACTORS OF ONTARIO

COLLEGE OF CHIROPRACTORS OF ONTARIO

- and -

DR. DIRK KEENAN

EXHIBIT No 2

EXAMINATION OF _____

CCO vs Dr. Keenan
DATE May 14, 2020

RESOLUTION AGREEMENT COLLEGE OF CHIROPRACTORS OF ONTARIO

PART 1 - AGREED STATEMENT OF FACTS

Background

1. Dr. Dirk Keenan ("Member") became a member of the College of Chiropractors of Ontario ("CCO") in 1984.
2. During the relevant period between June 1988 to April 1989, the Member practiced chiropractic at his clinic in Ottawa, Ontario ("Clinic").

Treatment of Patient A.

3. During the period June 1988 to April 1989, the Member provided approximately thirty three treatments to a patient known as "Patient A."
4. At the time when she first started receiving treatment from the Member, Patient A. was a 20 year old university student on a work term in Ottawa who was suffering from a sore back. The Member's clinic was near her workplace.

5. If Patient A. had testified, she would have said:
- a. On June 21, 1988, during Patient A.'s first treatment, the Member told her she had beautiful eyes, called her "my sweet," and said he would give her an almost 50% discount on fees. He took a photo of her lying on the table in her underwear. The Member had asked Patient A. to remove her underpants for the photo and she refused;
 - b. On June 23, 1988, the Member asked Patient A. if she wanted a "real massage" which she understood to mean she should be naked, and she refused;
 - c. On July 4, 1988, the Member gave Patient A. a massage during which she wore only panties and a gown;
 - d. On July 5, 1988, Patient A's 21st birthday, the Member said to Patient A., "You are not going to get me in trouble for this, are you?" When Patient A. said she wouldn't, the Member asked Patient A. to close her eyes while she sat on the treatment table and he gave her a deep "birthday kiss";
 - e. On July 12, 1988, the Member offered to give Patient A. a total body massage and when she refused, he told her to grow up. He also asked Patient A. why her boyfriend didn't stay in her room. During subsequent treatments, the Member frequently asked Patient A. for information about her sex life, including whether she had sex with her former boyfriends;
 - f. On July 20, 1988, the Member made a number of comments about how cute Patient A. was and told her that she could be a natural beauty. He was flirty and told her she could sit in his car if she wanted. He offered to drive her home after her next appointment;

- g. Over the next month, the Member flirted with Patient A. during her treatments. He invited her to go sailing with him, which she declined;
- h. On August 11, 1988, the Member asked Patient A. about her sex life, and asked her if she loved her boyfriends physically or mentally;
- i. On two occasions, the Member drove Patient A. home after treatments;
- j. On August 16, 1988, the Member told Patient A. that she looked nice. He invited Patient A. to go to the movies with him and she agreed to go. During the movie, he put his arm around her and put his hand on her leg. As they left the movies, he put his arm around her, and when Patient A. reminded him that he had a girlfriend, the Member said, "It's not as if I am married or engaged." The Member held her hand on the way to his home, sat her on his lap, told her about his sexual history, tried to kiss her breast, and asked her to sleep with him, saying that "nothing would happen." She refused and went home;
- k. On August 25, 1988, the Member asked to take a picture of Patient A. naked so he could compare it to an earlier picture he took of her bum. He hugged her and they kissed;
- l. On April 1, 1989, the Member told Patient A. that she had to be naked for a soft tissue massage and rolled his eyes and grimaced when she refused. Patient A. left her panties on and lay prone on the table for the massage. When the Member came in to the room, he took her panties off, which Patient A. found very upsetting; and
- m. On April 25, 1989, during her last appointment with the Member, the Member kissed Patient A.

The Member's Position on the Evidence and Allegations

6. The conduct at issue in this matter occurred in 1988 and 1989, when the *Drugless Practitioners Act* and Regulation 248 were in force. Regulation 248 provides at section 10:

10(1) The Board may, after a hearing, suspend or cancel the registration of any person found to be guilty of professional misconduct or to have been ignorant or incompetent.

7. The Member does not contest the evidence of Patient A.
8. If the Member had testified, he would have said that when he asked Patient A. to remove her clothes to be photographed, it was for the purpose of using the photographs to make a diagnosis pursuant to a particular technique.
9. The Member admits that in 1988 and 1989, it would be considered professional misconduct for a chiropractor to:
- a. kiss a patient;
 - b. ask a patient about their sex life;
 - c. take pictures of a patient in their underwear;
 - d. ask a patient to remove all of their clothes for a massage;
 - e. ask a patient out on a date;
 - f. tell a patient about details of the chiropractor's sex life;
 - g. sit a patient on his lap;
 - h. try to kiss a patient's breast;
 - i. ask a patient to sleep with him;
 - j. attempt to take pictures of a naked patient; and
 - k. take off a patient's panties when the patient refused to be naked for a massage.

The Member does not contest that his conduct towards Patient A., as set out above in paragraph 5, constitutes professional misconduct, as alleged in paragraph 4 of the Notice of Hearing.

The Member acknowledges that he received advice from his counsel, Allan [redacted], prior to entering into this Resolution Agreement. The Member agrees that he is entering into this Resolution Agreement and signing the Agreed Statement of Facts freely and voluntarily.

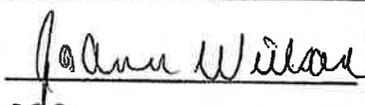
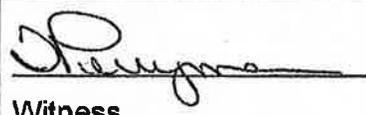
The Member and the GCO agree that this Agreed Statement of Facts may be admitted to the records.

	Date <i>May 12, 2020</i>	<i>Alan Dorell</i> Witness <i>[Signature]</i>
	Date	Witness
	Date	Witness

- 10. The Member does not contest that his conduct towards Patient A., as set out above in paragraph 5, constitutes professional misconduct, as alleged in allegation 1 of the Notice of Hearing.

Other

- 11. The Member acknowledges that he received advice from his counsel, Allan Freedman, prior to entering into this Resolution Agreement. The Member agrees that he is entering into this Resolution Agreement and signing the Agreed Statement of Facts freely and voluntarily.
- 12. The Member and the CCO agree that this Agreed Statement of Facts may be signed in counterparts.

_____	_____	_____
Dr. Keenan	Date	Witness
 _____	May 11, 2020 _____	 _____
cco	Date	Witness
_____	_____	_____
Prehearing Chairperson	Date	Witness

10. The Member does not contest that his conduct towards Patient A., as set out above in paragraph 5, constitutes professional misconduct, as alleged in allegation 1 of the Notice of Hearing.

Other

11. The Member acknowledges that he received advice from his counsel, Allan Freedman, prior to entering into this Resolution Agreement. The Member agrees that he is entering into this Resolution Agreement and signing the Agreed Statement of Facts freely and voluntarily.

12. The Member and the CCO agree that this Agreed Statement of Facts may be signed in counterparts.

Dr. Keenan	Date	Witness
CCO	Date	Witness
<i>A. Woodworth</i>	11/15/2020	
Prehearing Chairperson	Date	Witness

**DISCIPLINE COMMITTEE OF THE
COLLEGE OF CHIROPRACTORS OF ONTARIO**

COLLEGE OF CHIROPRACTORS OF ONTARIO

- and -

DR. DIRK KEENAN

EXHIBIT No 3

EXAMINATION OF _____

CCO vs Dr. Keenan
DATE May 1st, 2020

RESOLUTION AGREEMENT

COLLEGE OF CHIROPRACTORS OF ONTARIO

PART 2 - JOINT SUBMISSION ON PENALTY AND ON COSTS

Further to the pre-hearing conference of April 27, 2020 held before Dr. Drew Potter and in view of the Agreed Statement of Facts, the findings of professional misconduct made by the panel of the Discipline Committee, the Undertaking which is attached as Exhibit "A", the Reasons for Decision of the Board of Directors of Chiropractic dated April 6, 1991, which is attached as Exhibit "B" and the Inquiries, Complaints and Reports Committee Decision and Reasons dated April 24, 2018, which is attached as Exhibit "C", the College of Chiropractors of Ontario ("CCO") and Dr. Dirk Keenan ("Member") jointly request that the panel of the Discipline Committee make an 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 nine months ("Suspension") with the Suspension to take effect on May 31, 2020;
3. Directing the Registrar to impose the following terms, conditions and limitations ("Conditions") on the Member's certificate of registration:

- a. By November 30, 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: CCO Standard of Practice S-001: Chiropractic Scope of Practice; CCO Standard of Practice S-002: Record Keeping; CCO Standard of Practice S-013 Consent; CCO Standard of Practice S-014: Prohibition of a Sexual Relationship with a Patient; and CCO Guideline G-001: Communication with Patients; and
 - ii. provide evidence that he has successfully completed, at his own expense, the CCO's Legislation and Ethics Examination and its Record Keeping Workshop.
4. Directing the Registrar to suspend two months of the Suspension if the Member completes the Conditions set out in paragraph 3a, above, by November 30, 2020.
5. Requiring that the results of the proceeding be recorded in the public portion of the Register and published in the Annual Report or other publications at the discretion of the College of Chiropractors of Ontario.

The CCO and the Member also request that the Panel make the following order regarding costs:

1. Requiring the Member to pay \$12,000.00 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 ^{June 30, 2020} ~~November 31, 2020~~ with post-dated cheques for the ~~amount to be provided to the Registrar at the hearing.~~

*as amended
PW*

Dr. Keenan acknowledges that he received advice from his counsel, Allan Freedman, prior to entering into this Resolution Agreement, and affirms that he is signing the Joint Submission on Penalty and on Costs freely and voluntarily.

The CEO and Dr. Keenan agree that this Joint Submission on Penalty may be signed in counterparts.

Dr. Keenan <i>[Signature]</i>	Date <i>May 12/20</i>	<i>Jan Darrell</i> Witness <i>[Signature]</i>
CEO	Date	Witness
Prehearing Chairperson	Date	Witness

Dr. Keenan acknowledges that he received advice from his counsel, Allan Freedman, prior to entering into this Resolution Agreement, and affirms that he is signing the Joint Submission on Penalty and on Costs freely and voluntarily.

The CCO and Dr. Keenan agree that this Joint Submission on Penalty may be signed in counterparts.

_____	_____	_____
Dr. Keenan	Date	Witness
<u><i>John Keenan</i></u>	<u>May 11, 2020</u>	<u><i>[Signature]</i></u>
CCO	Date	Witness
_____	_____	_____
Prehearing Chairperson	Date	Witness

Dr. Keenan acknowledges that he received advice from his counsel, Allan Freedman, prior to entering into this Resolution Agreement, and affirms that he is signing the Joint Submission on Penalty and on Costs freely and voluntarily.

The CCO and Dr. Keenan agree that this Joint Submission on Penalty may be signed in counterparts.

Dr. Keenan	Date	Witness
CCO	Date	Witness
<i>[Signature]</i>	11/5/2020	
Prehearing Chairperson	Date	Witness

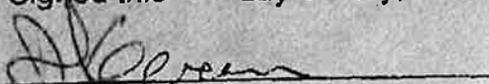
**UNDERTAKING
Exhibit "A"**

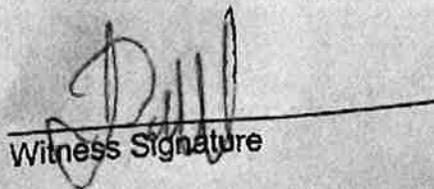
**To: The Registrar and General Counsel ("Registrar")
of the College of Chiropractors of Ontario ("CCO")**

I, Dr. Dirk Keenan, undertake to the Registrar and agree to do the following:

1. On or before November 30, 2020, I will:
 - a. review, and undertake in writing to comply with, all CCO regulations, standards of practice, policies and guidelines, including but not limited to: CCO Standard of Practice S-001: Chiropractic Scope of Practice; CCO Standard of Practice S-002: Record Keeping; CCO Standard of Practice S-013 Consent; CCO Standard of Practice S-014: Prohibition of a Sexual Relationship with a Patient; and CCO Guideline G-001: Communication with Patients; and
 - b. provide written evidence to the Registrar that I have successfully completed the CCO's Legislation and Ethics Examination and have attended the CCO's Record Keeping Workshop at my own expense.
2. I will pay to the CCO a total of \$12,000.00 for the partial payment of its costs and expenses related to the investigation, hearing and legal costs by December 31, 2020 and will providing post-dated cheques for that amount at the hearing.
3. I agree not to appeal or ask for a judicial review of the decision of the Discipline Committee.
4. I acknowledge that failure to abide by any of the terms of this Undertaking could result in the referral of specified allegations of professional misconduct to the Discipline Committee.
5. I acknowledge that I have been advised by the CCO to obtain legal advice prior to executing this Undertaking and have obtained the advice of my counsel, Allan Freedman. I am executing this Undertaking freely and voluntarily after reading and understanding its contents.

Signed this day of May, 2020


Dr. Dirk Keenan


Witness Signature

DISCIPLINE COMMITTEE OF THE
COLLEGE OF CHIROPRACTORS OF ONTARIO

COLLEGE OF CHIROPRACTORS OF ONTARIO

- and -

DR. RANDELL RICOHERMOSO

RESOLUTION AGREEMENT

EXHIBIT No. 2

EXAMINATION OF _____

CCO vs Dr. Ricohermoso

DATE March 4, 2020 MRSO

COLLEGE OF CHIROPRACTORS OF ONTARIO

PART 1 - AGREED STATEMENT OF FACTS

Background

1. Dr. Randell Ricohermoso ("Member") became a member of the College of Chiropractors of Ontario ("CCO") in 2014.
2. At the relevant time, the Member practiced chiropractic at the Wellness Group in Aurora, Ontario.
3. The Member does not have a prior complaint or discipline history at the CCO.

Patient "A."

4. Patient A. started receiving chiropractic treatments from the Member in September 12, 2017. Patient A. was a weightlifter who had injured her hips while deadlifting. She was also experiencing pain from hamstring tendonitis.
5. On November 23, 2017, Patient A. received her sixth chiropractic treatment from the Member. Usually, during treatments, the focus of attention was on Patient A.'s hips. However, during the November 23, 2017 treatment, the Member touched her differently. Rather than his usual firm touch to her back and glutes, the Member lightly slid his hands up and down her body, including over her glutes. The touch made her very uncomfortable. As a result, Patient A. suggested the Member work on her pectorals and shoulders, and he agreed to do so.
6. Patient A. recalls the Member making a comment, "the girls aren't getting in the way are they." The Member started the treatment over Patient A.'s clothes and then put his hand under her shirt and sports bra. He repeatedly touched and stroked her breast and nipple on the right side. He then repeated the treatment on her left side, again touching and stroking her breast and nipple under her bra.

7. Patient A. was very uncomfortable with the Member's conduct. She had panic attacks about it for a week afterwards.
8. The Member resigned his employment with the Wellness Group on January 2, 2018.
9. On February 8, 2018, the Member gave Patient A's boyfriend a letter to give Patient A. In that letter, the Member apologized for his conduct towards her.
10. Patient A. went to the police and on April 25, 2018, the Member was charged with sexual assault for his conduct towards Patient A.
11. On July 30, 2018, the Member indicated to the CCO that he was no longer practicing chiropractic.
12. On January 23, 2019, the Member pled guilty to one count of sexual assault.
13. On March 5, 2019, a sentencing hearing regarding the Member was held in Newmarket, Ontario. During the sentencing hearing, the court considered a number of mitigating and contextual factors, including that the Member had displayed insight and remorse regarding his sexual assault. He had pled guilty so that Patient A. did not have to go through cross-examination and a possibly protracted trial. The Member had lost his chosen vocation and would no longer be working in a clinical role with patients, had repeatedly expressed his remorse since the incident including through his guilty plea and letter of apology, had become reacquainted with his faith, had taken some steps through counselling to address the underlying issues which may have informed the offence, and the offence was out of character for him.
14. However, the Court also noted that the Member's sexual assault had left a profoundly painful and lasting impact on Patient A., was a violation of the Member's position of trust, and that the assault had occurred when Patient A. was vulnerable as she was supposed to be receiving a therapeutic procedure in a safe place.
15. Among other things, the Member was sentenced to a conditional sentence of imprisonment for 12 months to be served in the community with 9 of the months to be spent under house arrest, 18 months probation, and a requirement to provide DNA and be placed on the Sexual Offender Information Registry for 10 years.

Admissions

16. The Member admits, based on the facts set out above, that he committed the acts of professional misconduct alleged in the Notice of Hearing dated January 14, 2020, and in particular, on November 23, 2017, he:

- a. sexually abused Patient A. as alleged in allegation 1;
- b. contravened a standard of practice of the profession or failed to maintain the standard of practice expected of members of the profession with respect to his treatment and/or documentation and/or conduct towards Patient A. as alleged in allegation 2;
- c. abused Patient A. psychologically and/or emotionally as alleged in allegation 3; and
- d. engaged in conduct or performed an act or acts, that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable and unprofessional with respect to his treatment, conduct and documentation regarding Patient A. as alleged in allegation 4.

Other

17. The Member acknowledges that he received independent legal advice prior to entering into this Resolution Agreement. The Member agrees that he is entering into this Resolution Agreement and signing the Agreed Statement of Facts freely and voluntarily.

18. The CCO and the Member agree that this Agreed Statement of Facts may be signed in counterparts.

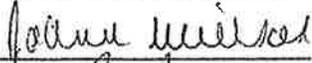
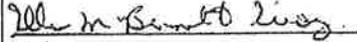
E-SIGNED by Dr. Randell Ricohermoso on 2020-05-12 18:32:40 GMT	2020-05-12	E-SIGNED by Destiny Grant on 2020-05-12 18:34:03 GMT
Dr. Ricohermoso	Date	Witness
	May 13, 2020	
CCO	Date	Witness
	May 11/20	
Prehearing Chairperson	Date	Witness

EXHIBIT No. 3

EXAMINATION OF _____

CCO vs Dr. Ricohermoso
 DATE May 14, 2020 maso

COLLEGE OF CHIROPRACTORS OF ONTARIO

4

**DISCIPLINE COMMITTEE OF THE
 COLLEGE OF CHIROPRACTORS OF ONTARIO**

COLLEGE OF CHIROPRACTORS OF ONTARIO

- and -

DR. RANDELL RICOHERMOSO

RESOLUTION AGREEMENT

PART 2 - JOINT SUBMISSION ON PENALTY AND ON COSTS

Further to the pre-hearing conference of April 29, 2020 held before Dr. Frazer Smith and in view of the Agreed Statement of Facts and the findings of professional misconduct made by the panel of the Discipline Committee, the College of Chiropractors of Ontario ("CCO") and Dr. Randell Ricohermoso ("Member") jointly request that the panel of the Discipline Committee make an Order:

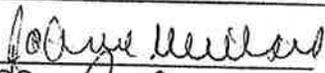
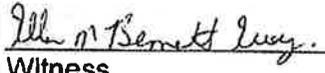
1. Requiring the Member to appear before the panel to be reprimanded.
2. Directing the Registrar and General Counsel ("Registrar") to revoke the Member's certificate of registration.
3. Requiring the Member to reimburse the CCO for funding provided for Patient A. under the program required under section 85.7 of the Health Professions Procedural Code.

The CCO and the Member also request that the Panel make the following order regarding costs:

1. Requiring the Member to pay \$8,500.00 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 September 30, 2021 with post dated cheques for the amount to be provided to the Registrar at the hearing.

Dr. Ricohermoso acknowledges that he received independent legal advice prior to entering into this Resolution Agreement, and affirms that he is signing the Joint Submission on Penalty and on Costs freely and voluntarily.

The CCO and Dr. Ricohermoso agree that this Joint Submission on Penalty and on Costs may be signed in counterparts.

E-SIGNED by Dr. Randall Ricohermoso on 2020-05-12 18:33:01 GMT	2020-05-12	E-SIGNED by Destiny Grant on 2020-05-12 18:34:07 GMT
Dr. Ricohermoso	Date	Witness
 CCO	May 13, 2020	Witness
 Prehearing Chairperson	May 11/20	 Witness

From: Jo-Ann Willson
Sent: Friday, April 24, 2020 2:55 PM
To: Rose Bustria
Subject: Fwd: Your Recent Inquiry

Exec, Council (me).

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
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.

Begin forwarded message:

From: Brianne Hadley <Brianne.Hadley@sunlife.com>
Date: April 24, 2020 at 2:54:40 PM EDT
To: Jo-Ann Willson <jpwillson@cco.on.ca>
Subject: RE: Your Recent Inquiry

Thank you!

Bri Hadley, GBA | Investigator | Fraud Risk Management
Sun Life
T: 1-800-361-2128 x. 442-3888 | E: brianne.hadley@sunlife.com

From: Jo-Ann Willson <jpwillson@cco.on.ca>
Sent: Friday, April 24, 2020 1:19 PM
To: Brianne Hadley <Brianne.Hadley@sunlife.com>
Subject: Your Recent Inquiry

Attached please find correspondence dated April 24, 2020 in response to your recent inquiry, and on behalf of the colleges listed. Thank you.

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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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April 24, 2020



Via E-mail (Brianne.Hadley@sunlife.com)

632

Ms Brianne Hadley
Investigator, Fraud Risk Management
Sun Life
600 Weber Street North-201S59
Waterloo, Ontario, N2V 1K4

Dear Ms Hadley:

Thank you for your inquiry dated April 21, 2020 (attached).

Our understanding is that there is no characterization of professions or categories of practitioners as essential and non-essential. Our understanding is that the focus is on whether the individual service provided was appropriate in all the circumstances. It is unlikely that a patient's perception as to whether a service was routine is determinative as some routine services are also essential.

The medical directives of the Chief Medical Officer of Health and the emergency regulations made under the *Emergency Management and Civil Protection Act* are not enacted by or directly enforced by the colleges. However, colleges have been encouraged by the authorities to provide guidance to the profession on criteria for evaluating care that is essential so as to prevent unwarranted risks of contracting the virus and to facilitate re-deployment of practitioners where feasible. However, our guidance is just that and the colleges are expecting its members to exercise professional judgment. This applies to both in-person and remote services. Our members know their patients best and have to balance complex, competing considerations in an environment where expectations are changing rapidly. If a complaint comes in, the Inquiries, Complaints and Reports Committee (ICRC) will look at all the circumstances to evaluate whether professional judgment was exercised or whether the practitioner acted so inappropriately so as to place the public at risk. Reducing the risk of harm to the public is the primary mandate of the colleges. The respective ICRC's will undoubtedly recognize the unique aspects of this time in assessing such complaints. While it is up to the ICRC's to make such a determination, we expect they will focus on examples where a member acted irresponsibly, for example, by unnecessarily risking the wellbeing of residents in a retirement home or long-term care facility.

Thus, we are not in a position to offer comprehensive advice to you as to when you should make a complaint. The colleges have a complaint and discipline process designed to ensure a thorough and fair investigation of any accusation of professional misconduct, consistent with the requirements of the *Regulated Health Professions Act* and profession specific acts.



All we can suggest is that where the conduct of the member was irresponsible, and/or places the public at risk, the ICRC's will review a resulting complaint closely. Where the issue is a difference of opinion as to whether professional judgment was properly exercised, the complaint is less likely to result in disciplinary action.

However, any decision by an ICRC not to refer a complaint to discipline or fitness to practise is reviewable before the independent Health Professions Appeal and Review Board, should any complainant disagree with a decision of the ICRC.

I trust that this will assist you deciding when it would be most helpful for you to make a complaint.

Yours truly,

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

Dr. Glenn Pettifer
Registrar and CEO
College of Denturists of Ontario

Fazal Khan, RO
Registrar, CEO
College of Opticians of Ontario

Rick Morris,
Ph.D., C. Psych.
Registrar & Executive Director
College of Psychologists of Ontario

Deborah Adams
Registrar
College of Registered Psychotherapists of Ontario

Ann Zeng
Registrar & CEO
College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario

From: Brianne Hadley [<mailto:Brianne.Hadley@sunlife.com>]
Sent: April 21, 2020 1:36 PM
To: cco.info <cco.info@cco.on.ca>; info@collegept.org; professionalconduct@cmt.com;
conduct@ctcmpao.on.ca; Meghan Clarke <mclarke@cocoo.on.ca>
Subject: Inquiry: COVID-19 actively practicing registrants & clinics

Good afternoon –

As you are aware, Sun Life reviews claims to ensure our group benefit plans are sustainable. Our reviews continue during this pandemic.

To help us, Sun Life has reviewed each College's published COVID-19 communication. Our understanding is that your members are either:

- Non-essential, and should not be practicing, effective March 25, 2020; or,
- Non-essential, and can practice virtually for some types of treatment; or,
- Essential, and should be providing emergency services only, effective March 25, 2020. Registrants must also document why the visit was urgent and the infection containment strategies that they used. Essential staff can provide virtual treatment.

We have received a number of claims which seem extend past this mandate. In some cases, patents and/or plan members told us that their services were routine. In some cases, the number of claims that we have does not seem to comply with these guidelines.

We reached out to Public Health. They asked us to contact you directly for guidance on how to report these cases. Please let me know how your College would like us to contact you in these situations, and others like them. If you have other guidance or information that may help us, please send that along.

We know that the Colleges focus on protecting the health of all Ontarians. So that you can be efficient, we want to give you the information you need, the way you need it. Thank you for your time.

Sincerely,

Bri Hadley, GBA | Investigator | Fraud Risk Management
Sun Life
T: 1-800-361-2128 x. 442-3888 | E: brianne.hadley@sunlife.com
600 Weber Street North-201S59 Waterloo, Ontario, N2V 1K4

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From: Jo-Ann Willson
Sent: Friday, May 15, 2020 3:31 PM
To: Rose Bustria
Cc: Joel Friedman
Subject: Fwd: Topics for QA/Advertising

QA and Council.

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

College of Chiropractors of Ontario
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Begin forwarded message:

From: President <President@cco.on.ca>
Date: May 15, 2020 at 2:22:21 PM EDT
To: "Dr. Colin Goudreau" <goudreaudc@gmail.com>
Cc: Jo-Ann Willson <jpwillson@cco.on.ca>, Rob MacKay <mackayrob@tbaytel.net>
Subject: RE: Topics for QA/Advertising

Good afternoon Dr. Goudreau,

Thank you, Colin, for sending these research articles. I appreciate you sending these research articles forward. Have a good long weekend.

Best regards,
 Dennis

Dennis Mizel, B.S., DC., FCCPDR
 President
***Note Address Change**
College of Chiropractors of Ontario
 59 Hayden Street, Suite 800
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From: Dr. Colin Goudreau <goudreaudc@gmail.com>
Sent: Friday, May 15, 2020 2:07 PM
To: President <President@cco.on.ca>
Subject: Topics for QA/Advertising

Good afternoon Dr. Mizel,

Hope you are keeping well. With some down time, I have been able to read a number of research articles. Two articles I found of some benefit for us as regulators are:

1) <https://chiromt.biomedcentral.com/articles/10.1186/s12998-020-00314-9>

The use of internet analytics by a Canadian provincial chiropractic regulator to monitor, evaluate and remediate misleading claims regarding specific health conditions, pregnancy, and COVID-19 (Published May 11 2020)

2) <https://chiromt.biomedcentral.com/articles/10.1186/s12998-020-00318-5>

Chiropractic students call for action against unsubstantiated claims (Published May 13 2020)

Obviously our next meeting in June will be high priority topics only, so when you deem it is appropriate to be apart of a Council Meeting agenda, I think it gives good insight on what another province is doing for website/social media claims (article #1), and the desire to further strengthen our regulatory action on unsubstantiated claims (article #2). It is not to meant to critique what we have done as a regulator, but give us insight or ability to pause and reflect on how we are functioning.

Have a great long weekend, talk soon enough,

Colin Goudreau, B.Hk., DC
Chiropractor

****55 Centre St****

Chatham, ON

N7M 4W3

519-784-9484

www.goudreaudc.com

If you have received this email in error, please disregard and delete at your earliest convenience.

From: Jo-Ann Willson
Sent: Friday, May 15, 2020 9:29 AM
To: Rose Bustria
Subject: FW: Shawn Thistle (RSE Education) This Morning

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

***Note Address Change**

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Subject: Shawn Thistle (RSE Education) This Morning

Twitter and Facebook



RRS Education @RRSEducation 13m

Pleased to see some cogent, timely student involvement in our profession during the COVID-19 pandemic..."Chiropractic students call for action against unsubstantiated claims" (Chiropractic & Manual Therapies - open access)

Have a read: ow.ly/13uj50zGoL5





Shawn Thistle

15 mins · 🌐



638

Pleased to see some cogent, timely student involvement in our profession during the COVID-19 pandemic... "Chiropractic students call for action against unsubstantiated claims" (Chiropractic & Manual Therapies - open access)

Have a read: <http://ow.ly/ZJR850zGoCR>



👍 2

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Marc Bronson, DC @MarcBronsonDC · 2h

Scientific chiropractic students: no more [#pseudoscience. bit.ly/2LthrHe](https://bit.ly/2LthrHe).
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[@CBCHealth](#). [#MedTwitter](#) [#AcademicTwitter](#)

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Commentary | [Open Access](#) | Published: 13 May 2020

Chiropractic students call for action against unsubstantiated claims

[Joshua Plener](#) , [Ben Csiernik](#), [Geronimo Bejarano](#), [Jesper Hjerstrand](#) & [Benjamin Goodall](#) - [Show fewer authors](#)



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Chiropractic students call for action against unsubstantiated claims

- [Joshua Plener](#)  [ORCID: orcid.org/0000-0001-5031-5965](https://orcid.org/0000-0001-5031-5965)¹,
- [Ben Csiernik](#)¹,
- [Geronimo Bejarano](#)²,
- [\[...\]](#)
- [Jesper Hjertstrand](#)³ &
- [Benjamin Goodall](#)⁴
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Abstract

Background

The 2019 coronavirus pandemic is a current global health crisis. Many chiropractic institutions, associations, and researchers have stepped up at a time of need. However, a subset of the chiropractic profession has claimed that spinal manipulative therapy (SMT) is clinically effective in improving one's immunity, despite the lack of supporting scientific evidence. These unsubstantiated claims contradict official public health policy reflecting poorly on the profession. The aim of this commentary is to provide our perspective on the claims regarding SMT and clinically relevant immunity enhancement, drawing attention to the damaging ramifications these claims might have on our profession's reputation.

Main text

The World Federation of Chiropractic released a rapid review demonstrating the lack of clinically relevant evidence regarding SMT and immunity enhancement. The current claims contradicting this review carry significant potential risk to patients. Furthermore, as a result of these misleading claims, significant media attention and public critiques of the profession are being made. We believe inaction by regulatory bodies will lead to confusion among the public and other healthcare providers, unfortunately damaging the profession's reputation. The resulting effect on the reputation of the profession is greatly concerning to us, as students.

Conclusion

It is our hope that all regulatory bodies will protect the public by taking appropriate action against chiropractors making unfounded claims contradicting public health policy. We believe it is the responsibility of all stakeholders in the chiropractic profession to ensure this is carried out and the standard of care is raised. We call on current chiropractors to ensure a viable profession exists moving forward.

Background

Chiropractic students are frequently reminded that it has never been a better time to be a chiropractor [1]. We the authors are excited at the prospect of joining the profession and making a difference, as we agree the future of chiropractic looks bright. However, we are questioning the above sentiment in light of the current global crisis of Coronavirus disease 2019 (COVID-19). The world is struggling to come to terms with COVID-19, chiropractic students are no exception. The delivery of education has changed, many campus clinics have closed, and future plans of graduating students have been placed in jeopardy. Despite these trying times, we appreciate and are encouraged by the initiative and collaborative spirit of the chiropractic profession. Chiropractic institutions have ensured the availability of quality education in an online format [2], associations have supported and advocated for their members [3], and researchers have appraised literature to assist with knowledge translation [4].

In spite of the above-mentioned efforts, a small minority of the profession has publicly claimed that chiropractic treatments have a role to play in the fight against COVID-19. Specifically, this minority of chiropractors, best characterized by the International Chiropractors Association (ICA) statement, have made unsubstantiated assertions that spinal manipulative therapy (SMT) can augment immune function to improve health outcomes [5]. Bearing this in mind, the goal of this commentary is to provide our perspective on the claims regarding SMT and clinically relevant immunity enhancement, drawing attention to the damaging ramifications these claims might have on our profession's reputation.

Main text

Shortly after the World Health Organization (WHO) declared COVID-19 a pandemic [6], the World Federation of Chiropractic (WFC), which supports the WHO on this matter, released a rapid review on March 19th, 2020 [4]. The review, which examined cited material claiming support for the effectiveness of SMT and immunity enhancement, concluded that "[there is] no credible, scientific evidence that spinal adjustment/manipulation has any clinically relevant effect on the immune system ..." [4]. As students, we are not only encouraged by the WFC's response, but support their strong and swift action in exposing unsubstantiated claims contradicting official public health policy. In addition, we are pleased with the numerous national chiropractic associations that released statements in support of the WFC's conclusions [7,8,9,10,11]. However, as mentioned above, a minority of chiropractors are contradicting the

WFC's review, spreading the belief that SMT can clinically enhance the body's immune response. This is deeply concerning to us, as these chiropractors are making unsupported claims while in positions of power and influence over trusting patients. Of even greater concern, these claims can lead to fatal consequences as a result of potential exposure while in the clinical environment. Fomites, such as furniture, treatment tables, and examination equipment, have the potential to create an optimal environment for virus transmission. Furthermore, the chiropractic profession has a very high score (96/100) pertaining to "physical proximity to others" [12], making social/physical distancing impossible. The benefits of any chiropractic treatment provided during COVID-19 must out-weigh the potential risk of spreading the virus to patients. At a time when social/physical distancing is required to 'flatten the curve', only emergency/acute care visits with the appropriate personal protective equipment should be carried out. The chiropractic profession is not in a position to continue non-emergent in-person visits, while still placing public health interests first.

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The need for evidence-based education

The aforementioned unsubstantiated claims conflict with the education received at many chiropractic institutions. We are proud of the institutions that have signed the International Chiropractic Education Collaboration Position Statement (ICECPS), clearly demonstrating their desire for an evidence-based approach to teaching and healthcare [13]. For us, it is disappointing that only two North American chiropractic programs have signed this position statement. At a time when scientifically unsupported claims are being made, we call for all chiropractic institutions to adopt the ICECPS position. We also believe the Councils on Chiropractic Education (CCE), who are the regulators and accreditors of chiropractic programs [14], need to participate in this effort. The CCE-International, which is recognized by the WHO as an information source, was established in 2003 to provide guidance to the CCEs [15]. Though the CCE-International supports an evidence-based musculoskeletal (MSK) model, this sentiment is not held by all CCEs [15, 16]. We are disappointed that some accredited schools continue to instruct non-evidence-based teachings [15,16,17]. Therefore, we urge all CCEs to take the necessary steps to ensure an evidence-based curriculum is universally adopted.

Reputational damage

In some countries, chiropractors fall below other medical professionals such as nurses and physicians, with respect to honesty and ethical standards [18]. As a result, significant reputational damage can follow when unfounded claims are made that undermine public health policy. Disappointingly, the increased media attention we have seen leads us to believe the damage has already begun. In a recent article published by the Canadian Broadcasting Corporation (CBC) on March 30th, 2020, the claims made by some chiropractors regarding SMT and immunity were said to "muddy the waters" and add unnecessary confusion to the public [19]. Similar news stories have been written by Fox6 in the state of Wisconsin and CBC in British Columbia [20, 21]. As a result of this media attention, we are deeply worried for future ramifications if these claims continue. Gíslason states "ongoing resistance to aligning with the scientific literature has been seen by some as the central issue in impeding professional legitimization, scientific and societal support and inclusion within the wider healthcare professional landscape" [22]. We believe unsubstantiated claims made by a select few are generalized to the profession. This has cast a dark shadow on the profession in the eyes of critics and the healthcare community.

Scientists are speaking out against misinformation currently circulating around COVID-19 [23, 24]. As Berinsky points out, rumors are easy to identify, but the spread of false information is difficult to undo [25]. However, research has shown that misinformation corrected by the original source has demonstrated greater success in rectifying the public message [25, 26]. Therefore, in order to mitigate some of the reputational damage, we call on all chiropractors and organizations spreading misinformation to retract their statements and issue corrections. As we realize this is unlikely, we call on regulators to issue retractions to unsubstantiated statements chiropractors have made, in addition to their normal punitive action.

Call for regulatory action

The unfounded claims regarding SMT and clinically relevant immunity enhancement is not only unsupported by evidence, but goes against standards set out by regulatory agencies [27,28,29]. We agree with the views of Marcon et al., that "it is hoped that the regulatory bodies will recognize these types of discourse [non-evidence-based claims] as problematic and will act accordingly" [30]. Inaction by regulatory bodies can lead to public confusion and negatively impact the image of the profession. If disciplinary actions are not taken by regulatory bodies, public perception will continue to be that all chiropractors agree with the false claims made by a small, yet vocal minority. This inaction will result in the continual spread of these unfounded beliefs [31]. We are concerned for the profession that we will be entering, as the profession's reputation will be tarnished if swift action is not taken against these chiropractors. While we appreciate and support the regulatory bodies who have begun to take action against these dangerous claims, we call for further action and decisiveness. Similar to statements made by Leboeuf-Yde et al., we feel it is time for the profession to act before it is too late [31]. As students, we call not only on regulatory bodies to step up, but all stakeholders who have a vested interest in the profession to pursue their professional responsibility; reporting such behaviour in order to protect the public interest and assist with regulatory enforcement of the profession.

Conclusions

The arguments expressed in this commentary are fueled by great concern, frustration, and embarrassment. We entered this profession wanting to make a difference in people's lives, now we fear for what the state of the profession will be once we graduate. It is our hope that regulatory bodies will hold chiropractors who make unsupported and potentially harmful claims accountable for their actions. We call for a strong stance to be taken against these unsubstantiated claims and do not condone this unacceptable behaviour. As students, we are worried for the profession's reputation and call on current chiropractors to ensure we have a viable profession moving forward.

Availability of data and materials

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Not applicable.

Abbreviations

COVID-19:

Coronavirus disease 2019

ICA:

International Chiropractors Association

SMT:

Spinal Manipulative Therapy

WHO:

World Health Organization

WFC:

World Federation of Chiropractic

ICECPS:

International Chiropractic Education Collaboration Position Statement

MSK:

Musculoskeletal

CCE:

Councils on Chiropractic Education

CBC:

Canadian Broadcasting Corporation

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Contributions

JP wrote the initial draft of the manuscript. BC, GB, JH, and BG contributed significantly toward the text and review of the manuscript draft. All authors read and approved the final manuscript.

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Good morning:

I watched a CCA webinar yesterday as part the Masterclass series that they have organized during the pandemic for members. The one yesterday featured Dr Greg Kawchuk and he spent part of the time talking about internet analytics and public regulation using data from the CCBC. He also had a discussion about data from Twitter regarding claims about chiropractic and immunity. This information would be really useful for CCO council to review. In fact, reviewing the webinar would be even better than just reading the paper, because he presented it so clearly and the webinar also had the discussion about Twitter which was not part of the paper.

I am attaching the paper for your review in the unlikely event that you have not read it. Perhaps this could be included in the package for the next meeting. As for the webinar, the link will be posted on the CCA website - likely next week and the applicable part of that webinar would only be approximately 10 minutes.

Regards,

Janet D'Arcy

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RESEARCH

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The use of internet analytics by a Canadian provincial chiropractic regulator to monitor, evaluate and remediate misleading claims regarding specific health conditions, pregnancy, and COVID-19

Greg Kawchuk^{1*} , Jan Hartvigsen^{2,3}, Stan Innes⁴, J. Keith Simpson⁴ and Brian Gushaty⁵

Abstract

Background: Internet analytics are increasingly being integrated into public health regulation. One specific application is to monitor compliance of website and social media activity with respect to jurisdictional regulations. These data may then identify breaches of compliance and inform disciplinary actions. Our study aimed to evaluate the novel use of internet analytics by a Canadian chiropractic regulator to determine their registrants compliance with three regulations related to specific health conditions, pregnancy conditions and most recently, claims of improved immunity during the COVID-19 crisis.

Methods: A customized internet search tool (Market Review Tool, MRT) was used by the College of Chiropractors of British Columbia (CCBC), Canada to audit registrants websites and social media activity. The audits extracted words whose use within specific contexts is not permitted under CCBC guidelines. The MRT was first used in October of 2018 to identify words related to specific health conditions. The MRT was again used in December 2019 for words related to pregnancy and most recently in March 2020 for words related to COVID-19. In these three MRT applications, potential cases of word misuse were evaluated by the regulator who then notified the practitioner to comply with existing regulations by a specific date. The MRT was then used on that date to determine compliance. Those found to be non-compliant were referred to the regulator's inquiry committee. We mapped this process and reported the outcomes with permission of the regulator.

Results: In September 2018, 250 inappropriate mentions of specific health conditions were detected from approximately 1250 registrants with 2 failing to comply. The second scan for pregnancy related terms of approximately 1350 practitioners revealed 83 inappropriate mentions. Following notification, all 83 cases were compliant within the specified timeframe. Regarding COVID-19 related words, 97 inappropriate mentions of the word "immune" were detected from 1350 registrants with 7 cases of non-compliance.

(Continued on next page)

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Conclusion: Internet analytics are an effective way for regulators to monitor internet activity to protect the public from misleading statements. The processes described were effective at bringing about rapid practitioner compliance. Given the increasing volume of internet activity by healthcare professionals, internet analytics are an important addition for health care regulators to protect the public they serve.

Keywords: Chiropractic, Internet analytics, Regulation, Misinformation

Background

On March 11, 2020, the World Health Organization (WHO) declared the COVID-19 outbreak to be a pandemic [1]. Appropriately, the global health care community responded by emphasising how to combat the disease through frequent hand-washing, sanitizing, and social distancing [2]. At the present time, WHO has stated that no vaccine has been identified for COVID-19 and there are no known interventions effective in preventing, or treating, a COVID-19 infection.

Unfortunately, some clinicians have used the COVID-19 pandemic to promote misinformation whether intentionally or otherwise. For example, cases have been identified where chiropractors have used their internet presence to promote interventions they claim will boost immunity [3, 4]. Such claims are wholly unsubstantiated as outlined in a recent report from the World Federation of Chiropractic [5]; a point emphasized emphatically by multiple national associations globally [6–14]. Without a doubt, the chiropractic profession recognizes this misinformation as potentially dangerous to the public and damaging to professional credibility [15–17].

In most countries, health care professions like chiropractic are overseen by a regulatory body whose duties include registration of members, ensuring ongoing competency and public protection. In protecting the public in British Columbia, Canada, the registrar investigates, adjudicates and forwards any noncompliant activities to its inquiry committee.

In identifying unsubstantiated claims and statements promoted by its registrants, regulatory bodies have traditionally relied on public surveillance to monitor and report potential missteps. Whereas this traditional approach may have dealt with a relatively low volume of regulatory incursions in the past (e.g. evaluation of printed media only), the current volume at which a profession can market itself electronically requires a parallel improvement in regulation. This is especially the case if the volume of complaints remains low and therefore less easy for the public to identify. Thus today, a passive regulatory approach of relying solely on public input may be insufficient given the rapidity that information is spread on the internet.

Despite electronic communications providing new challenges for regulators, this same technology also

provides a potential solution. One such solution is technology that searches specific websites and social media accounts. This technology can be modified to proactively monitor activity then allow regulatory bodies to construct timely interventions [18, 19]. While this approach is still evolving in many sectors, proactive monitoring has been used effectively within law enforcement to monitor and detect illegal activity on the internet for decades and continues to be recommended [20–22]. A similar approach for monitoring healthcare professions could address many of the issues that arise with traditional, time-consuming methods of regulation that rely solely on public reporting [23].

Recently, the College of Chiropractors of British Columbia (CCBC) became the first chiropractic regulatory body that we are aware of to use internet analytics in their regulation of registrants. Specifically, the CCBC commissioned software to identify internet content of their registrants that may contravene their established regulations to facilitate rapid remediation of unacceptable advertising.

The CCBC's use of internet analytics also provides researchers with a unique opportunity to better describe the frequency and content of registrant internet activity and to evaluate the effectiveness of the regulatory process in remediating these claims – something not yet reported in the literature. Should active use of internet analytics be effective in professional regulation, other jurisdictions may consider adopting this approach to enhance public safety.

In this paper, we report on internet analytics by the CCBC to monitor, evaluate and remediate potentially misleading health claims at three discrete time periods: when internet analytics were first employed by the CCBC in 2018 to identify inappropriate claims related to specific health conditions, then again in 2019 for specific claims related to pregnancy care and most recently in 2020 to identify inappropriate claims during the COVID-19 pandemic (details below).

Methods

MRT processes

Customized software was commissioned by the CCBC to provide internet analytics of their registrants and was delivered to the College in 2018 (Compliance Verification

Tools, Vancouver, British Columbia, Canada). This software, known as the Marketing Review Tool (MRT), scans websites and social media activity of all chiropractors in British Columbia. The software specifically searches for pre-defined words from a target list approved and maintained by the CCBC. Using this target list, searches performed by the MRT are made twice per month for websites, daily for social media and on demand as required. Following a search, the software returns cases where a word from the target list is identified. The CCBC then manually categorizes these cases into A) acceptable use of the target word (e.g. "our office is closed during the COVID crisis") and B) unacceptable use (e.g. "chiropractic can boost immunity). For any case deemed unacceptable, the chiropractor(s) registered with the website or social media account is sent a notice to remediate the questionable material immediately (e.g. deletion of content). A MRT scan can then be performed multiple times to determine the rate at which compliance is achieved. When the stated deadline for mandatory compliance is reached, a follow up scan can then be performed and final compliance determined. Any non-compliant activity is then dealt with by the CCBC who forwards these cases to its inquiry committee.

MRT use with specific conditions (October 2018)

The MRT was first used by the CCBC to review the internet activity of their registrants in relation to specific health conditions not permitted to be promoted or treated by registrants. These conditions were made known to registrants on October 3, 2018 with mandatory compliance to occur by November 1, 2018. The regulation providing the targeted words states:

As stated in section 14(1)(f) of the CCBC's Professional Conduct Handbook ("PCH"), chiropractors must not advertise health benefits of their services when there is no acceptable evidence that those benefits can be achieved. See Appendix "N" to the Handbook and the Efficacy Claims Policy for additional information.

The Board is concerned registrants may be making claims in marketing or directly to patients that chiropractic care has beneficial effects on some diseases, disorders and conditions when there is no acceptable evidence for those claims. This policy identifies efficacy claims that are not supported by acceptable evidence, and therefore, must not be made. <https://www.chirobc.com/efficacy-claims-policy/>

Due to the absence of acceptable evidence supporting such claims, registrants must NOT represent to patients or the public that chiropractic: (a) can be used to treat diseases, disorders or conditions such as: Alzheimer's disease, cancer, diabetes, infections, infertility, or Tourette's syndrome, or (b) has any beneficial effect on childhood

diseases, disorders or conditions such as: ADHD (or ADD), autism spectrum disorders including Asperger syndrome, cerebral palsy, Down syndrome, fetal alcohol syndrome, or developmental and speech disorders.

A scan of registrant internet analytics was then performed by the MRT in October, before the compliance deadline. Registrants associated with inappropriate messaging were notified before the compliance deadline so they could take corrective action. A subsequent scan was then performed on the compliance date and noncompliant cases were notified and forwarded to the CCBC inquiry committee.

MRT use with pregnancy conditions (December 2019)

On December 23, 2019, the CCBC released amendments to the Professional Conduct Handbook and the Efficacy Claims Policy regarding pregnancy. The regulation can be found here (<https://www.chirobc.com/amendments-to-the-professional-conduct-handbook-and-efficacy-claims-policy-webster-technique-and-pregnancy-related-conditions/>) and states:

Due to the absence of acceptable evidence supporting such claims, registrants must NOT represent to patients or the public that chiropractic: (a) has any beneficial effect on fetal development or position such as: breech/breech turning or position and intrauterine/in utero constraint. (b) has any beneficial effect on labour or birth such as: easier or shorter labour, preventing the need for medical interventions and preventing premature or traumatic birth. (c) has any beneficial effect on hormone function or postpartum depression.

After the adoption of this policy and subsequent notification of registrants, internet analytics based on selected pregnancy target words were generated from the MRT on December 23, 2019 prior to the compliance deadline of January 30, 2020. Registrants associated with inappropriate messaging were notified before the compliance deadline so they could take corrective action. A subsequent scan was then performed on the compliance date and noncompliant cases were notified and forwarded to the CCBC inquiry committee.

MRT use with COVID-19 (march 2020)

On March 13, 2020, target words were added to the MRT system in response to the COVID pandemic with the expected date of compliance set to the same day. Adding these words to the target list did not require new regulations be passed by the CCBC as claims related to infectious disease were already disallowed through existing regulations.

The PCH states: 9.5 The prevention and treatment of infectious disease is not within the scope of chiropractic practice.

The CCBC also released an announcement to the public that claims promoting treatment or supplements to improve immunity were inappropriate. (<https://www.chirobc.com/novel-coronavirus-covid-19/>) A surveillance scan was performed on March 18, 2020 for words such as COVID, corona, and immune and derivative words. Noncompliant cases were notified to take immediate corrective action. Further scans were then performed and noncompliant cases were notified and forwarded to the CCBC inquiry committee by March 31, 2020.

Data acquisition

In all three applications of the MRT, our research team was provided with anonymized, aggregated data from the CCBC beginning March 24, 2020 and ending March 31, 2020. This anonymized data (provided by the CCBC with permission given for analysis) consisted solely of numerical totals and dates for all three MRT applications: estimates of the number of websites/social media accounts reviewed by MRT, subsequent cases of potentially inappropriate or non-compliant word use, estimates of the number of registrants and the number of non-compliant cases. Approval for this project was provided by the University of Alberta Human Research Ethics Board (Pro00099878).

Results

Specific health conditions

Approximately 750 websites and 650 social media pages of approximately 1250 CCBC registrants were reviewed with the MRT resulting in 250 potentially inappropriate communications (Table 1, Fig. 1). A scan was then conducted on the compliance deadline that identified 65 registrants as non-compliant. Subsequent scans were then performed which showed that all non-compliant cases were resolved except for 2 that remained outstanding and were later resolved through the inquiry committee.

Pregnancy related conditions

This MRT scan identified 636 potential cases from approximated 1350 registrants (Table 1, Fig. 1). Further evaluation by the CCBC classified 83 cases as inappropriate. Internet analytics generated by MRT on the compliance date showed full compliance by all registrants.

COVID-19 and immunity related issues

The MRT scan returned over 4773 potential cases from approximately 1350 registrants. Specifically, there were 1479 potential cases for “corona” and/or “covid” and 2387 cases for “immune” (Table 1, Fig. 1). After review by the CCBC to eliminate acceptable use of target words (e.g. wash your hands frequently during the COVID crisis), 97 cases were inappropriate in their use of the word “immune”. No inappropriate cases were identified for use of “corona” or “covid”. Notices to remove inappropriate material were emailed in March 2020. Subsequent MRT scans showed that the majority of registrants responded promptly and removed questionable content. As of March 31, 2020, there were 7 sites yet to comply and the names of registrants associated with these sites were passed to the CCBC inquiry committee for further investigation.

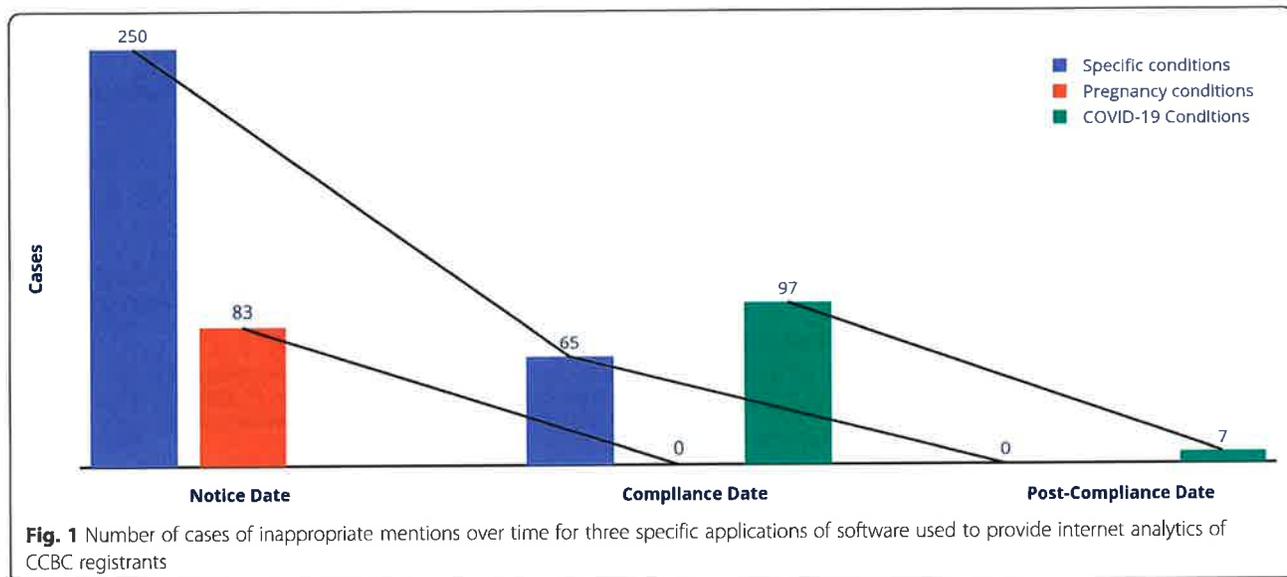
Discussion

We describe the novel use of internet analytics to monitor the social media activity of the chiropractic profession in British Columbia, Canada. Data presented demonstrate this technology can effectively monitor vast amounts of internet activity by registrants over a short period enabling the regulatory body to effectively bring about compliance. Although other Canadian professions are now in possession of this software, we are not aware of any prior report in the literature that describes the use of internet analytics to improve health care regulation in the chiropractic profession.

Traditionally, regulators have relied on public-reporting of inappropriate communications to provide input into their regulatory processes. Although we did

Table 1 Number of cases of inappropriate mentions over time for three specific applications of MRT used to provide internet analytics of CCBC registrants

	Notice Date	Compliance Date Outstanding	Post Compliance Outstanding
Specific Conditions	October 3, 2018	November 1, 2020	December 2019
	250 inappropriate mentions / approximately 1250 registrants	65 inappropriate mentions / approximately 1250 registrants	2 inappropriate mentions / approximately 1250 registrants
Pregnancy Conditions	December 23, 2019	January 30, 2020	Unnecessary
	83 inappropriate mentions / approximately 1350 registrants	0 inappropriate mentions / approximately 1350 registrants	
Immune Conditions	March 13, 2020	March 13, 2020	March 2020
		97 inappropriate mentions / approximately 1350 registrants	7 inappropriate mentions / approximately 1350 registrants



not receive data regarding the number of public complaints made to the CCBC during the time in which MRT has been in use, the CCBC communicated that there are occasions when a public concern is brought to their attention before the next scheduled MRT scan. These concerns are acted on immediately. Still, it is doubtful that this level of public surveillance can identify the number of potential cases of inappropriate word use compared to MRT scanning. While public input remains important to the regulatory process, a modern regulatory body whose registrants are increasingly engaged with the public on the internet should not rely exclusively on public input to monitor their registrants when internet analytics are now available.

While both the public and internet surveillance components of a modern regulatory approach are important, neither can be effective without significant human effort. On the public side, effort is needed to not only identify and interpret incursions, but also to ensure they are reported to the regulator promptly. The public must be made aware by the regulator of what is appropriate and inappropriate to make safe health care decisions. Similarly, use of internet analytics by a regulator requires commitment to performing and analyzing scans regularly. Either way this information is obtained, the regulator must use its existing processes to the fullest to address potential concerns. This is important for protecting the public and to act as a deterrent for future incursions given a rapidly evolving health care environment where competition for patients is becoming substantially more intense. This is especially true for the chiropractic profession whose integration into mainstream healthcare is evolving but whose record of advertising practices in some jurisdictions is unsatisfactory [24, 25].

There would appear to be no substantial downside for regulators to adopt internet analytics in their daily operations to evaluate registrant compliance of regulatory directives [26] although challenges may exist regarding cost, training, and/or time to process identified cases.

Limitations

Current scanning techniques used with the MRT software do not detect target words placed over images (e.g. memes) or text/voice content within video sources. Technologies to address these situations are being tested. The MRT software cannot presently scan all Facebook content as only recent posts are available to the scanner; older posts require user scrolling to be visible.

The MRT software is only effective as the target words used in its searches. The software cannot scan for implication or meaning. As the software allows the user to input new target words, the scan can be expanded as needed to include terms for existing or new regulations.

While we have been informed verbally that MRT software has been ordered by health care professions other than chiropractic, we are not aware that the MRT software is being actively employed in these jurisdictions. Widespread use of MRT software and communication between regulatory bodies as they gain experience in internet analytics may further improve its efficiency.

Importantly, MRT scanning also identifies cases from non-chiropractors who are associated with the registrant through a common clinic website or social media account (e.g. physiotherapy, massage, etc). Cases from associated professions are not pursued by the CCBC nor are they passed forward to other regulatory agencies.

Finally, we cannot assume that all chiropractors knowingly post misinformation on the internet. Although not

presented here, the authors know of paid subscription services that provide chiropractors and their websites/social media with “news feeds” that may provide questionable content. Still, individual practitioners remain responsible for what is displayed in their name. This places the onus on these services to review their standards of business and become vigilant, evidence-based content providers.

Conclusion

Internet analytics are an effective way to monitor website and social media activity of registrants. Use of internet analytics through MRT software is useful for regulatory bodies to keep pace with the high volume of internet activity produced by their registrants and may bring about rapid compliance to existing regulations.

Abbreviations

CCBC: College of chiropractors of British Columbia; MRT: Marketing Review Tool

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Authors' contributions

All authors (GK, JH, SI, JKS, BG) developed, wrote, edited and proofread this work. The author(s) read and approved the final manuscript.

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All data generated or analysed during this study are included in this published article.

Ethics approval and consent to participate

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Consent for publication

Not applicable.

Competing interests

GNK reports active research grants unrelated to this work from The Natural Sciences and Engineering Research, The National Institutes of Health, The Alberta Spine Foundation, The American Orthotic and Prosthetic Association, The New Frontiers in Research Fund and the Canadian Chiropractic Research Foundation. Travel expenditures unrelated to this work in the past year include Kiropraktik i Sverige Live, Et liv i bevegelse" (ELIB), the Nordic Institute of Chiropractic and Clinical Biomechanics, The American Chiropractic Association, The National Institutes of Health, The British Columbia Chiropractic Association, and The World Federation of Chiropractic. He is the Chair of the World Federation of Chiropractic Research Council. Fees for medical-legal expertise unrelated to this work from the Canadian Chiropractic Protective Association. JH reports that he holds multiple research grants from Danish and international funding agencies and charities. He has received coverage of travel expenditures from multiple sources internationally in connection with speaking engagements. Within the past year he has received speaking fees from Parker Seminars and Novartis. He is a member of the World Federation of Chiropractic Research Council. SI has no declarations. JKS declares that he has no conflict of interest related to the subject matter or materials discussed in this manuscript. BG has no declarations.

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 Sadly this was necessary, but proud to work with these great scientists!

Greg Kawchuk @GNK1
 150 scientists unite together to counter misinformation that chiropractic care boosts immunity.
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Statement of the global chiropractic community against the pseudoscientific claim that chiropractic care boosts immunity

[Bussières, J., David Cassidy, Jan Hartvigsen, Greg N. Kawchuk, Minor, Michael Schneider & and more than 140 signatories](#) et al. *Journal of Chiropractic Medicine* 2020; 21(1): 1-10

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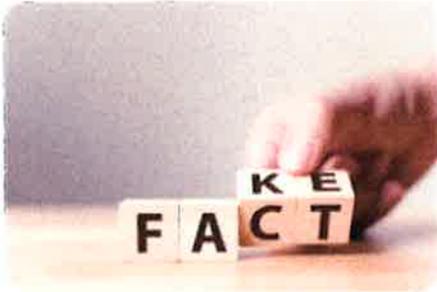
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COMMENTARY

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A united statement of the global chiropractic research community against the pseudoscientific claim that chiropractic care boosts immunity

Pierre Côté^{1,2,3*}, André Bussièrès^{4,5}, J. David Cassidy³, Jan Hartvigsen^{6,7}, Greg N. Kawchuk⁸, Charlotte Leboeuf-Yde⁹, Silvano Mior^{2,10}, Michael Schneider^{11,12} and and more than 140 signatories# call for an end to pseudoscientific claims on the effect of chiropractic care on immune function

Abstract

Background: In the midst of the coronavirus pandemic, the International Chiropractors Association (ICA) posted reports claiming that chiropractic care can impact the immune system. These claims clash with recommendations from the World Health Organization and World Federation of Chiropractic. We discuss the scientific validity of the claims made in these ICA reports.

Main body: We reviewed the two reports posted by the ICA on their website on March 20 and March 28, 2020. We explored the method used to develop the claim that chiropractic adjustments impact the immune system and discuss the scientific merit of that claim. We provide a response to the ICA reports and explain why this claim lacks scientific credibility and is dangerous to the public. More than 150 researchers from 11 countries reviewed and endorsed our response.

Conclusion: In their reports, the ICA provided no valid clinical scientific evidence that chiropractic care can impact the immune system. We call on regulatory authorities and professional leaders to take robust political and regulatory action against those claiming that chiropractic adjustments have a clinical impact on the immune system.

Keywords: Chiropractic, Spinal manipulation, Immunity, Pseudoscience, Coronavirus

Background

We are currently facing the greatest global public health crisis in a century. Fighting the coronavirus pandemic has required that we change the way we live and observe strict public health guidelines. This is necessary because, at this time, there are no effective vaccines, treatments

or cures for COVID-19 [1, 2]. Chiropractors, as members of the health care system, should disseminate the best available public health information to the public [3]. Any attempt to behave otherwise can be misleading and potentially dangerous to individual patients and the public at large.

On March 20, 2020, the International Chiropractors Association (ICA), a US based chiropractic organization, posted a report claiming that chiropractic adjustments can boost immune function with the implication that it might be helpful in preventing COVID-19 [4]. In their

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report, the ICA states that: “Although there are no clinical trials to substantiate a direct causal relationship between the chiropractic adjustment and increased protection from the COVID-19 virus, there is a growing body of evidence that there is a relationship between the nervous system and the immune system” and “The observation that those who use chiropractic regularly and do not become ill with cold, flu, or other community shared illnesses is frequent within the profession and should not be ignored” [4]. The ICA position directly contradicts the World Health Organization (WHO) that unequivocally states that “there are no effective health interventions to prevent or treat coronavirus infections” [1, 2], and the World Federation of Chiropractic (WFC) that states that “there is no credible scientific evidence that chiropractic spinal adjustments/manipulations confers or boosts immunity” [3].

On March 28, 2020, the ICA posted a revised report which reiterated the information included in the first report, with the addition of references supporting the link between chiropractic care and immune function [5]. In both reports, the ICA claims that their review of the literature confirms “An association between spinal manipulation and the autonomic nervous system” and that “These studies suggest mechanisms by which spinal influences may mediate a clinically significant impact on immune function.” Therefore, the main message of both reports is that chiropractic care can have a clinically meaningful impact on immune system function. We discuss the scientific validity of the claims made by the ICA.

Main body

We investigated the approach used by the ICA to support their claim that chiropractic adjustments impact the immune system. We compared the ICA claim to the findings and conclusions of one systematic review of the literature on the effect of spinal manual therapies on autonomic nervous system activity [6] and two systematic reviews on the efficacy and effectiveness of chiropractic treatment and manual therapy on the prevention and treatment of non-musculoskeletal disorders [7, 8]. Further, we used a list of warning signs of pseudoscience to assess the scientific merit of the claims [9]. Finally, 153 researchers from 11 countries (8 co-authors and 145 signatories) who are involved in research relevant to chiropractic reviewed and endorsed our response.

While the ICA states “that no claims can be made about COVID-19 and chiropractic”, their report implies that chiropractic adjustments can boost the immune system through its effect on the nervous system. The ICA claim rests on two assumptions: i) chiropractic adjustments have a beneficial effect on the nervous system and ii) chiropractic adjustments will improve the immune

system through the nervous system. These assumptions are not supported by robust evidence that chiropractic adjustments are efficacious or effective in improving immune function [6–8]. We consider that proclaiming the benefits of chiropractic adjustment/spinal manipulation on immunity during a pandemic is plainly irresponsible and demonstrates a lack of understanding of science, the coronavirus pandemic and public health risks.

Our critical review of the reports suggest that the ICA created a positive narrative for the effect of chiropractic adjustments and immune function report by selectively assembling a series of unconnected basic science studies [4, 5]. This strategy, called “emphasis on confirmation”, is a warning sign of pseudoscience [9]. Moreover, this approach fails to respect the established boundaries that exist between basic and clinical research. For example, two of the basic science studies included in the ICA report were led by one of the signatories of this commentary, Stephen Injeyan DC, PhD [10, 11]. According to Dr. Injeyan: “No published studies have so far demonstrated the clinical significance of spinal manipulation and immune enhancement, our research included. Our studies were conducted in asymptomatic subjects, in vitro cellular models, and the outcomes were measured shortly following SMT. There are no parallels between our experimental research and clinical care.” By only citing basic science experiments, the ICA appear to have overlooked the WHO guidance on implementation research, which clearly states that basic science experiments do not provide relevant justification for implementation of a health intervention [12].

Any health care intervention must be evaluated for its clinical efficacy and effectiveness in well-designed randomized controlled trials before it is implemented in clinical practice [12]. This requirement is not new; it was first implemented by the US Food and Drug Administration in 1962 [13]. With this in mind, it is all the more noteworthy that none of the studies cited in the ICA report provide evidence that chiropractic adjustments actually prevent the onset of infectious diseases in healthy individuals, or improve the health of patients suffering from a viral infection. We call on the ICA to explain why it does not adhere to internationally accepted standards of research implementation but instead rely on unconnected basic science studies when linking chiropractic care to immune system function.

The ICA also relied on anecdotal evidence to support their claim; this is another warning sign of pseudoscience [9]. For example, the authors state: “The observation that those who use chiropractic regularly and do not become ill with colds, flu, and other community shared illnesses is frequent within the profession and should not be ignored” [4, 5]. At best, this type of anecdotal

evidence is useful to generate research hypotheses to be tested in high quality randomized clinical trials. To our knowledge, the hypothesis that chiropractic care reduces the risk of becoming ill with viral colds, flu, and other community shared illnesses has never been properly tested. Any claims suggesting otherwise lack scientific merit and should not be used to justify treating patients with chiropractic adjustments.

Advancing extraordinary claims without providing extraordinary evidence should raise significant concerns about the scientific validity of the ICA's position. In their reports, the ICA claims that individuals who received chiropractic care during the 1918 Spanish flu pandemic were 51 to 91 times less likely to die than those who were treated by medical doctors [4, 5]. These effect sizes are too large to be trustworthy and are a red flag of pseudoscience, because extraordinary claims require extraordinary evidence [9]. Using data from a 100-year-old non-published, non-randomized controlled trial to suggest that chiropractic adjustments reduces mortality from the flu is scientifically and socially irresponsible.

Pseudoscience has the potential to mislead and misinform at any time; even more so in the midst of a pandemic when the public is vulnerable. The current coronavirus pandemic demands that we act responsibly by adopting sound public health practices as recommended by the WHO [14]. These include but are not restricted to regular handwashing, respiratory etiquette, physical distancing, staying at home, limiting trips outside the home except to obtain food or medicine and wearing a mask if symptomatic [14]. We have seen widespread adherence to the guidance around COVID-19, but as scientists and clinicians we have a public health duty to sound the alarm and denounce pseudoscientific claims such as the ones made by the ICA in its reports.

Conclusion

We call on regulatory authorities and professional leaders to take appropriate political and regulatory action against those making direct or indirect unsubstantiated claims that spinal adjustments can boost immunity, or benefit patients with infectious diseases, especially coronavirus infections. Above all, these actions must aim to protect the safety and well-being of patients and the public.

Abbreviations

FDA: Food and Drug Administration; ICA: International Chiropractors Association; WHO: World Health Organization; WFC: World Federation of Chiropractic

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All authors (Pierre Côté, André Bussièrès, J. David Cassidy, Jan Hartvigsen, Greg Kawchuk, Charlotte Leboeuf-Yde, Silvano Mior, Mike Schneider) developed, wrote, edited and proofread the commentary. All signatories reviewed the commentary and endorsed its content. The author(s) read and approved the final manuscript.

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Subject: fyi

Good afternoon:

Just in case you haven't seen this article, I thought I would attach fyi and potentially for distribution to council. This was the other part of the information that was presented at the CCA webinar that I mentioned last week.

Janet D'Arcy

RESEARCH

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Misinformation about spinal manipulation and boosting immunity: an analysis of Twitter activity during the COVID-19 crisis

Greg Kawchuk^{1*} , Jan Hartvigsen^{2,3}, Steen Harsted², Casper Glissmann Nim^{4,5} and Luana Nyiró⁶

Abstract

Background: Social media has become an increasingly important tool in monitoring the onset and spread of infectious diseases globally as well monitoring the spread of information about those diseases. This includes the spread of misinformation, which has been documented within the context of the emerging COVID-19 crisis. Understanding the creation, spread and uptake of social media misinformation is of critical importance to public safety. In this descriptive study, we detail Twitter activity regarding spinal manipulative therapy (SMT) and claims it increases, or “boosts”, immunity. Spinal manipulation is a common intervention used by many health professions, most commonly by chiropractors. There is no clinical evidence that SMT improves human immunity.

Methods: Social media searching software (Talkwalker Quick Search) was used to describe Twitter activity regarding SMT and improving or boosting immunity. Searches were performed for the 3 months and 12 months before March 31, 2020 using terms related to 1) SMT, 2) the professions that most often provide SMT and 3) immunity. From these searches, we determined the magnitude and time course of Twitter activity then coded this activity into content that promoted or refuted a SMT/immunity link. Content themes, high-influence users and user demographics were then stratified as either promoting or refuting this linkage.

Results: Twitter misinformation regarding a SMT/immunity link increased dramatically during the onset of the COVID crisis. Activity levels (number of tweets) and engagement scores (likes + retweets) were roughly equal between content promoting or refuting a SMT/immunity link, however, the potential reach (audience) of tweets refuting a SMT/immunity link was 3 times higher than those promoting a link. Users with the greatest influence on Twitter, as either promoters or refuters, were individuals, not institutions or organizations. The majority of tweets promoting a SMT/immunity link were generated in the USA while the majority of refuting tweets originated from Canada.

Conclusion: Twitter activity about SMT and immunity increased during the COVID-19 crisis. Results from this work have the potential to help policy makers and others understand the impact of SMT misinformation and devise strategies to mitigate its impact.

Keywords: Social media, Twitter, Spinal manipulation, Chiropractic, Misinformation, Immunity

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Introduction

More than half of all persons on earth (53.5%) are estimated to now have regular internet access with 47% in low-middle income countries and 86.6% in high income countries [1]. With this level of penetration, the internet is the most influential tool on earth for distributing information, whether it be accurate or otherwise. Therefore, understanding the creation, spread and uptake of internet misinformation is of critical importance [2] given that misinformation can be given credibility and create negative impacts [3, 4].

Social media has been used in recent decades to anticipate various health events including the spread of infectious disease [5] and new cases of back pain [6]. With recent advances in social media analytics, it is now possible to not only apply these tools to anticipate the onset and spread of various health conditions, but to also identify the onset and spread of information about those conditions. Specifically, various studies have been conducted that show how social media can be used in this regard [7], how social media is consumed [8] and how it can be used to set agendas [9, 10]. Importantly, social media is not always a positive force. Many publications now document how social media can create and disseminate misinformation [11–14]. Even in the short time since the COVID crisis was declared a pandemic on March 11, 2020 [15], several publications have now documented various types of misinformation arising during the COVID crisis [16–18] including potential treatments, methods of prevention and protection, dietary recommendations and disease transmission [19].

While all misinformation is concerning, the public does not expect misinformation to be propagated by regulated health professions whose activities are overseen for public protection. Unfortunately, this has not been the case during the COVID-19 outbreak. Claims that personal immunity can be improved or “boosted” through spinal manipulative therapy (Axén I Bergström C, Bronson M, Côté P, Glissman CN Goncalves G, Hebert J, Hertel AJ, Innes S, Larsen KO, Meyer A, Perle SM, O’Neill S, Weber K, Young K, Leboeuf-Yde C: Putting lives at risk: Misinformation, chiropractic and the COVID-19 pandemic, in submission), an intervention applied by many professions but most commonly by chiropractors [20], appeared on social media as the COVID crisis evolved. Not only is there no clinical evidence of this claim [21], major organizations representing those who provide SMT reacted immediately to condemn the promotion of this idea as potentially dangerous to public health [21–29].

In this descriptive study, we detail how Twitter activity can be used to not only document the magnitude and time course of misinformation describing a link between spinal manipulative therapy (SMT) and boosting immunity, but how social media activity promotes or refutes these claims. Specifically, our study aimed to answer the following research questions:

- Has Twitter activity describing a relation between SMT and “boosting” immunity increased during the COVID-19 crisis?
- What is the magnitude and engagement of Twitter activity that promotes or refutes an SMT/immunity link?
- Does Twitter activity differ between health professions that are mentioned in relation to SMT and immunity?
- What are the demographics (i.e. language, country) of Twitter authors who promote or refute a SMT/immunity link?

We anticipate that knowledge gained from answering these questions will be important not only in predicting future internet misinformation about SMT, but also in preventing and/or mitigating its impact.

Methods

Search

Social media searching was performed using Talkwalker Quick Search (Luxembourg, Luxembourg). Similar to tools used for searching health literature (e.g. EMBASE), Talkwalker performs searches of specific internet content including social media platforms, news agencies, forums and blogs. Talkwalker’s functionality allows searching to be limited to specific content sources, date ranges, electronic devices and many other parameters using standard Boolean syntax. Analysis of search results can be performed in several ways including descriptive metrics generated by Talkwalker using existing data (e.g. sex distribution), derived metrics generated by Talkwalker using artificial intelligence algorithms (e.g. sentiment) and user-generated metrics obtained by downloading raw search results directly into other software (e.g. Excel, SPSS).

For this project, Talkwalker searches were performed exclusively on Twitter for the 3 months before March 31, 2020. Twitter was searched preferentially for the following reasons. First, the entirety of Twitter is searchable (except for direct messaging which is a private discussion between Twitter users) compared to sources such as Facebook whose users must purposefully make their activity available for searching. Second, Twitter is a one-to-one communication model where direct dialogue is possible between all users compared to news media where unbalanced communication occurs through a one-to-many model. Finally, Twitter activity is unmoderated creating potential for a full range of conversation (except for content excluded by Twitter’s rules and policies).

Our primary search (Search #1) was constructed of three main components using Boolean syntax: 1) [procedure] terms related to SMT, 2) [profession] terms related to professions most often associated with SMT and 3) an

immunity term [immun*]. In this study, we limited professions to be those that most often provide SMT (chiropractic, physiotherapy, naturopathy, osteopathy and naprapathy). No additional filters were used (e.g. language). Procedure terms included wildcard representations of words commonly used to describe SMT including manipulation, adjustment and SMT. Profession terms included wildcard card representations of chiropractic, physical therapy, naturopathy, osteopathy and naprapathy. As Talkwalker lacks the ability to perform Boolean operations *between* searches (i.e. union, intersection, difference), we performed additional searches to explore how search terms contributed to the primary search. Search #2 and Search #3 were performed to understand the impact of procedures and professions on the main search. Similarly, we conducted searches #4–8 to understand if procedure terms occurred more frequently for specific professions. Searches #9–13 were performed to understand how individual professions were linked specifically to immunity. Finally, Search #1 was performed again for the 12 months before March 31, 2020 as this is the longest period Talkwalker can search backwards in time (not listed in Table 1).

The above searches identified tweets that contained the search terms in the body of the tweet as words and/or hashtags (e.g. #chiropractic). For each individual tweet identified, multiple attributes describing its content were provided including date, creator, content, country of origin, language, likes, retweets, followers etc. A glossary of Twitter-related terms such as #hashtag can be found in Table 2.

Mentions over time

The above searches resulted in mentions (see Table 2) over time that were then tallied and plotted.

Tone coding and sentiment

Tweets arising from Search #1 were first coded for their tone using the Twitter Tone Index (TTI). The TTI (Table 3) is a nominal index constructed for the purpose of this paper from a training set of 86 tweets that resulted in four coding options: 1) promoting a relation between SMT and/or a profession providing SMT and improved immunity, 2) refuting that same relation, 3) neutral content or 4) irrelevant content. This sample of 86 tweets was then scored independently by four evaluators (LN, SH, CN, JW) to calibrate their use of the TTI. This calibration resulted in 95% of tweets having at least three authors in agreement, and a Fleiss Kappa score of 0.85 interpreted as ‘almost perfect agreement’ [31]. These same evaluators then independently assessed each tweet arising from Search #1 using the TTI. Tweets not having at least 3 evaluators in agreement were discussed to agree on a majority TTI rating. Unresolved ties were broken by a fifth evaluator (GK). Additionally, the sentiment score of each tweet as determined by a proprietary Talkwalker artificial intelligence algorithm scored Tweets using positive or negative integers. The sentiment score is a rolling sum. If 3 Tweets have sentiment scores of 1, 2, 3 and another 3 Tweets have scores of -1, -2, -3, then the resulting sentiment score for that topic is 0.

Profession coding

Following TTI scoring, four evaluators (LN, SH, CN, JW) individually scored tweets arising from Search #1 regarding professions mentioned within each tweet (chiropractic, physical therapy, naturopathy, osteopathy, naprapathy). Tweets that did not mention a relevant profession were coded as “none mentioned”.

Table 1 Twitter searches performed in Talkwalker. Searches #1–13 were conducted over three months between January 01/01/2020 to March 31, 2020. Search #14 (not listed here) was a replicate of Search #1 conducted over the 12 months before March 31, 2020

#	Search components	Specific search terms
1	[procedures] OR [professions] AND [immun*]	(adjust* OR manipul* OR smt OR chiro* OR physio* OR "physical therap*" OR naturo* OR osteo* OR napra*) AND immun*
2	[procedures] AND [immun*]	(adjust* OR manipul* OR smt) AND immun*
3	[professions] AND [immun*]	(chiro* OR physio* OR "physical therap*" OR naturo* OR osteo* OR napra*) AND immun*
4	[procedures] OR [chiropractic] AND [immun*]	(adjust* OR manipul* OR smt OR chiro*) AND immun*
5	[procedures] OR [physiotherapy] AND [immun*]	(adjust* OR manipul* OR smt OR physio* OR "physical therap*") AND immun*
6	[procedures] OR [naturopathy] AND [immun*]	(adjust* OR manipul* OR smt OR naturo*) AND immun*
7	[procedures] OR [osteopathy] AND [immun*]	(adjust* OR manipul* OR smt OR osteo*) AND immun*
8	[procedures] OR [naprapathy] AND [immun*]	(adjust* OR manipul* OR smt OR napra*) AND immun*
9	[chiropractic] AND [immun*]	chiro* AND immun*
10	[physiotherapy] AND [immun*]	(physio* OR "physical therap*") AND immun*
11	[naturopathy] AND [immun*]	naturo* AND immun*
12	[osteopathy] AND [immun*]	osteo* AND immun*
13	[naprapathy] AND [immun*]	napra* AND immun*

Table 2 A glossary of Twitter-related terms

Engagement	The number of times a tweet is liked and retweeted.
Follower	A Twitter user who subscribes to the Tweets (i.e. posts) of another Twitter user.
Hashtag (#)	A word or phrase preceded by a hash sign (#) used on social media to identify a specific theme or topic.
Influencer	An individual who has the power to affect purchase decisions of others because of their authority, knowledge, position, or relationship with their audience (Talkwalker's definition).
Like	When a Twitter user acknowledges another user's tweet (i.e. post).
Mention	Any Twitter activity that contains the search terms (Tweets, retweets, likes etc.)
Potential Reach	The number of potential followers (i.e. subscribers) reached by the Tweet.
Retweet	When a tweet is retweeted (re-posted) by another Twitter user.
Sentiment Score	Sentiment is an expression of the emotional tone behind the tweet that attempts to summarize the attitudes and opinions being expressed. The sentiment score is an integer value which sums the sentiment values of individual mentions [30].
Tweet	A post on Twitter made by an individual on their own behalf or as a representative of a group/organization.

Tweets not having at least 3 evaluators in agreement were discussed to agree on a majority rating. Unresolved ties were broken by a fifth evaluator (GK). Importantly, it was possible to code only whether tweets mentioned a profession; it was not possible to determine if or how the author was associated with a specific profession.

Tweet themes (word frequency)

The content of all tweets obtained from Search #1 were pooled, analyzed for word frequency by a public website [32], then separated by TTI value (promoting or refuting).

Influencers

Influencers were considered to be tweet authors having an engagement score (retweets + likes) of greater than zero. Tweets from each author were segregated by their TTI value and sorted by engagement score.

Demographics

Descriptive statistics from Search #1 were derived for each Twitter user including language, and country of origin using geographical coordinates.

Results

Mentions over time

Total mentions over the 3 month study period are described in Table 4 and visualized in Figs. 1, 2 and 3. Graphing the results of search #1 displays the number of mentions over time. There is a peak of mentions on March 9th. (19.5k mentions, Fig. 1). Searches 2 and 3 indicate that almost 26,000 of the mentions from Search #1 are procedure terms, while profession terms account for ~12,000 mentions in Search #1. Searches #4–8 demonstrate that search results varied between professions mentioned when all other terms were held constant. This finding, that Twitter activity is not distributed evenly between professions, was confirmed in Searches #9–13 (Fig. 3). This figure also shows that mentions involving a profession differ over time; Twitter activity related to most professions peaked near March 9, 2020 and then waned or oscillated. In contrast, Twitter activity related to mentions of “chiropractic” increased on March 9 and were sustained until the end of the study period.

In the 12 months before March 31, 2020 (Fig. 4), baseline Twitter activity consisted of a relatively low volume of mentions punctuated by small activity peaks. This baseline activity preceded a large activity peak coinciding with the onset of the COVID crisis.

Table 3 Twitter Tone Index (TTI)

Tweet Content	Coding Description	Example Hit (bold = search terms)
Promoting	A tweet that suggests directly or indirectly that a SMT/profession improves or boosts immunity	#chiropractic boosts your immune system up to 200%
Neutral	Factual, not misleading (as defined by WHO etc.)	-Wash your hands often, #chiropractic #immunity
Refuting	A tweet that directly or indirectly refutes a SMT/profession for promoting or boosting immunity.	-Naturopathic treatment can boost the immune system (screen capture). This is false!
Not Relevant	A tweet with unrelated content	-What are the roadblocks for treating osteosarcoma with immunotherapy ?

Table 4 Mentions over time

#	Search	Mentions	Engagement	Sentiment	Potential Reach
1	(adjust* OR manipul* OR smt OR chiro* OR physio* OR "physical therap*" OR naturo* OR osteo* OR napra*) AND immun*	37,308	98,699	+ 6%/- 24%	59,982,489
2	(adjust* OR manipul* OR smt) AND immun*	26,159	65,335	+ 4%/- 29%	44,384,042
3	(chiro* OR physio* OR "physical therap*" OR naturo* OR osteo* OR napra*) AND immun*	12,105	34,323	+ 12%/-14%	16,478,381
4	(adjust* OR manipul* OR smt OR chiro*) AND immun*	28,420	68,692	+ 5%/- 28%	51,023,438
5	(adjust* OR manipul* OR smt OR physio* OR "physical therap*") AND immun*	31,042	81,019	+ 5%/-26%	50,685,999
6	(adjust* OR manipul* OR smt OR naturo*) AND immun*	27,983	68,884	+ 5%/-28%	45,634,407
7	(adjust* OR manipul* OR smt OR osteo*) AND immun*	28,463	76,621	+ 4%/- 27%	46,086,149
8	(adjust* OR manipul* OR smt OR napra*) AND immun*	26,341	65,701	+ 4%/-29%	44,405,522
9	chiro* AND immun*	3217	4316	+ 17%/- 25%	7,519,329
10	(physio* OR "physical therap*") AND immun*	4893	15,693	+ 12%-9%	6,302,693
11	naturo* AND immun*	1986	3839	+ 11%/16%	1,441,794
12	osteo* AND immun*	2304	11,287	+ 6%/-4%	1,702,107
13	napra* AND immun*	0	0	N/A	0

Tweet coding and sentiment

There were 1118 individual tweets generated from Search #1 (Table 5). When coded to the TTI, 778 tweets were classified as not relevant with the remaining tweets divided between promoting (187 (24%)), refuting (141 (18%)) and neutral (12 (2%)). Although both promoting and refuting tweets were similar in their engagement scores (3319 vs. 3590), refuting tweets had a potential reach that was 3 times greater than promoting tweets (4,626,820 vs. 1,558,937). Overall, Talkwalker sentiment scores were positive for promoting tweets and negative for refuting tweets.

When these 1118 tweets were coded for the 5 professions related to SMT, there were 809 tweets where a

profession was not mentioned and 7 tweets mentioning an irrelevant profession. Of tweets mentioning a profession relevant to SMT, some mentioned a single profession while others mentioned multiple professions; a distinction retained in our coding (Table 5). From all mentions of professions (11280), chiropractic was mentioned most often (237 (21%)) compared to naturopathy (64 (6%)). Tweets mentioning chiropractic had a potential reach of 4,549,642 Twitter users with a total engagement of 3515 and a total sentiment score of - 10 while for naturopathy, the potential reach was 634,365 with a total engagement of 3114 and a total sentiment score of + 30.

When analyzing mentions of profession for tweets that either promoted (189 mentions) or refuted (148

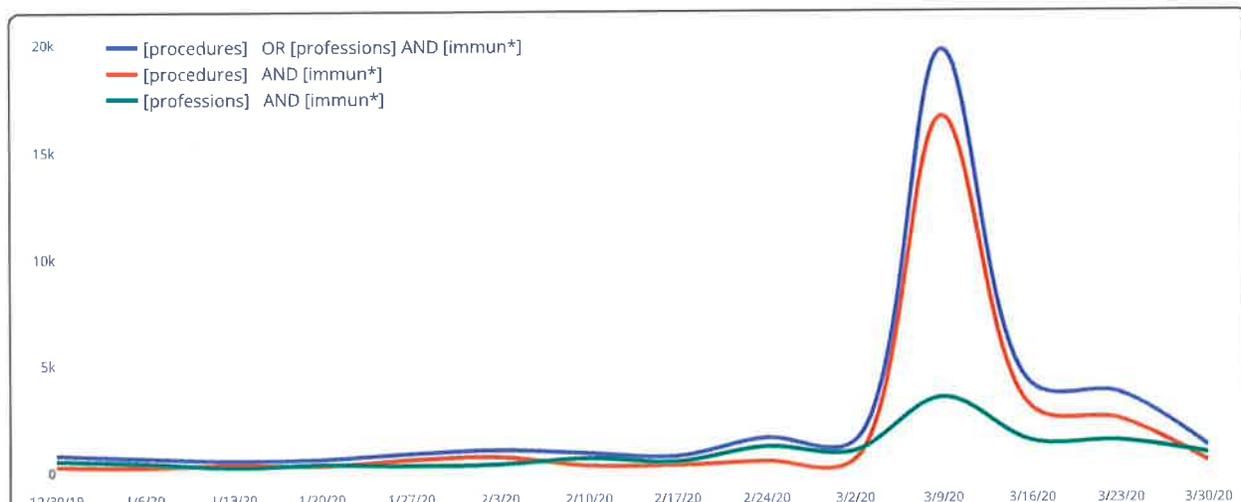
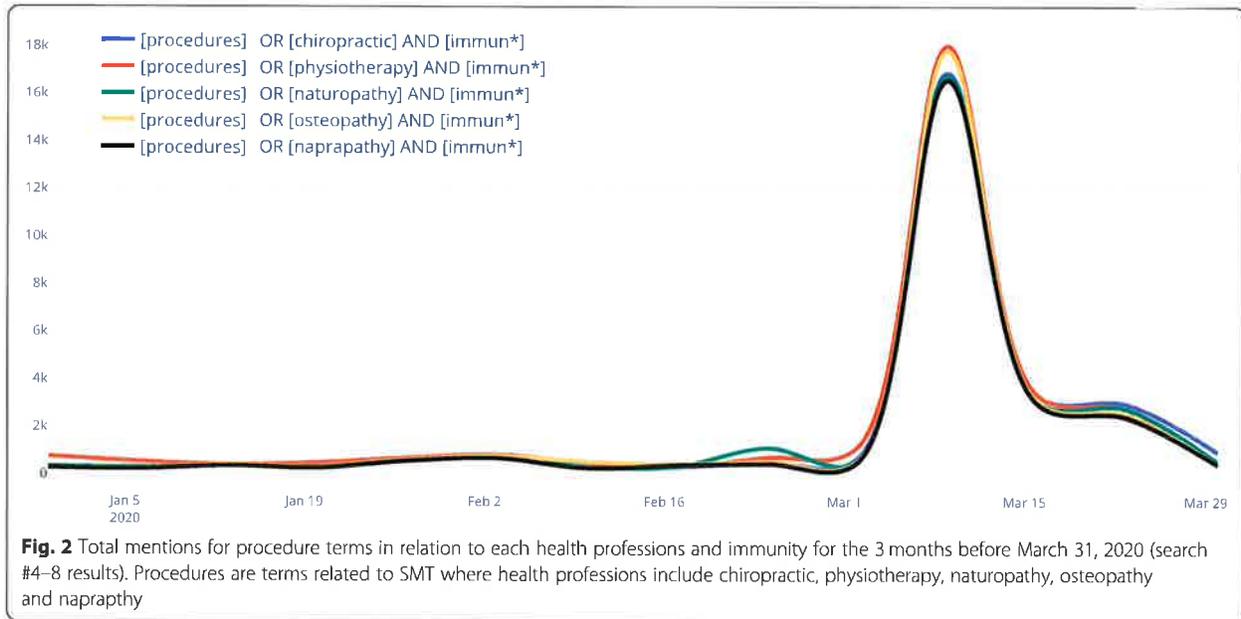


Fig. 1 Total mentions for the 3 months before March 31, 2020 in total and segregated by procedure and profession (search #1–3 results). Procedures are terms related to SMT where health professions include chiropractic, physiotherapy, naturopathy, osteopathy and napraphy



mentions) a link between SMT and immunity, chiropractic was mentioned 108/189 times (57%) in promoting tweets and 123/148 times (83%) in refuting tweets. Naturopathy was the next-most mentioned profession with 40/189 (21%) mentions in promoting tweets and 20/148 (14%) mentions in refuting tweets.

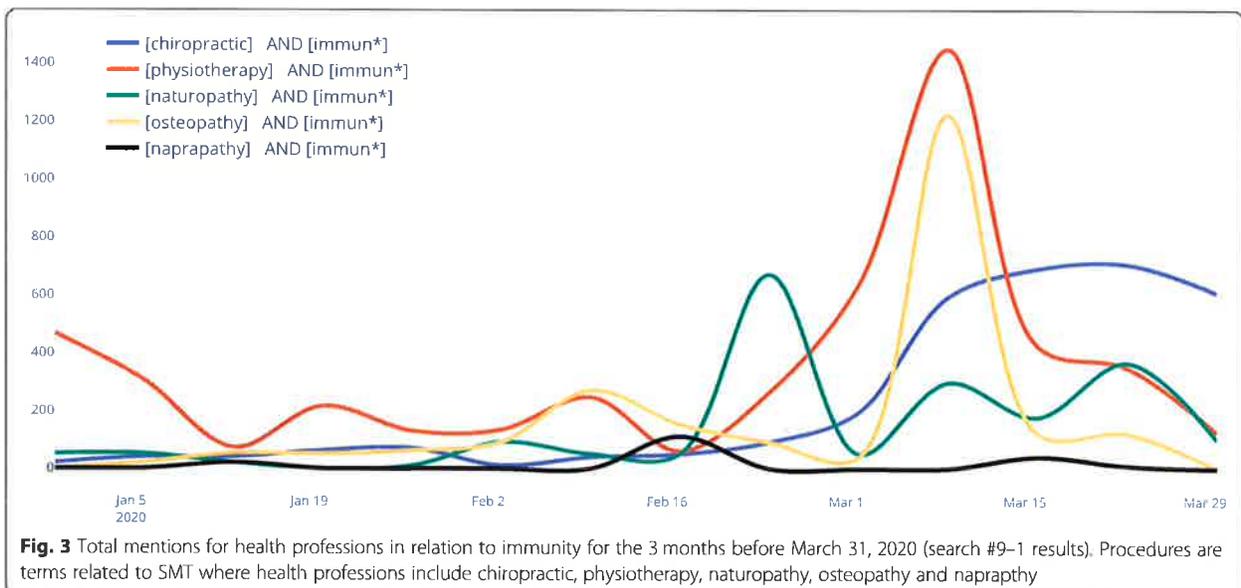
Tweet themes (word frequency)

The major themes (frequent words) contained within the 1118 tweets from Search #1 are presented in Table 6. Terms related to chiropractic and the term “boost” were the most common themes with “evidence” mentioned

only in the refuting themes. The expression “adjustment” was used more frequently than the expression “manipulation” or “spinal manipulation”.

Influencers

In total, there were 132 Twitter authors having engagement scores of > 0 for the study period. Table 7 stratifies these authors into those creating promoting or refuting tweets. While total engagement was similar between both these groups, the potential reach in the refuting group was 3.29 times larger.



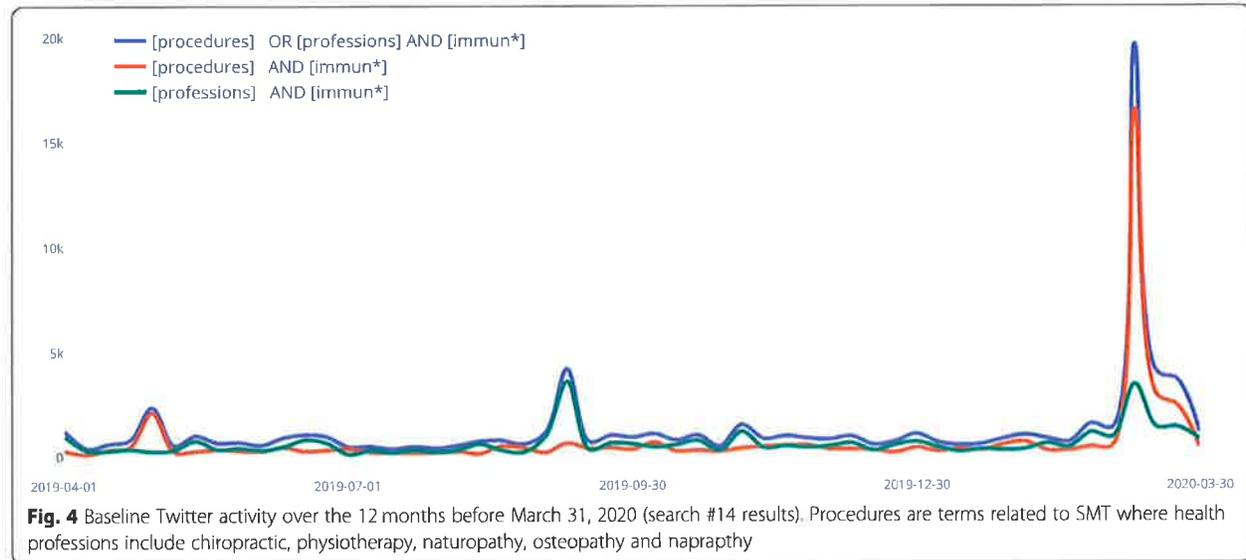


Table 5 Tweet coding for tone, mentioned profession and sentiment

Tone	Profession mentioned	Count	Reach	Engagement	Retweets	Likes	Sentiment
Neutral	Chiropractic	3	12,807	4	2	2	0
	Naturopathy	3	16,522	32	7	25	0
	None Mentioned	2	6126	11	10	1	5
	Osteopathy+Physiotherapy+Other Profession	1	513	0	0	0	5
	Physiotherapy	3	3504	22	1	21	0
Neutral Total		12	39,472	69	20	49	10
Not relevant	Chiropractic	2	305	3	1	2	-5
	Chiropractic+Other Profession	1	1664	8	0	8	5
	Naturopathy	1	1624	4	0	4	-5
	None Mentioned	774	22,822,193	74,621	24,049	50,572	-720
Not relevant Total		778	22,825,786	74,636	24,050	50,586	-725
Promoting	Chiropractic	108	40,341	163	44	119	210
	Naturopathy	38	201,344	185	44	141	70
	Naturopathy+Other Profession	2	53,525	1712	511	1201	5
	None Mentioned	30	1,261,529	1242	388	854	20
	Osteopathy	2	646	1	1	0	0
	Other Profession	4	989	11	3	8	10
Physiotherapy	3	563	5	2	3	-5	
Promoting Total		187	1,558,937	3319	993	2326	310
Refuting	Chiropractic	117	4,263,261	2393	557	1836	-210
	Chiropractic+Naturopathy	4	123,829	670	209	461	-5
	Chiropractic+Naturopathy+Other Profession	2	107,435	274	87	187	-5
	Naturopathy	14	130,086	237	64	173	-30
	None Mentioned	3	1755	5	0	5	-10
Physiotherapy+Other Profession	1	454	11	1	10	-5	
Refuting Total		141	4,626,820	3590	918	2672	-265
Grand Total		1118	29,051,015	81,614	25,981	55,633	-670

Table 6 Top 20 themes (word frequency) contained in Tweets for all tweets and those scored as promoting or refuting misinformation

Rank	Promoting	Occurrences	Refuting	Occurrences
1	chiropractic	81	boost	78
2	boost	44	chiropractors	50
3	help	40	chiropractic	50
4	immunity	36	chiropractor	36
5	care	35	adjustments	31
6	#chiropractic	30	prevent	27
7	health	26	covid	27
8	healthy	23	immunity	24
9	adjustments	23	cbc	24
10	body	21	evidence	24
11	virus	20	#coronavirus	22
12	#coronavirus	19	pandemic	22
13	coronavirus	18	claiming	20
14	vitamin	16	#covid19	19
15	#immunesystem	15	posts	18
16	systems	14	claims	16
17	adjustment	14	ontario	15
18	sleep	13	spinal	15
19	#health	12	people	15
20	naturopath	12	help	14

Demographics

Demographics from Search # 1 were segregated by TTI value (promoting or refuting) and are displayed in Table 8. For both promoting and refuting tweets, the majority of authors were male. English was the predominant language. The country of origin differed between promoting and refuting tweets. Tweets promoting a link between spinal manipulation and immunity were created most often in the United States. Canada generated the greatest number tweets refuting this link (Table 8). Figures 5 and 6 were plotted using longitude and latitude data associated with each tweet.

Discussion

This paper presents the novel finding that Twitter misinformation regarding a SMT/immunity link increased dramatically during the onset of the COVID crisis. Further, activity levels and engagement were roughly equal between tweets promoting a SMT/immunity link and tweets refuting this claim. Interestingly, the potential audience (reach) of tweets refuting these claims was 3 times higher than those promoting these claims.

Mentions over time

The majority of search results (i.e. mentions) from Search #1 were coded as not relevant on the TTI and did not mention a specific profession (778 (70%)). Combined with tweets having a neutral tone (12 (2%)), the vast majority of mentions from Search #1 were not relevant to our analysis. While our search terms could have been made more restrictive to reduce this number of irrelevant mentions (e.g. using "spinal manip*"), we preferred to err on the side of having too many search results that were then coded by our team rather than construct too narrow a search that potentially missed relevant tweets.

Clearly, Twitter mentions about a SMT/immunity link increased during the onset of the COVID-19 crisis with peak activity being almost 5 x higher on March 9, 2020 (19.7k mentions) compared to any other peak activity in the prior 12 months (e.g. September 9, 2019, 4.2k mentions). This suggests that mentions during the COVID-19 crisis were intentional and not an aberration of baseline activity. To further assess baseline Twitter activity, we evaluated the second largest peak of mentions in the preceding 12 months (September 9, 2019, 4.2k mentions). This activity consisted almost entirely of twitter content unrelated to the aims of the paper. However, our analysis did reveal a smaller activity peak on October 21, 2019 that appeared to be related to an automated message delivered from a web content subscription service.

"Chiropractic care can improve your immune system, mobility, strength, and so much more. If you want to see a positive change in your health, schedule an appointment with us".

This specific tweet appeared in 17/21 unique tweets on October 21, 2019 within hours of each other. These 17 tweets generated a total potential reach of 54 users and an engagement score of 1 (retweets + likes). In contrast, a single tweet in the same time period that refuted this message generated a potential reach of 2657 users with an engagement score of 25.

Tweet coding and sentiment

When a tweet is made, it automatically goes out to all persons who follow (i.e. subscribe) the author's Twitter account. While sometimes the potential reach of that author is in the thousands or even millions, there is no guarantee that their followers open their device and see the tweet let alone read it. Therefore, the number of followers, or the potential reach of an author is a measure of the *potential* impact of a tweet. In contrast, if someone acknowledges a tweet by giving it a like or retweeting it (i.e. rebroadcasting it to their own followers), this confirms that the original tweet was both read and acknowledged indicating a true interaction between users.

Table 7 Tweets of the top 25 promoting and refuting influencers (of 132) sorted by descending engagement scores where engagement scores were > 0. Row values of SumReach and SumEngagement are the total potential reach and engagement respectively for all posts by that author. Totals at the bottom of the table are for all 132 authors having an engagement score of > 0 (row data for authors ranked 26–66 are not shown)

Promoting (25 of 66)				Refuting (25 of 66)			
Rank	Count	SumReach	SumEngagement	Rank	Count	SumReach	SumEngagement
1	1	53,525	1712	1	9	483,032	1422
2	1	3099	741	2	1	16,078	369
3	1	31,796	165	3	2	93,324	276
4	1	1,133,212	141	4	30	88,888	257
5	1	1642	99	5	1	211	157
6	1	48,991	98	6	1	19,188	139
7	1	464	84	7	3	11,780	118
8	1	18,230	28	8	1	2,878,804	73
9	1	3714	23	9	1	8731	69
10	1	77	19	10	1	188,258	59
11	1	3390	17	11	1	16,910	58
12	1	727	17	12	1	11,531	49
13	1	7487	11	13	1	7334	49
14	1	127	11	14	1	847	46
15	1	913	10	15	1	3106	45
16	1	721	8	16	18	3904	32
17	1	7380	7	17	1	24,573	31
18	1	2773	7	18	3	9745	30
19	1	2074	7	19	2	4110	25
20	1	775	7	20	1	2175	24
21	1	68	6	21	1	6710	21
22	1	34	6	22	1	4100	15
23	1	3	6	23	3	3994	15
24	1	346	5	24	1	17,692	14
25	1	317	5	25	1	924	13

Considering this, tweets that refute a SMT/immunity link had almost 3 times the potential reach compared to those that promoted this link although the engagement between these two groups was similar. This is an important finding as it suggests that promoting tweets create as much engagement as refuting tweets but with the important note that refuting tweets have the potential of reaching many more persons with their message. Still, it is highly likely that the engagement and potential reach of promoting and refuting tweets have differing audiences who are unaligned in their belief systems about SMT and immunity [33].

Regarding professions mentioned in tweets, our coding revealed that our initial wildcard search terms for physiotherapy and osteopathy were too broad resulting in tweets having topics related to physiology and osteology for example. Following coding to eliminate these

tweets, chiropractic was the profession most often referenced with 4 times more mentions than the next profession (naturopathy). These data suggest that the majority of twitter activity regarding a SMT/immunity link is associated with the chiropractic profession with the total number of posts being roughly equal between those promoting and those refuting this link.

Tweets themes

Tweet themes do not appear to be a good indicator of the impact of specific content as the frequency of the theme is not related to the potential reach or engagement associated with the message; an infrequent theme may be posted in a tweet with far greater reach and engagement than higher ranked themes with lower reach and engagement.

Table 8 Demographics describing sex, age, and language of Twitter content related to all searches

Sex	Promoting Authors	Refuting Authors
Female	51	19
Male	78	98
Unknown	58	24
Language	Promoting Authors	Refuting Authors
English	186	141
French	1	0
Country	Promoting Tweets	Refuting Tweets
United States	89,249	28,278
Canada	3167	38,488
United Kingdom	2586	3664
Australia	1351	1989
Uruguay	1259	0
Puerto Rico	1070	0
Mexico	979	0
France	925	0
Kenya	898	0
Spain	643	0
Malaysia	423	0
India	413	0
Nigeria	225	0
Singapore	155	0
Burkina Faso	54	0
Burmuda	0	2356
Denmark	0	667

Influencers

The top influencers for tweets promoting and refuting a SMT/immunity link each had engagement scores that were ~1000 points higher than the next influencer. This shows influence distribution is not equal within each group. Even more so, top influencers appear to be individuals and not academic institutions, regulatory bodies or professional organizations. Thus, few institutions (e.g. universities, associations) were identified as influencers although some individuals with a specific institutional affiliation could be identified. Although Twitter data is publicly available, and Twitter users agree to make their information available publicly, we have chosen not to identify user names of influencers so as not to inadvertently legitimize those who promote misinformation.

Demographics and global distribution

The majority of those promoting or refuting a SMT/immunity link were male and English speakers. Interestingly, tweets promoting a SMT/immunity link most commonly originated in the United States. Although tweets rarely were affiliated with specific institutions, we note that the majority of chiropractic, naturopathic and osteopathic schools in the world are in the United States. In contrast, the majority of tweets refuting a SMT/immunity link were from Canada which suggests that geographic proximity between countries is not a factor in establishing a position on this topic. These data likely reflect the distribution of Twitter use around the world. The United States is the number one user of Twitter with Japan in second place and Canada in 12th place [34].



Fig. 5 Global heat map of tweet location stratified by those promoting or refuting a message of boosting immunity

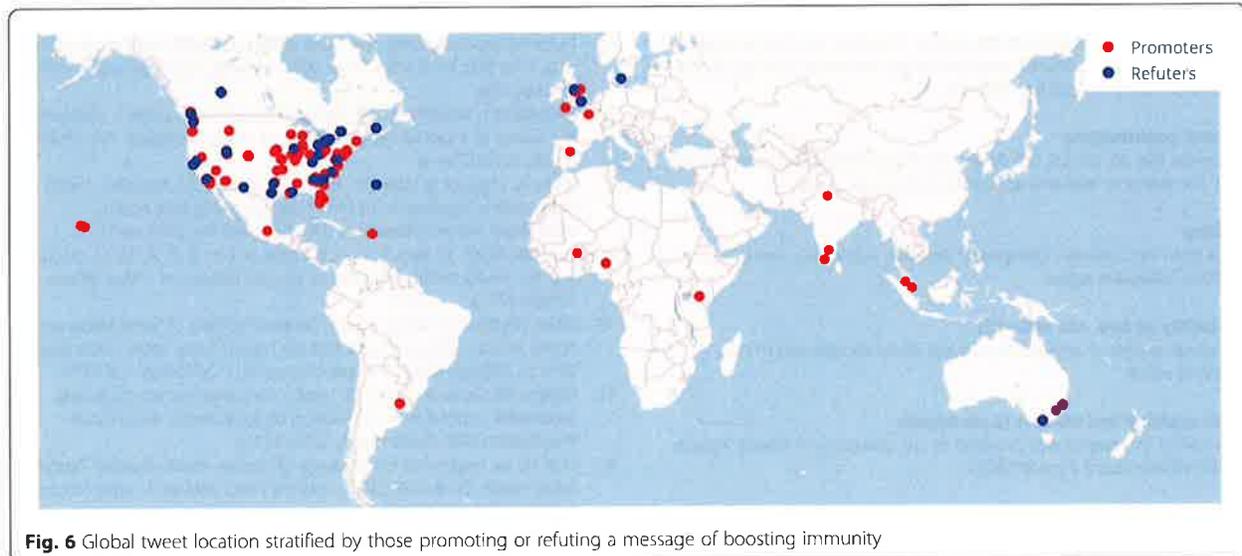


Fig. 6 Global tweet location stratified by those promoting or refuting a message of boosting immunity

Strengths and limitations

Results from this work have the potential to help policy makers and others understand the impact of SMT misinformation and devise strategies to mitigate its impact. Specifically, our results suggest that while the potential reach of messaging that refutes misinformation about SMT was substantial, very few institutions added to this total. Assuming that most institutions related to SMT stand to gain from combating misinformation about SMT (educational programs, associations, regulators, health care administrators etc), these same institutions should re-evaluate their social media strategies lest their silence be taken to be complicit of misinformation or lead to their own demise from an erosion of public trust.

The results reported here are different from those presented previously by investigators who explored chiropractic messaging on Twitter in December of 2015 [35]. In this prior work, Tweets refuting claims about questionable benefits from SMT, including changes in immunity, appeared to be less in proportion compared to those promoting such claims. Possible explanations for these incongruent results include the methodologies used, the year/month of data collection and an increasing awareness of social media misinformation especially during the covid crisis.

While Talkwalker can assess other electronic data sources, only Twitter provides full access to its “firehose”, the entirety of its activity except for direct messaging between users (a private channel of communication between users). As a result, the data from this paper are presumed to be robust in that they represent all activity taking place on a single social media platform although search results from Talkwalker have not been compared against other services/techniques for accessing Twitter data.

Although Twitter provides a window into conversations within a social media community, it is limited in that it does not represent all persons in the world. Presently, Twitter ranks 13th in total monthly users; Facebook has 2.45 billion active monthly users compared to Twitter’s 340 million [36].

Some of the data used in this study were obtained from proprietary algorithms available from Talker-Walker Quick Search but whose methods of calculation were not available to us (e.g. sentiment scores). Similarly, Talkwalker Quick Search uses artificial intelligence to derive some demographic information not directly included in Twitter user profiles (age, occupation and interests). These proprietary metrics of defining user profiles were not used in our analysis.

Conclusion

Twitter activity regarding misinformation about spinal manipulation and immunity increased above baseline levels during the COVID crisis. Direct Twitter activity (posts, likes, retweets, engagement) was similar between tweets promoting and refuting a SMT/immunity link. Importantly, tweets refuting a SMT/immunity link had the potential to be viewed by 3 times more people than tweets promoting this link. Whether promoting or refuting in tone, the chiropractic profession was most often mentioned in tweets compared to other professions associated with SMT provision. Results from this work have the potential to help policy makers and others understand the impact of SMT misinformation and devise strategies to mitigate its impact.

Abbreviations

COVID: Coronavirus Disease; SMT: Spinal Manipulative Therapy; TTI: Twitter Tone Index

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Authors' contributions

All authors (GK, JH, SH, CN, LN) developed, wrote, edited and proofread this work. The author(s) read and approved the final manuscript.

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Availability of data and materials

All data generated or analysed during this study are included in this published article.

Ethics approval and consent to participate

Approval for this project was provided by the University of Alberta Human Research Ethics Board (Pro00099881).

Consent for publication

Not applicable.

Competing interests

GK reports active research grants unrelated to this work from The Natural Sciences and Engineering Research, The National Institutes of Health, The Alberta Spine Foundation, The American Orthotic and Prosthetic Association, The New Frontiers in Research Fund and the Canadian Chiropractic Research Foundation. Travel expenditures unrelated to this work in the past year include Kiropraktik i Sverige Live, Et liv i bevægelse" (ELIB), the Nordic Institute of Chiropractic and Clinical Biomechanics, The American Chiropractic Association, The National Institutes of Health, The British Columbia Chiropractic Association, and The World Federation of Chiropractic. He is the Chair of the World Federation of Chiropractic Research Council. Fees for medical-legal expertise unrelated to this work from the Canadian Chiropractic Protective Association. JH reports that he holds multiple research grants from Danish and international funding agencies and charities. He has received coverage of travel expenditures from multiple sources internationally in connection with speaking engagements. Within the past year he has received speaking fees from Parker Seminars and Novartis. He is a member of the World Federation of Chiropractic Research Council. SH has no declarations. CN has no declarations. LN has no declarations.

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**The Effect of Spinal Adjustment /
Manipulation on Immunity and the
Immune System: A Rapid Review of
Relevant Literature.**

World Federation of Chiropractic.
March 19, 2020

The Effect of Spinal Adjustment / Manipulation on Immunity and the Immune System: A Rapid Review of the Relevant Literature

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World Federation of Chiropractic.

March 19, 2020

Introduction

The world is currently in the midst of a global health crisis due to the spread of Coronavirus Disease 2019 (COVID-19). The World Health Organization (WHO) has declared COVID-19 a pandemic, meaning that it is being spread uncontrolled across country borders. At the time of writing, COVID-19 is affecting some 143 countries worldwide and there have been over 200,000 reported cases. As testing for COVID-19 has been limited, it is estimated that the true prevalence of COVID-19 is far greater than the situation reports have stated.

WHO has issued information and guidance with a view to reducing the spread of COVID-19 and controlling the pandemic. This information has included correcting misinformation about COVID-19.

The World Federation of Chiropractic (WFC) has supported WHO in its advice and recommendations and on March 17, 2020 issued an advice note to the worldwide chiropractic profession.

One of the key messages contained in the WFC advice note highlighted the lack of credible, scientific evidence supporting claims of effectiveness of spinal adjustment / manipulation in boosting immunity and strengthening the immune system. Immunity is defined as the ability of an organism to resist disease, either through the activities of specialized blood cells or antibodies produced by them in response to natural exposure or inoculation, or by the injection of antiserum, or the transfer of antibodies from a mother to her baby via the placenta or breast milk.

This rapid review considers materials the WFC is aware have been cited in support of claims of effectiveness for spinal adjustment / manipulation in conferring or enhancing immunity.

1. Pero R, Flesia J, (1986) University of Lund, Sweden

Citation: None available.

Overview: It has been reported that in 1986 Dr Ronald Pero, a Professor of Medicine in Environmental Health at New York State University, collaborated with Dr Joseph Flesia, a basic science researcher and chiropractor. Reports state that subjects receiving chiropractic care (n=107) had a 200% greater immune competence than those who had not received chiropractic care and a 400% greater immune system competence than those with cancer or other serious disease.

Response: Numerous attempts have failed to retrieve this study. Without the original study to review, no scientific assessment of its claims can be made. Therefore, the "Pero and Flesia" study does not constitute credible, scientific evidence that spinal adjustment / manipulation enhances or confers immunity nor should it be used as a basis to provide care.

2. Enhanced phagocytic cell respiratory burst

Citation: Brennan PC, Kokjohn K, Kaltinger CJ, Lohr GE, Glendening C, Hondras MA, McGregor M, Triano JJ. Enhanced phagocytic cell respiratory burst induced by spinal manipulation: potential role of substance P. *J Manipulative Physiol Ther.* 1991 Sep;14(7):399-408. PMID:1719112.

<https://www.ncbi.nlm.nih.gov/pubmed/1719112>

Overview: This study examined the effect of spinal manipulation on the respiratory burst of polymorphonuclear neutrophils (PMN) and monocytes in asymptomatic adults. The investigators found changes in levels of substance P in subjects who underwent spinal manipulation but not in subjects who underwent sham manipulation.

Response: The clinical meaning of the study's results regarding cellular activity is not known. No clinical research has been performed in this area. Therefore, it is not known if these observations have any effect on human health. This report does not constitute credible, scientific evidence that spinal adjustment /

manipulation enhances or confers immunity.

3. Enhanced *in-vitro* interleukin-2 production following spinal manipulation

Citation: Teodorczyk-Injeyan JA, Injeyan HS, McGregor M, Harris GM, Ruegg R. Enhancement of *in vitro* interleukin-2 production in normal subjects following a single spinal manipulative treatment. *Chiropr Osteopat.* 2008 May 28;16:5. doi: 10.1186/1746-1340-16-5. PMID: 18507834; PMCID: PMC2423359. <https://www.ncbi.nlm.nih.gov/pubmed/18507834>

Overview: The purpose of this study was to report on spinal manipulation-related changes in the production of the immunoregulatory cytokine interleukin 2 (IL-2) in asymptomatic adults. This study found a short-term increase in IL-2 with spinal manipulative intervention, with or without cavitation.

Response: The clinical meaning of these *in vitro* observations of cellular activity on human health is not known. No clinical research has subsequently been performed in this area.

4. Interleukin-2-regulated *in vitro* antibody production following single spinal manipulative treatment.

Citation: Teodorczyk-Injeyan JA, McGregor M, Ruegg R, Injeyan HS. Interleukin 2-regulated *in vitro* antibody production following a single spinal manipulative treatment in normal subjects. *Chiropr Osteopat.* 2010 Sep 8;18:26. doi: 10.1186/1746-1340-18-26. PMID: 20825650; Central PMCID: PMC2945351. <https://www.ncbi.nlm.nih.gov/pubmed/20825650>

Overview: The purpose of this study was to determine if spinal manipulation-related augmentation of *in vitro* interleukin-2 synthesis in asymptomatic adults is associated with the modulation of interleukin 2-dependent and/or interleukin-2-induced humoral immune response. While the augmentation of IL-2 induced IgG or IgM synthesis in subjects receiving spinal manipulation, the amount did not exceed the physiological range of normal human response.

Response: The clinical meaning of these *in vitro* observations of cellular activity on human health is not known. No clinical research has been performed in this area. Further, the authors state "The clinical significance of the elevated responsiveness to IL-2 demonstrated in this *in vitro* study is presently unclear."

5. Effects of specific upper cervical adjustments on CD4 counts in HIV positive patients.

Citation: Hightower BC, Pflieger B, Selano J. The Effects of Specific Upper Cervical Adjustments on the CD4 Counts of HIV Positive Patients. *Chiropractic Research Journal* 1994 ;3(1):32-39. No PubMed ID available – this publication is not indexed by PubMed
https://www.chiroindex.org/?search_page=articles&action=&articleId=5619

Overview: This project sought to demonstrate if upper cervical specific adjustments have a profound effect on the physiology, serology and immunology of HIV positive individuals. No statistically significant differences between the treatment and control group were found.

Response: With only 5 subjects in the experimental treatment group, no description of how the study was conducted or analyzed, and no reporting of absolute change in CD4 values, these results are highly questionable. Further, the authors state "...it must be noted that we cannot generalize our findings to the general population." The clinical meaning of these *in vitro* observations of cellular activity on human health is not known.

6. Reports of decreased mortality in chiropractic/osteopathic patients during flu epidemics.

Citation: Kendrick Smith R. One hundred thousand cases of influenza with a death rate of one fortieth of that reported under conventional medical treatment. Proceedings of the Annual Convention of the American Association of Clinical Research, New York City (October 18,1919) Reproduced in *J American Osteo Assoc.* 2000 May; 100(5): 320-323.

Overview: It is claimed that the treatment of patients by chiropractors during the influenza pandemic of 1918 resulted in fewer deaths than those treated by medical doctors.

Response: These narrative reports of historical events do not equate to scientific studies. Their lack of methodological structure or data analysis is likely to have resulted in incomplete information and a high likelihood of bias. We note that even those who have written about these events in a positive light (<https://doi.org/10.7556/jaoa.2013.036>) concede that there is no way to tell if these observations can be attributed to manual medicine and care philosophy or "statistical issues of reporting". These various reports do not provide the necessary evidence to justify the use of spinal adjustment / manipulation for infectious diseases.

7. Effects induced by spinal manipulative therapy on the immune and endocrine system

Citation: Colombi A, Testa M. The effects induced by spinal manipulative therapy on the immune and endocrine systems. *Medicina* 2019; 53:448. doi 10.3390/medicina55080448.

Overview: This was a narrative review of the available literature that aimed to provide an overview of the available evidence supporting the biological plausibility of high-velocity, low-amplitude thrust on the immune-endocrine system. Following a search, 4 studies were retrieved studying the effect of spinal manipulation on the immune system.

Response: The authors concluded that "While spinal manipulation may stimulate the neuroimmunoendocrine system, the evidence supporting a biological account for the application of high-velocity, low-amplitude thrust manipulation in clinical practice is mixed and conflicting." It also concluded that the clinical relevance of most of the studies remained unanswered as they were conducted on healthy subjects. This study supports that there is no current basis for which to provide spinal adjustment / manipulation for the purpose of conferring or enhancing immunity.

Conclusion

No credible, scientific evidence that spinal adjustment / manipulation has any clinically relevant effect on the immune system was found. Available studies have small sample sizes and a lack of symptomatic subjects.

At the time of writing, there exists no credible, scientific evidence that would permit claims of effectiveness for conferring or enhancing immunity through spinal adjustment / manipulation to be made in communications by chiropractors.

In the event that new scientific evidence emerges, it will be critically appraised using scientific methods of analysis.

Acknowledgments

The WFC is grateful to the Research Committee for its work in compiling this rapid review:

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The International
Chiropractors Association

Immune Function
and
Chiropractic

What Does the
Evidence
Provide?

28 March 2020

Second Edition

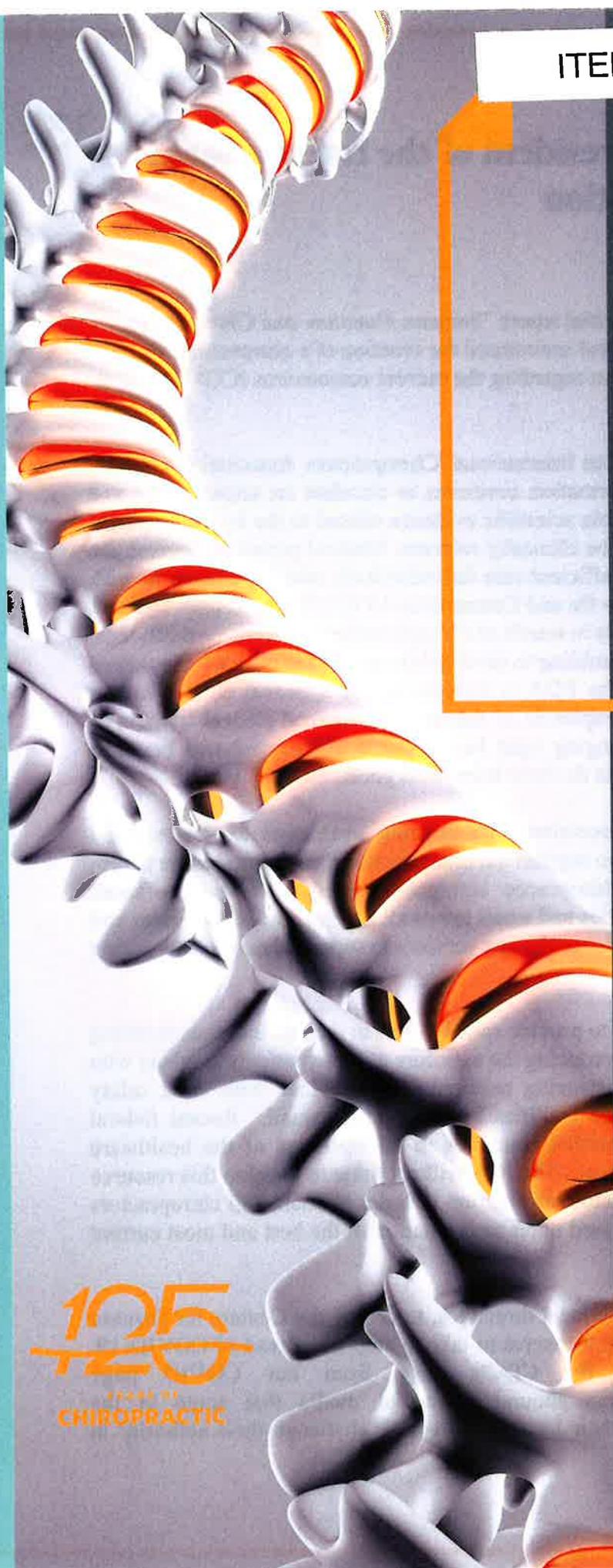


1926 - 2020

*Celebrating 94 Years of
Service to the Chiropractic
Profession and the Public*



105
120
YEARS OF
CHIROPRACTIC



A Message from the President of the International Chiropractors Association

March 28, 2020

One week ago, the ICA released its initial report "*Immune Function and Chiropractic What Does the Evidence Provide?*" and announced the creation of a comprehensive collection of resources and information regarding the current coronavirus (COVID-19) at <http://www.chiropractic.org/covid/>.

As we release the second edition of the International Chiropractors Association's report, with 7 additional references, misinformation continues to circulate on social media and various websites regarding the available scientific evidence related to the immune system and how much of that evidence may be clinically relevant. Medical personnel around the world are grappling with providing sufficient care for individuals who have taken ill with upper respiratory illnesses such as the flu and Coronavirus-19 (COVID). Researchers and scientists are fast tracking clinical trials in search of a 'magic bullet'. Government officials, operating with little evidence, are scrambling to enact public policies to mitigate the threats to our communities world-wide. The FDA is expediting the approval for the use of promising treatments prior to the completion of the usually required clinical trials. The "rules of the game" are rapidly changing right before our eyes as regulators begin to recognize that too much "red tape" can do more harm than good.

The current focus on COVID-19 necessitates an ongoing evaluation of the essential services provided by chiropractors who support the non-infectious, urgent and acute neuromusculoskeletal conditions. The chiropractic community, most of whom are small business owners dispersed in large cities and small towns all around the United States and the world, continues to provide essential healthcare services to support their patients during this time of extreme stress.

Many chiropractors have the capacity to provide spinal x-rays in their offices thus reducing the burden on emergency rooms; and reducing the exposure of these patients to others who are potentially infectious. Social distancing requirements combined with strict safety protocols are stressing all health care facilities both large and small. Recent federal legislation seeks to provide much needed resources to all members of the healthcare community as we all unite to do our part. The ICA will continue to develop this resource and provide access to the latest available information in order to enable all chiropractors world-wide to make their decisions based upon an evaluation of the best and most current evidence available.

ICA urges its members to listen to the local directives, to follow the Centers for Disease Control and Prevention's guidance on measures to take to stop the spread of COVID-19. We have provided a link to the CDC's page from our COVID page (<http://chiropractic.org/covid>). Rumors abound on social media that some in the chiropractic profession may ignore their local directives or challenge their authority in



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court. We ask that no chiropractor make this his or her “I am Spartacus” moment. The ICA is confident that as more pandemic modeling data becomes available each day, new short term public policies will be adopted.

ICA also affirms that our doctors should retain the rights to use their best judgement, in conjunction with the local directives, and conditions in their own communities to determine if and how they will be open during these challenging times. We appreciate those who are providing chiropractic to first responders and hospital personnel. As essential healthcare service providers, our members are needed more than ever to serve those under extreme stress.

Recognizing the desire of our members to help their current patients and community, the ICA has since COVID-19 was declared a global pandemic given clear guidance to our members that **no claims may be asserted that chiropractic is a prophylactic or cure for COVID-19.** The virus is so new, that no studies have been conducted evaluating the immune response of COVID-19 patients to chiropractic adjustments.

The current global health crisis surrounding the COVID-19 Pandemic has resulted in changes in our everyday lives and has created increased levels of stress, anxiety, and fear. Scientific evidence has validated that long-term exposure to stress negatively effects the immune system.

As an essential health care provider, the chiropractor is in a unique position to assist their patients during this time of heightened stress. Although there are no clinical trials to substantiate a direct causal relationship between the chiropractic adjustment and increased protection from the COVID-19 virus, there is a growing body of evidence that there is a relationship between the nervous system and the immune system.

In publishing this report, the ICA provides to our membership, at their request, a summary of existing research; and calls for expanded research resources. This second edition of this report makes minor edits and adds additional studies.

Yours in health,

A handwritten signature in black ink that reads "Stephen P. Welsh, DC".

Stephen P. Welsh, DC, FICA
President

Immune Function and Chiropractic – What Does the Evidence Provide?

Introduction

“Scientific advances are predicated on new knowledge that is robust and reliable and that serves as a solid foundation on which further advances can be built.” [1]

Evidence and observation have since the inception of caregiving driven the decision making of caregivers. As caregiving became medicine, and now has evolved into health care, experts in health research have established a methodology known as evidence-based medicine or evidence-based health care to describe the ideal process of clinical decision making by health care professionals. Almost simultaneous to this was the promotion of meta-analysis and systematic reviews as methods of gathering the evidence on a topic and drawing quality conclusions. One of the great challenges with the promotion of systematic review has been the almost singular focus on examining randomized controlled trials and eliminating all other peer reviewed published studies from the pool of papers to be evaluated. In fact, one paper cited in this report started with a body of evidence of more than 1,300 articles and eliminated all but 8 to use in their systematic review.

David L. Sackett, the modern founder of Evidence-Based Health provided clarity to the intention. An evidence-based practice, “...aims at integrating individual clinical expertise with the best available external clinical evidence from systemic research and patient values.[2]

Every day, a million times a day, chiropractors make evidence-informed decisions with their patients. As a result, about a million times a day, safe, effective chiropractic care is provided world-wide.



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In 2020, the chiropractic profession celebrates the 125th anniversary of the founding of the profession by D.D. Palmer. He is quoted as saying, *“One question was always uppermost in my mind in my search for the cause of disease. I desired to know why one person was ailing and his associate, eating at the same table working in the same shop, at the same bench, was not. Why? What difference was there in the two persons that caused one to have pneumonia, catarrh, typhoid or rheumatism, while his partner, similarly situated, escaped? Why?”*^[3]

The questions raised by the founder of chiropractic relate to the immune system and are questions still in need of further research 125 years later.

“Medicine is the study of disease and what causes man to die. Chiropractic is the study of health and what causes man to live.”¹



Attributed to
BJ Palmer, DC, PhC
Founder of the International
Chiropractors Association

¹ One of our sage members provided that this quote was actually from Clarence S. Gonstead, DC, who made significant contributions to the field. The quote is widely attributed to Dr. Palmer, however; we wish to note that it may have originally been a statement from Dr. Gonstead.



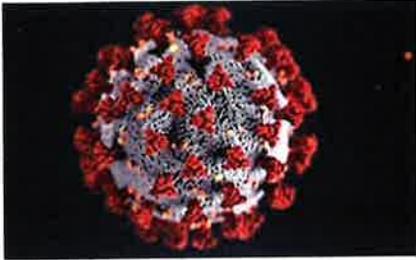
COVID-19 and the Need for Research

Stanford researcher, John P.A. Ioannidis stated, “The current coronavirus disease, Covid-19, has been called a once-in-a-century pandemic. But it may also be a once-in-a-century evidence fiasco. At a time when everyone needs better information, from disease modelers and governments to people quarantined or just social distancing, we lack reliable evidence... “. [4]

The Coronavirus-19 Global Pandemic, the need for fact-based, peer reviewed information, and the International Chiropractors Association (ICA) affirmation to the global chiropractic community that subluxation-based chiropractic practice is scientific and evidence-based, brings together several key points:

1. Research is essential to improving access to chiropractic as displayed in the recently completed 10 year chiropractic study by the US Department of Defense which confirmed that chiropractic to improve key fitness characteristics among active duty service personnel with low back pain and could lead to improve military readiness in such individuals.[5] As a result TRICARE is looking to expand access to chiropractic.
2. There is an urgent need to expand significantly the level of research funding available to US chiropractic institutions for basic and clinical research and partnering entities.
3. Many chiropractic peer reviewed publications are not PubMed Indexed and need to be for ease of information gathering both inside and outside the chiropractic community.
4. A lack of peer reviewed research is not proof of a lack of benefit.
5. One should not discount the important of clinical observation and patient reports, they are the foundation from which the evidence-base is built.

Coronavirus 19 (COVID-19) is so New there is No Credible Scientific Evidence to Support any Type of Treatment



As of March 2020, there are no cures for COVID-19 accepted in the scientific community. There are no recognized cures in conventional medicine or alternative health approaches for COVID-19. There are no vaccines, no drugs, no natural remedies, no alternative therapies that have been tested and the outcomes peer reviewed to meet any credible evidence-based standard in science. This includes chiropractic.

The ICA has previously provided clear reminders to its members of the importance of not advertising in any form the suggestion that chiropractic can cure, treat, prevent, or mitigate COVID-19 because the evidence to substantiate such a claim does not exist.

The evidence does not exist because the research on COVID-19 and chiropractic has not been conducted, just as it has not been conducted on most other treatment options that might be considered as potentially helpful or for potential ‘off label use’. In the first edition of this report, we noted there were 44 clinical trials registered with clinicaltrials.gov for COVID-19. Not even one was for any non-drug, non-biologic approach. As of March 28, 2020, there are now 202 registered clinical trials. Among these are IV vitamin C, numerous other drugs including thalidomide: dietary supplements, Traditional Chinese Medicine, and observational studies about additional adverse outcomes such as myocardial damage. There are no studies that addressing the relationship between the nervous system and the immune system and the effects of chiropractic care. Answers for scientific questions never asked through research will never be answered to the satisfaction of the scientific community.

If Chiropractic Cannot Cure or Prevent, COVID-19, Then Why Talk Immune Function?

The conversation about immune function is bigger than COVID-19 infection alone. The ICA has been clear that no claims can be made about COVID-19 and chiropractic. We make this statement on every document we issue in regard to this pandemic.

A healthy functioning immune system is critical to overall health and wellness. It is vital to the body’s innate ability to seek balance in health sometimes referred to as homeostasis, as Cannon referred to as the ‘Wisdom of the Body’[6]. The conversation that all the experts in public health have been promoting is to use every means available to support one’s immune system during the pandemic. (Adequate sleep, good nutrition, frequent hand washing with soap, etc.) There are other factors to consider as well. For example, the stress every member of the public, first responders, and health care professionals are feeling

as a result of the changes in our everyday lives from the global pandemic. This stress is creating unprecedented levels of anxiety, and fear in some. Scientific evidence has validated that long-term exposure to stress negatively effects the immune system.

The issue of anxiety and stress has become so prevalent that the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH) have begun promoting information to the public. From the CDC's website "Stress during an infectious disease outbreak can include:

- Fear and worry about your own health and the health of your loved ones
- Changes in sleep or eating patterns
- Difficulty sleeping or concentrating
- Worsening of chronic health problems
- Increased use of alcohol, tobacco, or other drugs

Among the recommendations to support oneself through the stress includes, 'take care of your body'.^[7] "Psychological conditions, such as stress or depression, are known to compromise immune defenses and increase the likelihood of infections."^[8]

Wayne Jonas, MD in his book, *How Healing Works*, wrote about the principles of healing, "In condition after condition, system after system, and person after person, I found three common factors that induced healing:

- (1) the rituals that helped a person have a meaningful experience,
- (2) the support of the whole person, and
- (3) the regular stimulation of a biological response.

The specific treatments and agents used varied by person, culture, theory, and place, but the processes were the same. Whole systems science showed us that a person is an ecosystem – more like a garden to be cultivated than a car to be fixed."^[9]

Chiropractic supports the whole person. Vitalistic chiropractors address more than just the mechanics of the spine.

"While other professions are concerned with changing the environment to suit the weakened body, chiropractic is concerned with strengthening the body to suit the environment."

Dr. B.J. Palmer



We Cannot Ignore the Affects that Weeks or Months of Fear, Stress and Anxiety Created by the COVID-19 Global Pandemic Response May have on Health Status

Renowned endocrinologist and expert in integrative health care Professor Leonard Wisneski, MD, FACP provided a history of scientific knowledge around the effects on human health related to exposure to stress, stress syndrome, and stress response in his textbook, "The Scientific Basis for Integrative Health". The chapter summarizing the literature on the effects on stress and health, noting that a 1991 study published in the *New England Journal of Medicine* building on historical anecdotal data found that 'psychological stress was associated in a dose response manner with an increased risk of acute infectious respiratory illness.'[10, 11]

The science literature is significant supporting the likelihood that the effects of the worry, stress, fear and anxiety that people around the world are feeling every day for weeks on end will have detrimental effects on their health; at a time when a simple visit to any health care provider is limited.

A recently published report summarized what the extensive body of peer reviewed science supports, "Emerging from this large body of research is substantial evidence that exposure to life stress and adversity can negatively affect human functioning, disease risk, and longevity." And "...human brain and immune system are principally designed to keep the body biologically safe, which they do by continually monitoring and responding to social, physical, and microbial threats in the environment. ... When sustained, however, this multilevel biological threat response can increase individuals' risk for several inflammation-related disease conditions that dominate present-day morbidity and mortality."[12]

Immune Function

"The overall function of the immune system is to prevent or limit infection...The immune system can distinguish between normal, healthy cells and unhealthy cells by recognizing a variety of "danger" cues called danger-associated molecular patterns (DAMPs). Cells may be unhealthy because of infection or because of cellular damage caused by non-infectious agents like sunburn or cancer. Infectious microbes such as viruses and bacteria release another set of signals recognized by the immune system called pathogen-associated molecular patterns (PAMPs)... When the immune system first recognizes these signals, it responds to address the problem. If an immune response cannot be activated when there is sufficient need, problems arise, like infection. On the other hand, when an immune response is activated without a real threat or is not turned off once the danger passes, different problems arise, such as allergic reactions and autoimmune disease.



The immune system is complex and pervasive...All immune cells come from precursors in the bone marrow and develop into mature cells through a series of changes that can occur in different parts of the body.”[13]

Two Pillars of the Immune System The Immune system is built upon two pillars – the innate immunity and adaptive immunity (sometimes referred to as acquired immunity).[14-17]

Innate Immunity is the nonspecific first line of defense in our immune system. Innate has not been sensitized by external actions such as previous infections or vaccinations. It is not stimulated by specific antigens.

Adaptive Immunity, sometimes referred to as acquired or specific immunity is a subset of the immune system that develops very specialized responses as a result of exposure to pathogens. The system creates immunological memory to create an enhanced response to protect if the same pathogen exposure happens at a subsequent time. The adaptive immune system sometimes has challenges distinguishing between harmful and harmless foreign molecules, which is associated with conditions such as hay fever or seasonal allergies.

What is measured to study immune function? Researchers conducting scientific investigation start with a theory or hypothesis and determine what can be measured to gather valid information to answer whether the theory or hypothesis has merit. In looking at immune function, the below are a snapshot of measurements that are used in research to measure issues related to immunity.

1. T-lymphocytes (T-cells) are often used in studies to evaluate the immune response.[5] T-Cells are “important players in the adaptive arm of the immune system.” Because the central nervous system (CNS) is an immune-privileged site, immune response in the CNS are relatively restricted. The unique nature of the communication between the CNS and the immune system can be observed, for example, in the dialog between the CNS and T-cells.”[18, 19]

2. “Chemokines are chemotactic cytokines that control cell migration and cell positioning throughout development, homeostasis, and inflammation. The immune system, which is dependent on the coordinated migration of cells, is particularly dependent on chemokines for its function. Not only do chemokines guide immune effector cells to sites of infection or inflammation, but they also coordinate interactions between immune cells. By doing so, chemokines promote interactions between the innate and adaptive immune systems, thus shaping and providing the necessary context for the development of optimal adaptive immune responses.”[20]

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3. Neuropeptides expression has been studied extensively. More than 10,000 papers have been published as a result. Neuropeptides are short sequences of amino acids that function either directly or indirectly to modulate synaptic activity. In addition, neuropeptides may also function as primary neurotransmitters.[21] Recent research findings point to the role of “neuropeptide in immune functions”[8]
4. Substance P (SP) is a neuropeptide that is released from sensory nerve endings and is widely present in nerve fibers. SP acts on bones and related tissues by binding to receptors, thereby regulating bone metabolism, cartilage metabolism, and fracture healing. SP, a signaling substance, is recognized by both the immune system and the nervous system.[22]
5. Cytokine interleukin 2 (IL 2) is pivotal in T-cell dependent immune responses. There are well established protocols to utilize IL 2 assessment to study ability of T-cell to become activated.[23]
6. CD4 T lymphocytes counts are the essential measure of progression of disease in HIV patients.[24, 25]

Chiropractic and the Nervous System

A professional librarian conducted a systematic literature of seven databases. Only 18 controlled studies were evaluated based on the *a priori* criteria. The effects of high velocity, low amplitude spinal manipulation were evaluated. **An association between the spinal manipulation and the autonomic nervous system was confirmed through multiple measurers.** The authors noted a need for high-quality studies that include patients, well characterized for pain duration and outcome measure baseline values and address the relation between changes in neurophysiology and pain.[26]

In a study of 21 young men with cervical pain and shoulder stiffness but without abnormalities in neck-to-shoulder MR images and without history of any prior treatments were evaluated. An MRI examination of the neck to shoulder area was conducted on all patients. The MR images were used as a reference for the anatomical locations of cervical muscles in the PET imaging. After spinal manipulation, PET imaging was conducted, cervical muscle tension was measured bilaterally at the superior part of the trapezius muscle using a tissue hardness meter and the mean value of three measurements were recorded. Salivary amylase levels were also measured for each subject using an amylase monitor to evaluate changes in autonomic nervous system (ANS) function.

The researchers “observed metabolic changes in the brain and skeletal muscles, as well as reductions in subjective pain, muscle tension, and salivary amylase, after spinal manipulation intervention. These results may be associated with reduced sympathetic nerve activity, suggesting that spinal manipulation induces a kind of relaxation similar to



that achieved by biofeedback. **The brain response to spinal manipulation may reflect the psychophysiological relaxation that accompanies reduced sympathetic nerve activity.**[27]

A 2005 basic science review of chiropractic summarized the state of the science in several areas including the nervous system response to chiropractic spinal manipulation. The review confirmed that between 1997 and 2005 the basic science body of evidence confirming a relationship between chiropractic spinal manipulation and the central nervous system. **They concluded, basic science studies support chiropractic theory that spinal subluxation and spinal manipulation impact neurologic function. In addition, the interdependence of nervous, endocrine, and immune systems has been discussed here. These studies suggest mechanisms by which spinal influences may mediate a clinically significant impact on immune function** [28]

The Nervous System and the Immune System

The Nervous System and the Immune System Cross-Talk “Considerable evidence has mounted to support active communication between the nervous system and the immune system. The nervous system, including the brain and the peripheral divisions can either stimulate or inhibit various activities of both the innate and adaptive immune systems. Conversely, the immune system, through the release of cytokines, can influence the activity of the nervous system. Several excellent reviews have addressed the subjects of nervous and immune system “cross-talk” in great detail. Very recently, however, several peptides, recognized initially for their neural or neuroendocrine signaling functions have been shown to exhibit potent antimicrobial activity. This discovery signals the possibility that the nervous system, through utilization of these peptides, has the capacity to deliver anti-infective agents directly to innervated sites localized with great spatial specificity and delivered rapidly. **The nervous and neuroendocrine systems, in principle, have the potential to serve a direct immune function.**”[29]

The aforementioned Cramer, et. Al, 2005 review notes, “The central nervous system and immune system share modulator and receptor mechanisms by which the two systems communicate. Their interaction maintains both basal and stress-related homeostasis through two major pathways: the systemic sympathetic nervous system (SNS) and hypothalamic-pituitary-adrenal (HPA) axis... The immune system is now thought to be ‘tuned’ by contrasting neural influences...When internal or external influences disturb homeostasis, both the SNS and HPA axis are activated, thereby increasing the peripheral levels of catecholamines and glucocorticoids to restore the steady state of the internal milieu. The review notes the most extensive body of science regarding chiropractic and the immune system at the time was by Brennan. Two noted findings were that a single spinal manipulation “enhanced polymorphonuclear cell activity that was associated with a slight,

but statistically significant, rise in plasma substance P.” In another study they found patients presenting with neuromusculoskeletal complaints had reduced numbers of circulating natural killer cells; but these cells were not functionally impaired.[28]

A 2018 article reporting on the study design of clinical trial designed to provide knowledge regarding the underlying mechanisms of the effects of Spinal manipulation provided the following analysis of the evidence: “Chiropractic care including spinal manipulative therapy (SMT) has been found to be a safe, effective and cost-effective non-invasive treatment for some types of spinal pain. SMT has both local and regional pain reducing effects as well as central nervous system effects such as a general reduction of pain sensitivity. SMT is thought to decrease pain by mechanically affecting muscular and joint function (i.e. normalizing muscle tone and improving joint mobility). However, recent experimental research has suggested that SMT may also be influencing the incoming /ascending pain signals (local nociceptive input affecting dorsal horn excitability or temporal summation) and/or the excitability of the central pain regulating mechanisms. A systematic review concluded that short-term sympathetic upregulation can be found with SMT, regardless of the spinal area being treated. This raises the question of whether the pain reducing effect of SMT is associated with a modulation of autonomic nervous system (ANS) activity.”[30]

Scientific Evidence

Chiropractic, Spinal Manipulation, and Adjustment

ICA is issuing this report and will continue adding to this list of studies that may be of interest to our members and the greater chiropractic community at large. The following studies include a review of the literature on the effects of spinal adjustment (manipulation) on immune function. The list also includes those studies in which biomarkers which also play a role in immune function are studied.

1. **Neuroimmunomodulation and a Possible Correlation with Musculoskeletal System Function** From 1989 – “There is an increasing body of evidence that the nervous system is capable of modulating the immune response. Receptors for neuromodulators and neurohormones have been found on human T lymphocytes. Activation of these receptors can be stimulatory or inhibitory depending on the neuroactive substance. The immune system may be able to communicate with the nervous system using neuromodulators and neurohormones secreted by lymphocytes. Sympathetic innervation of lymphoid tissues is not restricted to blood vessels and smooth muscle, but directly supplies lymphocytes and blood precursor cells. It is theorized that spinal fixations may adversely affect the immune response through somatosympathetic reflexes. Spinal manipulation can correct the spinal fixations and may eliminate the adverse effects of somatosympathetic reflexes.”[31]

2. **A Literature Review sought to determine the effects of spinal manipulation on biochemical markers** in humans and establish the level of evidence for changes in biochemical biomarkers. Spinal Manipulation (SM), defined as a high-velocity, low-amplitude thrust technique. Among the outcome measured sought were neuropeptides (neurotensin, oxytocin, SP) (2) inflammatory (TNF, IL) and (3) endocrine (cortisol, epinephrine, nor-epinephrine, luteinizing hormone) biomarkers from any body fluids (blood/urine/saliva). After removal of duplications, 1217 citations were screened. That was culled down to 96 abstracts screened, 45 full-text articles were assessed for eligibility. And a total of 8 trials included in the review.

The review found the studies varied in study design, quality, and outcomes. The conclusion after the review was that a moderate level of evidence existed in the eight studies which found that spinal manipulation influences various biomarkers typically identified as ones not only involved in pain perception/modulation but also play an important role in inflammation, tissue healing and immune response. Studies in the review found that Spinal Manipulation influences various biochemical markers. Spinal Manipulation can increase Substance P, neurotensin, oxytocin and interleukin levels and may influence cortisol levels post-intervention.[32]

3. **Low Back Pain and the production of Chemokines.** In a study evaluating the role of inflammation in nonspecific low back pain, an assessment of the production of migratory nociceptive chemokines, and sE-selectin (which activates endothelial cell production) in patients with acute and chronic low back pain before and after spinal manipulation with a single high velocity low amplitude manipulative thrust to the involved segment in the lumbosacral region was conducted. Six adjustments were provided over a span of two weeks with the single thrust and no other additional treatment modalities. The 3-armed study was completed by 19 patients with acute low back pain; 23 with chronic low back pain; and 21 asymptomatic volunteers.

There were differences in mediators both within their own start and finish measures as well as between groups. Researchers documented significant differences existing in the levels of the studied chemokines between low back pain patients and the asymptomatic controls. Several of the chemokines studied were significantly augmented in acute low back pain patients when compared to the control patients. The production of one of the measured chemokines, CCL4, was significantly higher in the acute low back pain patients than the chronic low back pain patients at baseline, while the other measurements were not significantly different. Conversely, while the plasma content of sE-selectin varied somewhat between groups, compared with controls, the levels were not significantly different in the acute low back pain group but were significantly elevated in the chronic low back pain group. The outcomes after the two-week intervention period found that the mean chemokine production declined across the board in both groups of low back pain patients while remaining essentially unchanged in the asymptomatic group. The spinal manipulation protocol had no statistically significant effect on the sE-selectin production which remained significantly elevated in chronic low back pain patients and unchanged in the acute patients. This is the first step in evaluating the effect of chiropractic on

chemokines and sE-selectin and what the changes may or may not mean in relation to both the inflammatory markers and immune system function. One of the still unanswered questions is whether the decline in certain chemokines production after spinal manipulation produces an immune response that provides a statistically significant level of protection against any or all bacterial or viral infection presentations to the body. Another unanswered question is whether or not a full adjustment, not just one thrust, provides a different response in the chemokine and sE-selectin responses.[33]

4. **Measuring Biomarkers for Pain before and after chiropractic care in female patients with acute non-specific mechanical neck pain.** Twenty-eight female patients aged 20 to 45 years with acute non-specific mechanical neck pain (NS-MNP) participated in the study. Of these, 13 subjects were randomly assigned to the experiment arm, and 15 to the control group which received a sham manipulation. The objective of the study was to determine if a consistent biochemical response or change in neuropeptide or cortisol serum concentrations occurred after cervical spinal manipulation. While the cortisol levels did not change significantly in either group after the cervical spinal manipulation; there was a significant increase in three of the neuropeptides of interest (oxytocin, neurotensin, and orexin). It is postulated that spinal manipulation may be capable of modulating these biomarkers. [34]

5. **Spinal Manipulation effect on interleukin-2 production.** The study measured the effect of spinal manipulation on selected parameters of the immune response. The study had three arms – the control group, a group that received spinal manipulation with cavitation (the audible release); and spinal manipulation without cavitation. The goal was to gather knowledge not only on the immune response, but also to determine if cavitation provides a measurable difference in outcomes. The outcomes of the study included a statistically significant increase in the production of IL-2 in both of the arms of the study in which patients received spinal manipulation relative to baseline and to the control group at 20 minutes post adjustment. An increase in IL-2 was also found 2 hours later. There were no differences between the two adjustments arms, meaning that cavitation did not appear to change the outcomes. In this study as with many others, the authors state, “the biological mechanisms associated with spinal manipulation are poorly understood.” The authors also stated that earlier studies have demonstrated increased activity of the innate immune response components following a single spinal manipulation. The authors concluded that a single high velocity, low amplitude thrust to the thoracic spine of asymptomatic subjects causes a significant enhancement in IL-2 secretion in vitro.[23]

6. **Spinal Manipulative Thrust Reduces Inflammatory Cytokines.** In a study of 64 asymptomatic subjects, were separated into three arms of the study, one to receive a single adjustment of the thoracic spine. The second group was a sham manipulation and the third was a venipuncture control. The authors stated, “the present study supports the hypothesis that the spinovisceral reflex effect can encompass functional activity of the immune system. We believe this to be the first report to demonstrate that a single manipulative thrust to an aberrant vertebral motion segment in the upper thoracic spine of asymptomatic subjects results in downregulation of the capacity of human leukocytes for

the production of proinflammatory cytokines induced by lipopolysaccharide (LPS)-induced inflammatory response in invitro, in control subjects submitted to multiple venipunctures, became augmented.” The authors concluded there is a time dependent attenuation of LPS-induced production of the inflammatory cytokines unrelated to systemic levels of Substance P after spinal manipulative thrust. The central mechanism of action was not known.[35]

7. **CD4 Count response to Upper Cervical Adjustment.** A 1994 Randomized Clinical Trial found that the CD4 counts in HIV positive patients in the control group experienced a 7.96% decrease while those who received an upper cervical adjustment experienced a 48% increase in CD4 cell levels. While the study was limited by small subject groups, the outcomes are compelling.[36]

8. **Spinal Manipulation and Immune Response Literature Review.** A lay language summary of the existing research posted online provides the following summary, “The studies described above demonstrate an accumulation of evidence that indicates spinal manipulation may influence the immune system's response to various stimuli. Three of the studies suggest that manipulation consistently reduced the production of pro-inflammatory mediators associated with tissue damage and pain from articular structures. Two studies provide evidence that manipulation consistently reduced the production of pro-inflammatory mediators associated with tissue damage and pain from articular structures. Two studies provide evidence that manipulation may induce and enhance production of the immunoregulatory cytokine IL-2 and the production of immunoglobulins as well.”[37]

9. **A literature review of tumor necrosis factor (TNF),** well-known inflammatory cytokine in the pathological development of various human diseases, its physiological roles and the molecular mechanisms underlying spinal manipulation therapy (SMT) and we propose a novel mechanism by which SMT may achieve clinical benefits by using certain beneficial features of TNF.[38]

10. **Cervicogenic headache (CHA) response to adjustment.** A small study, out of Hungary, two patients with whiplash injury and disk herniation developed CHA associated with very high TNF-alpha levels. After manipulative therapy, these patients became symptom-free, and their TNF-alpha levels decreased substantially.[39]

11. **Neuro Response to Vertebral Subluxation.** A literature review was conducted concerning human or animal studies of neural responses to vertebral subluxation, vertebral displacement or movement, or both.[40]

12. **Autonomic Nervous System Response.** To review recent findings from basic physiologic research about the effects of somatic stimulation of spinal structures on autonomic nervous system activity and the function of dependent organs. The collective experience of the chiropractic profession is that aberrant stimulation at a particular level of the spine may elicit a segmentally organized response, which may manifest itself in dysfunction within organs receiving autonomic innervation at that level. The authors

observation is that this experience is at odds with classic views of neuroscientists about the potential for somatic stimulation of spinal structures to affect visceral function. The authors concluded that, “Recent neuroscience research supports a neurophysiologic rationale for the concept that aberrant stimulation of spinal or paraspinal structures may lead to segmentally organized reflex responses of the autonomic nervous system, which in turn may alter visceral function.”[41]

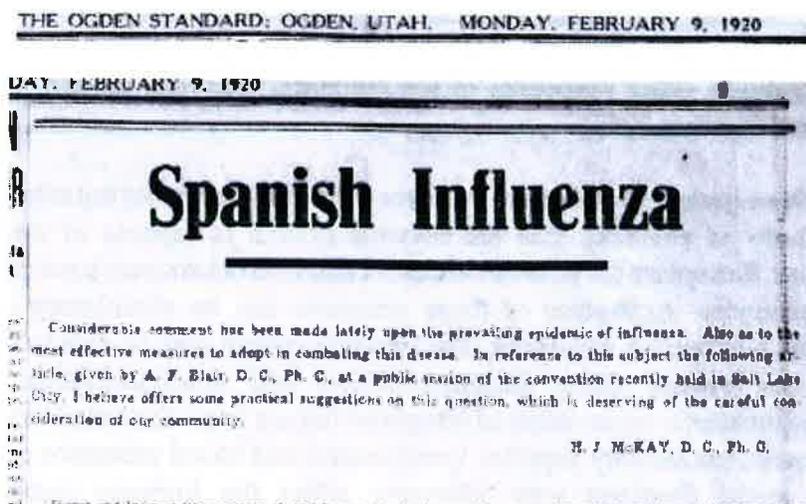
13. **Spinal Manipulation to reduce adverse effects of somatosympathetic.** “There is an increasing body of evidence that the nervous system is capable of modulating the immune response. Receptors for neuromodulators and neurohormones have been found on human T lymphocytes. Activation of these receptors can be stimulatory or inhibitory depending on the neuroactive substance. The immune system may be able to communicate with the nervous system using neuromodulators and neurohormones secreted by lymphocytes. Sympathetic innervation of lymphoid tissues is not restricted to blood vessels and smooth muscle, but directly supplies lymphocytes and blood precursor cells. It is theorized that spinal fixations may adversely affect the immune response through somatosympathetic reflexes. Spinal manipulation can correct the spinal fixations and may eliminate the adverse effects of somatosympathetic reflexes.”[31]

Anecdotal Evidence is Still Evidence

It is important to remember that the first forms of evidence, the precursor to formal research, is observation and anecdotal evidence. The observation that those who use chiropractic regularly and do not become ill with colds, flu, and other community shared illnesses is frequent within the profession and should not be ignored. It should instead lay the groundwork for a multi-site research study conducted within ICA Affiliated Chiropractic Colleges to study the whole person, all systems within the body and the health outcomes over time with regular chiropractic care. In this type of study, qualitative and quantitative analysis can take place, including the effects on the immune system. We cannot leave the study of immune function to small, well intentioned studies looking at a single spinal manipulation. We need a replication of what happens in chiropractic routinely. A secondary opportunity is practice-based research networks that can gather credible data for the development of peer-reviewed journal reports.

After the publication of the first edition of this report, the ICA was contacted by academic researchers who suggest that chiropractic colleges do not have the capacity in their research departments to conduct such research. The ICA shares this statement without a qualifier on its merit and notes, that if chiropractic colleges have not yet had the ability to develop this research capacity, then we as a community need to work to grow this capacity and to develop positive affiliations with other academic institutions to achieve the capacity to have well designed clinical and basic science research conducted.

The 1918 Influenza History



No discussion of immune function and chiropractic can be complete without including the history of chiropractic during the 1918 influenza outbreak known commonly as the Spanish Flu.

Chiropractors are all taught the history of chiropractic including the account prepared by Wayne R. Rhodes, DC in writing about the history of chiropractic in the state of Texas. While this is not a scientific paper, it was published by Dr. Rhodes' peers in the Texas Chiropractic Association. It is provided for information purposes.

“The 1917 - 1918 influenza epidemic swept silently across the world bringing death and fear to homes in every land. Disease and pestilence, especially the epidemics, are little understood even now and many of the factors that spread them are still mysterious shadows, but in 1917-1918 almost nothing was known about prevention, protection, treatment or cure of influenza. The whole world stood at its mercy, or lack of it.”

He continues, “Chiropractors got fantastic results from influenza patients...” The statistics speak for themselves: In 1918, a time when there were no validated treatments for flu, the epidemic killed millions world-wide. While the below data were gathered by the Osteopathic Association, the data were not prepared in a scientific article and subjected to the peer review process of journals. The information was gathered in Davenport, Iowa, home of Palmer College and reported across the country in meetings and even in newspapers.[42, 43]

Data Provided from the 1918 Spanish Flu Comparing Treatment/Death Numbers				
Location	Patients Treated by Medical Doctors (MDs)	Deaths in Medical Patients	Number of Patients Treated by Doctors of Chiropractic (DCs)	Deaths in Chiropractic Patients
Davenport, Iowa	4,953	274	1,635	1
State of Iowa	93,590	6,116 (1 in 15 deaths)	(Excluding Davenport)– 4,735	6
State of Oklahoma			3,490	7
	In Oklahoma, after medical doctors gave up 233 patients as lost, chiropractors were called in with 208 survivors and 25 deaths			
Nationally			46394	54
New York City Influenza	For every 10,000	950	For every 10,000	25
New York City Pneumonia	For every 10,000	6400	For every 10,000	100

In addition to the above data from the United States, Chiropractic is known to have been used during the 1918 Influenza outbreak in France. Dr. S.T. McMurrain (DC) provided care in the influenza ward of Base Hospital No. 84 in Perigau. The medical officer in charge during the outbreak sent all influenza patients for chiropractic adjustments. The outcomes were so impressive that Dr. McMurrain would be commissioned in the Sanitary Corps. [44]

There are chiropractors today, who earnestly seek to have this studied during this COVID-19 pandemic and are willing to participate at their local hospitals, or to provide care in their own clinics to hospital personnel, first responders, and others who are at high risk for COVID-19 in a research project if asked.

Conclusion

Chiropractic is a health care discipline which emphasizes the inherent recuperative power of the body to heal itself without the use of drugs or surgery. The practice of chiropractic focuses on the relationship between structure (primarily the spine) and function (as coordinated by the nervous system) and how that relationship affects the preservation and restoration of health. It is founded upon the principle that the body’s innate recuperative power is affected by and integrated through the nervous system.

The current global health crisis surrounding the COVID-19 Pandemic has resulted in changes in our everyday lives and has created increased levels of stress and anxiety, and fear. Scientific evidence has validated that long-term exposure to stress negatively effects the immune system.



As an essential health care provider, the chiropractor is in a unique position to assist their patients during this time of heightened stress. Although there are no clinical trials to substantiate a direct causal relationship between the chiropractic adjustment and increased protection from the COVID-19 virus, there is a growing body of evidence that there is a relationship between the nervous system and the immune system. As a service to chiropractors around the world, and their patients, the ICA has committed to developing and maintaining this library of relevant scientific evidence.

The Way Forward

The International Chiropractors Association calls upon all our colleagues within the profession to join with us in seeking greater research resources for our academic institutions and their research partners. An increase in funding allotted through the current emergency pandemic appropriation and in future years will lead to the necessary clinical research required to validate the role of doctors of chiropractic in promoting health and vitality through a healthy, balanced immune response.

We call upon our policy makers and legislators world-wide to support these efforts.

The Mission of the International Chiropractors Association is to protect and promote chiropractic throughout the world as a distinct health care profession predicated upon its unique philosophy, science, and art of subluxation detection and correction. We will continue to work each day to fulfill this mission.

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Please address any questions and provide any additional research studies to

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URL: <http://www.chiropractic.org>

15 DAYS TO SLOW THE SPREAD

Listen to and follow the directions of your **STATE AND LOCAL AUTHORITIES**.

IF YOU FEEL SICK, stay home. Do not go to work. Contact your medical provider.

IF YOUR CHILDREN ARE SICK, keep them at home. Do not send them to school. Contact your medical provider.

IF SOMEONE IN YOUR HOUSEHOLD HAS TESTED POSITIVE for the coronavirus, keep the entire household at home. Do not go to work. Do not go to school. Contact your medical provider.

IF YOU ARE AN OLDER PERSON, stay home and away from other people.

IF YOU ARE A PERSON WITH A SERIOUS UNDERLYING HEALTH CONDITION that can put you at increased risk (for example, a condition that impairs your lung or heart function or weakens your immune system), stay home and away from other people.



For more information, please visit

CORONAVIRUS.GOV

DO YOUR PART TO SLOW THE SPREAD OF THE CORONAVIRUS

Even if you are young, or otherwise healthy, you are at risk and your activities can increase the risk for others. It is critical that you do your part to slow the spread of the coronavirus.

Work or engage in schooling **FROM HOME** whenever possible.

IF YOU WORK IN A CRITICAL INFRASTRUCTURE INDUSTRY, as defined by the Department of Homeland Security, such as healthcare services and pharmaceutical and food supply, you have a special responsibility to maintain your normal work schedule. You and your employers should follow CDC guidance to protect your health at work.

AVOID SOCIAL GATHERINGS in groups of more than 10 people.

Avoid eating or drinking at bars, restaurants, and food courts — **USE DRIVE-THRU, PICKUP, OR DELIVERY OPTIONS.**

AVOID DISCRETIONARY TRAVEL, shopping trips, and social visits.

DO NOT VISIT nursing homes or retirement or long-term care facilities unless to provide critical assistance.

PRACTICE GOOD HYGIENE:

- *Wash your hands, especially after touching any frequently used item or surface.*
- *Avoid touching your face.*
- *Sneeze or cough into a tissue, or the inside of your elbow.*
- *Disinfect frequently used items and surfaces as much as possible.*

CORONAVIRUS.GOV

School operations can accelerate the spread of the coronavirus. Governors of states with evidence of community transmission should close schools in affected and surrounding areas. Governors should close schools in communities that are near areas of community transmission, even if those areas are in neighboring states. In addition, state and local officials should close schools where coronavirus has been identified in the population associated with the school. States and localities that close schools need to address childcare needs of critical responders, as well as the nutritional needs of children.

Older people are particularly at risk from the coronavirus. All states should follow Federal guidance and halt social visits to nursing homes and retirement and long-term care facilities.

In states with evidence of community transmission, bars, restaurants, food courts, gyms, and other indoor and outdoor venues where groups of people congregate should be closed.

A Critical Evaluation of the World Federation of Chiropractic's Fatally Flawed Review of Immunity & Chiropractic

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Abstract

The objective of this paper is to provide a critical evaluation of the World Federation of Chiropractic's (WFC) "Rapid Review" of the role of chiropractic in immunity and their conclusions. The WFC claims to have reviewed 7 items including an unpublished report with no citation, four studies involving enhancement of immune markers following chiropractic intervention (including enhanced respiratory burst, increased interleukin 2, and increased CD4 cell counts), a review of literature on the evidence supporting stimulation of the neuroimmunoendocrine system and a review of one hundred thousand cases of influenza managed by osteopathy during the 1918 flu pandemic.

All of the reports they reviewed demonstrated positive findings in support of manual methods such as chiropractic adjustments and manipulation in effecting a positive immune response.

Despite these positive findings, the WFC Research Committee came to the opposite conclusion that no credible, scientific evidence exists that spinal adjustment / manipulation has any clinically relevant effect on the immune system.

Our critical evaluation reveals that their conclusion is based on flawed methodology, a grossly incomplete review of the literature, unfounded interpretations of the results of the studies, and bias demonstrated by the authors. It is well established that the nervous system controls and coordinates all functions and systems of the human body including immunity and the immune system. Many in chiropractic consider that this relationship confers salutogenic benefits in people undergoing chiropractic care. The scientific literature reviewed here, while limited, demonstrates a positive, salutogenic effect from chiropractic on the human immune system.

Key Words: *World Federation of Chiropractic, immunity, chiropractic, adjustment, manipulation, vertebral subluxation, coronavirus, COVID-19*

Background

The World Federation of Chiropractic (WFC) has issued what they call a "rapid review" of materials that they are "... aware have been cited in support of claims of effectiveness for spinal adjustment/manipulation in conferring or enhancing immunity."¹

The "rapid review" was conducted by the World Federation of Chiropractic's Research Committee made up of the following individuals:

- Greg Kawchuk DC, PhD - Canadian Memorial Chiropractic College Adjunct
- Christine Goertz DC, PhD - Palmer College of Chiropractic Honorary Alumna
- Iben Axén DC, PhD - Institut Franco-Européen de Chiropratique
- Martin Descarreaux DC, PhD - Université du Québec à Trois-Rivières
- Simon French B.App.Sci (Chiro), MPH, PhD - Macquarie University

- Mitch Haas MA, DC – University of Western States
- Jan Hartvigsen DC, PhD - Nordic Institute of Chiropractic
- Carolina Kolberg BSc (Chiro), PhD - Latin American Federation of Chiropractic
- Michele Maiers DC, MPH, PhD – Northwestern Health Sciences University

The Flawed “Rapid Review”

The Research Committee of the WFC claims to have reviewed these “materials,” which include 7 items.²⁻⁸ They claim the first one is an unpublished report for which they do not provide a citation (Pero). Four studies involve enhancement of immune markers following chiropractic intervention; one study on enhanced respiratory burst, two studies on increased interleukin 2, and one on increased CD4 cell counts. They also cite a review of literature on the evidence supporting stimulation of the neuroimmunoendocrine system and a review of one hundred thousand cases of influenza managed by osteopathy during the 1918 flu pandemic.

All of the reports they reviewed demonstrated positive findings in support of manual methods such as chiropractic adjustments and manipulation in effecting a positive immune response. Despite these positive findings, the WFC Research Committee came to the following bizarre, highly nuanced conclusion:

“No credible, scientific evidence that spinal adjustment / manipulation has any clinically relevant effect on the immune system was found. Available studies have small sample sizes and a lack of symptomatic subjects. At the time of writing, there exists no credible, scientific evidence that would permit claims of effectiveness for conferring or enhancing immunity through spinal adjustment / manipulation to be made in communications by chiropractors. In the event that new scientific evidence emerges, it will be critically appraised using scientific methods of analysis.”

The Research Committee’s use of the word “credible” to support their claim that there is no evidence of a “clinically relevant effect” is without definition. They do not define “credible” or what (in their opinion) would be considered “credible” evidence.

They further state that they were not able to find credible research, however they admittedly did not look for it. The fact that they did not conduct a literature review is especially strange because the title of their document deceptively implies that this was an actual review of the scientific literature. It was not.

By failing to establish the criteria for credible evidence, they are able to arbitrarily dismiss any evidence offered that does not support their position. A proper review of literature should specify search and inclusion criteria. The review should describe which databases were searched, what years, and search terms employed. Failure to do so results in the exclusion of relevant evidence. Furthermore, the use of amorphous and undefined terms such as “credible” leads to cherry-picking based on dogma. The result is a concealment of

material facts that the naive reader may assume do not exist. This is a political response masquerading as a scientific pursuit.

Another undefined term the WFC Committee used is “clinically relevant.” Use of this term leads to the same problems described above regarding “credible.”

Furthermore, they state that if new evidence emerges, “it will be critically appraised using scientific methods of analysis.” The flawed rapid review does not use a scientific method of analysis.

A Flawed Methodology

Kawchuk and his co-authors give a cursory description of the methodology they used for their review as follows:

“This rapid review considers materials the WFC is aware have been cited in support of claims of effectiveness for spinal adjustment / manipulation in conferring or enhancing immunity.”

This approach is methodologically flawed. The methods described by Kawchuk and his co-authors for their “review,” are the use of “**materials the WFC is aware**” of. Kawchuk and his co-authors do not reveal where the documents in their review “have been cited.” Are they referring to a peer-reviewed research journal or a MEME posted on social media? Where are their references? Disguising their methodologically flawed “report” as a “review of the relevant literature” is deceitful.

Perhaps they were not able to find “credible” research because they did not use a credible methodology to look for it. Unfortunately, chiropractic colleges and regulatory authorities have endorsed the WFC’s methodologically flawed “review” even though the researchers did not look for relevant literature. Instead, they relied on 7 items they were “aware have been cited.”

Kawchuk and his WFC co-authors claim they did not find any credible evidence that: spinal adjustment/manipulation “**has any**” clinically relevant effect on the immune system.

The facts are that even though their methodology was flawed they did “review” research papers published in indexed journals. These were papers that were scientifically validated through the peer-review process and published by journal editors. Further, this peer-reviewed research did report on several clinically relevant effects on the immune system following chiropractic intervention, which is plainly evident when one reviews the research.

Unfounded Assertions and Flawed Conclusions

The WFC researchers make several unfounded assertions in an attempt to buttress their flawed conclusions regarding clinical relevance.

They claim (without evidence) that clinical meaning of the results regarding enhanced respiratory burst and increased interleukin 2 are not known. Perhaps this is because these

researchers are not clinicians and do not have the capacity to apply these studies to clinical practice in an evidence-informed model. Either way, we would suggest that the researchers review what respiratory burst is and review the role of interleukin in the immune response. Perhaps that would help them understand the effect that enhancing these processes through chiropractic might have on human health. That is, after all, the job of the clinician in an evidence-informed model.

Another unfounded assertion of the WFC researchers is their concern about a small sample size in the CD4 study. They imply that *only* results found in large sample sizes can be used to inform clinical practice. That view is contrary to all accepted norms. Interestingly, they criticize the methodology of the CD4 study even though it was published in a peer-reviewed indexed journal, unlike their methodologically flawed rapid review.

The WFC researchers claim that the immune biomarker studies cannot be used to inform clinical practice because only asymptomatic subjects were used. Such an approach is a logical fallacy because the claim itself reveals that they know full well that the results of those studies *are* clinically relevant. Thus, the WFC has created a false narrative revolving around claims of “boosting, enhancing, and stimulating” the immune system through the application of chiropractic care. Applying these data to clinical practice is the job of the clinician.

A Misguided Model of Evidence-Informed Practice

The WFC researchers seem to have developed their own model for Evidenced Informed Practice, and they have decided not to share the elements of that model with their readers. For example, they dismiss the review of osteopathy during the 1918 flu pandemic out of hand, claiming erroneously that “these narrative reports of historical events do not equate to scientific studies.” In the well-entrenched model of evidence-informed practice, all types and levels of evidence are included for evaluation in the evidence domain. Further, the WFC’s flawed methodology left out numerous other published papers on the osteopathic response to the 1918 pandemic. To say nothing of the available literature on the response and outcomes from chiropractic care – which they did not review at all. These are further symptoms of their flawed and biased methodology leading to unfounded assertions, flawed conclusions, and ultimately a misguided model of evidence-informed practice.

The WFC purports to support evidence-informed practice however, this report demonstrates that WFC’s claim of an evidence-informed approach is a performative contradiction. Sackett defines evidence-based practice as: “The conscientious, explicit, and judicious use of the current best evidence in making decisions about the care of individual patients...[It] is not restricted to randomized trials and meta-analyses. It involves tracking down the best external evidence with which to answer our clinical questions.” That evidence is then considered in light of the specific patient’s clinical circumstances, the desires of the patient, and the clinical experience of the practitioner to make patient-centered clinical recommendations.^{9,10}

The problem with the WFC’s tactic is not, as Sackett proposed, “. . . integrating individual clinical expertise and the best external evidence.” Every doctor does that. The problem is the cavalier dismissal of evidence by the WFC that doesn’t fit into a rigid hierarchy. This dismissal includes the compartmentalizing of the profession into two classes: (1) an oligarchy of researchers; and (2) doctors who are reduced to mere technicians following the flow charts and algorithms promulgated by the elite.

Bias & Epistemic Trespassing

Another major flaw of the “rapid review” by the WFC researchers is bias. The credibility of the review should be questioned even further because some of the authors are known critics and deniers of vertebral subluxation theory and clinical practice. For example complaints about Kawchuk’s presentation during a WFC Research Conference were filed with the WFC by the International Chiropractors Association (ICA). Kawchuk, compared bringing a child to a vitalistic chiropractor to bringing them to a Catholic priest at a children’s school. According to the ICA’s President, this was:

“. . . so offensive, to so many people, that this behavior alone should be sufficient to immediately take the action recommended by the ICA. The demonstrated religious intolerance and blatant offensive behavior on a public stage speaks for itself. This behavior cannot be excused under any circumstances.”

In a separate presentation at the same conference, Hartvigsen suggested that subluxation was imaginary. He said that the practice of using x-rays to identify subluxation and outcomes of care was “absolutely rubbish.”

These researchers are not only biased regarding the theoretical basis for the chiropractic profession, but they are also epistemic trespassers on the topic of immunity. To our knowledge, none of them have degrees in immunology, nor have they published on the topic. Yet here they are, presenting their opinions in a flawed review on that very topic.

The WFC has repeatedly attacked the management of vertebral subluxation in a vitalistic, salutogenic model and the WFC endorses chiropractic as only the treatment of musculoskeletal pain syndromes.

Kawchuk and his co-authors’ continue to demonstrate obvious disdain for vertebral subluxation theory in a vitalistic, salutogenic model. They hold a limited view of chiropractic as the management of pain syndromes only. These flaws, added to their epistemic trespassing, reveal widespread bias and ignorance of chiropractic’s foundation. Anyone relying on their flawed document must contend with those issues.

Conclusion

The Real Motivation for Releasing this Document

Finally, in their conclusion, we find Kawchuk, his co-authors, and the WFC’s motivation for the production of this flawed document:

“At the time of writing, there exists no credible, scientific evidence that would permit claims of effectiveness for conferring or enhancing immunity through spinal adjustment/manipulation to be made in communications by chiropractors.”

The key here is *claims of effectiveness in communications by chiropractors*. Herein we find the real motivation to produce this document by the WFC and its supporters. They sought to limit the ability of chiropractors to communicate on the topic.

Within hours of the WFC releasing this “review” it was endorsed or otherwise adopted by several organizations, regulatory boards, and at least one chiropractic school. These groups all have political connections to the WFC and hold a similar bias against traditional chiropractic theory and practice. The regulatory boards then used the document as a rationale to outright threaten their licensees for communicating any inference that chiropractic plays a role in immunity. The president of the chiropractic college that endorsed the review threatened that chiropractors making such claims would be “under the hand of the law” as a result.

Any regulatory authority relying on this document to persecute chiropractors will have to contend with the fact that the conclusion regarding communications is based on flawed methodology, a grossly incomplete review of the literature, unfounded interpretations of the results of the studies, and bias demonstrated by the authors. Further, the process by which these regulatory authorities arrived at the decision to endorse it will have to be revealed during the disposition of any complaints against practitioners as well as through any open records requests and sunshine laws. According to the Supreme Court of the United States, active market players serving on regulatory boards that restrain the trade of their fellow licensees who are in direct competition with them may put themselves at risk for legal action without the support of the state.

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ITEM 6.9

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WFC Review of Immunity & Chiropractic Fatally Flawed - Says Foundation for Vertebral Subluxation

Saturday, March 28, 2020 - 16:32

FOUNDATION FOR VERTEBRAL SUBLUXATION



Researchers Use Eminence Instead of Evidence in Opinion Piece

As the world was starting to grapple with the emergence of Coronavirus and its related pandemic, chiropractors around the world were gearing up to care for millions of people suffering from the emotional stress and physical strain of daily life in a new normal. Meanwhile other chiropractors

were gearing up to see how much trouble they could cause for chiropractors who chose to remain open and serve the suffering masses.

Within just a few days those chiropractors who deny the vitalistic, salutogenic model of vertebral subluxation had "leaders" within the profession to help them wreak their havoc. **The World Federation of Chiropractic's Research Committee** under the leadership of **Greg Kawchuk DC, PhD - Adjunct Faculty at Canadian Memorial Chiropractic College** and **Christine Goertz DC, PhD - Palmer College of Chiropractic Honorary Alumna** led the Committee in the development and dissemination of a **deeply flawed** hit piece falsely claiming that there is *no* credible, scientific evidence that chiropractic has any clinically relevant effect on the immune system.

They went on to reveal the real purpose of the flawed document falsely claiming that there was no evidence that would permit claims of effectiveness for conferring or enhancing immunity through chiropractic to be made in communications by chiropractors.

Immediately following the release of the hit piece several state chiropractic regulatory boards including Texas and Wisconsin endorsed the document and sent threatening notices about discussing immunity to chiropractors licensed in their states.

Parker University President William Morgan DC conducted an interview with Parker's Director of Research **Katherine Pohlman DC, Ph.D** who echoed the WFC's document snickering in an interview about it stating **"There is no credible research" to support such claims.** Morgan threatened chiropractors that if they suggested chiropractic boosted immunity that they would be **"under the hand of the law"** and that chiropractors were **"making claims that they can't back up"**.

Pohlman is the current Director of Research at Parker University, was previously a researcher at Palmer and has made false claims recently in regards to research on chiropractic and autism stating:

"We don't have any current evidence to make any sound, safe statements"

Sound familiar?

In addition to Parker University and several regulatory boards endorsing the flawed document, several prominent **Subluxation Deniers** in the United States and Canada have been using the document to encourage the public to file complaints against chiropractors that remain open during the Coronavirus pandemic.

BLOGS

[Foundation for Vertebral Subluxation Releases Viewbook](#)

[National Board Says Very Few Chiropractors Will Be Able to Keep Doors Open in Colorado Amid Coronavirus](#)

[WFC Review of Immunity & Chiropractic Fatally Flawed - Says Foundation for Vertebral Subluxation](#)

[New Research on Breastfeeding & Chiropractic](#)

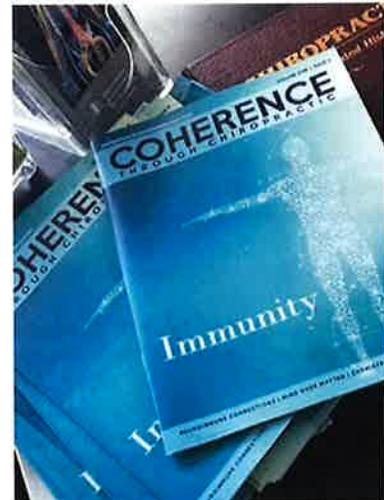
[New Research Sheds Light on Dogs & Chiropractic](#)

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IGNORANCE IS NOT BLISS!



COHERENCE



GET YOUR COPY TODAY!

Robert Maybee DC who practices in Portland, Oregon and runs an anti-chiropractic group called Forward Thinking Chiropractic Alliance **thanked** the World Federation of Chiropractic, Parker University and the American Chiropractic Association telling his fellow Deniers that:

"You are now properly armed with FACTS thanks to the WFC and Parker and ACA"

He was instructing his army of trolls to copy other chiropractors websites and Facebook pages where they were discussing immunity and use those screen shots to report them to the regulatory boards.

Another leader of Deniers in Canada - **Marc Bronson DC from Canadian Memorial Chiropractic College** - put out a call for **volunteers across Canada** to find and submit complaints to regulatory boards throughout Canada about any chiropractors making posts pertaining to immunity. He stated he had already been sent over 100 images. **Bronson created a template** for his trolls to use in filing the complaints.

The individuals on the WFC Research Committee represent or are affiliated with several chiropractic schools as well:

- Greg Kawchuk DC, PhD - Canadian Memorial Chiropractic College Adjunct
- Christine Goertz DC, PhD - Palmer College of Chiropractic Honorary Alumna
- Iben Axén DC, PhD - Institut Franco-Européen de Chiropratique
- Martin Descarreaux DC, PhD - Université du Québec à Trois-Rivières
- Simon French B.App.Sci (Chiro), MPH, PhD - Macquarie University
- Mitch Haas MA, DC – University of Western States
- Jan Hartvigsen DC, PhD - Nordic Institute of Chiropractic
- Carolina Kolberg BSc (Chiro), PhD - Latin American Federation of Chiropractic
- Michele Maiers DC, MPH, PhD – Northwestern Health Sciences University

The Foundation for Vertebral Subluxation reviewed the WFC document and issued a rebuttal stating:

"This is a political response masquerading as a scientific pursuit" with ". . . the use of amorphous and undefined terms such as 'credible' leading to cherry-picking based on dogma."

The Foundation found widespread bias in the "rapid review" by the WFC researchers. stating:

"The credibility of the review should be questioned even further because some of the authors are known critics and deniers of vertebral subluxation theory and clinical practice."

For example, complaints about Kawchuck's presentation during a WFC Researcher Conference were filed with the WFC by the International Chiropractors Association (ICA). Kawchuk, compared bringing a child to a vitalistic chiropractor to bringing them to a Catholic priest at a children's school. According to the ICA's President, this was:

"... so offensive, to so many people, that this behavior alone should be sufficient to immediately take the action recommended by the ICA. The demonstrated religious intolerance and blatant offensive behavior on a public stage speaks for itself. This behavior cannot be excused under any circumstances."

[CLICK HERE](#) for more on that story

In a separate presentation at the same conference, Hartvigsen (another WFC Researcher who authored the report) suggested that subluxation was imaginary. He said that the practice of using x-rays to identify subluxation and outcomes of care was "absolutely rubbish."

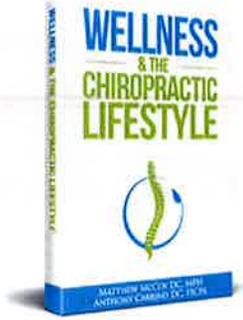
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The WFC has repeatedly attacked the management of vertebral subluxation in a vitalistic, salutogenic model and the WFC endorses chiropractic as only the treatment of musculoskeletal pain syndromes.

The Foundation points out the real motivation for the WFC Deniers to produce their report. The key here, they say, are **claims of effectiveness in communications by chiropractors**. Herein we find the real motivation to produce this document by the WFC and its supporters. **They sought to limit the ability of chiropractors to communicate on the topic - an effort to restrain trade.**

And it was organized. Within hours of the WFC releasing this "review" it was endorsed or otherwise adopted by several organizations, regulatory boards, and at least one chiropractic school. These groups all have political connections to the WFC and hold a similar bias against traditional chiropractic theory and practice. The regulatory boards then used the document as a rationale to outright threaten their licensees for communicating any inference that chiropractic plays a role in immunity.

The Foundation concluded its review of the flawed document stating:



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ON PURPOSE - YOU ARE NOT ALONE



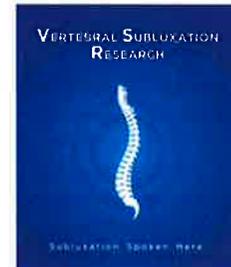
CHIROFUTURES MALPRACTICE INSURANCE PROGRAM



MIND VIRUS



SUBLUXATION SPOKEN HERE . . .



FOUNDATION FOR VERTEBRAL SUBLUXATION



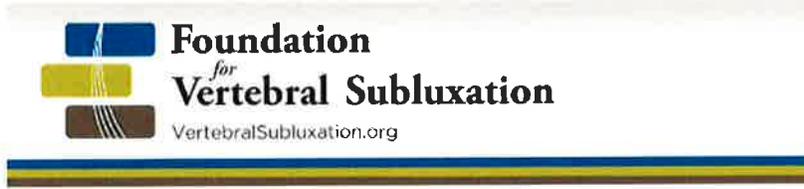
CHIROPRACTIC IS . . .

"The conclusions are based on flawed methodology, a grossly incomplete review of the literature, unfounded interpretations of the results of the studies, and bias demonstrated by the authors".

[CLICK HERE](#) to review the document from the Foundation for Vertebral Subluxation Research

ABOUT Foundation for Vertebral Subluxation

The mission of the Foundation is to advocate for and advance the founding principles and tenets of the chiropractic profession in the area of vertebral subluxation through research, education, policy and service.



Twent

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Begin forwarded message:

From: MARK FOULLONG
Date: April 8, 2020 at 6:47:09 AM EDT
To: Tina Perryman <TPerryman@cco.on.ca>, Jo-Ann Willson <jpwillson@cco.on.ca>
Subject: Please confirm receipt and distribution to requested recipients: Thank you.

April 6th, 2020.

Jo-Ann Willson, Registrar
Tina Perryman, Manager, Inquiries, Complaints & Reports
ATTN: Complaints Committee
ATTN: Executive Committee

Re: Chiropractic & Immunity

Dear Colleagues:

I would like it to be very clear that this letter is NOT part of my response to the allegations directed to myself or my office in the Ryan Armstrong complaint spree, and very clearly wish for it NOT to be included in our response which is why I've sent these letters separately.

I am writing you to address the letter received from Ms Perryman, marked private and confidential on March 19th regarding a older office newsletter that was posted on our

website a year or more ago, and also to address Dr. Mizel's president's message dated March 16th, 2020.

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First, as already confirmed via email to Ms. Perryman, at the College's recommendation the immune newsletter posting was removed that day. Over and above that, I would like to confirm (and you can verify by your screenshot of the post) that no reference or mention was made to Covid-19 or coronavirus as it was posted long before any of this was on anybody's radar, certainly our own. To be very clear, this post was not made in response to or anticipation of the current Covid-19 declared pandemic.

That said the sentiment in the letter from Ms. Perryman and in Dr. Mizel's president's message seemed to be to remove and avoid any and all past or planned posts to do with anything coronavirus, covid-19 as well as those that address chiropractic and immunity.

Given the current global crisis and the obvious increased and focussed scrutiny on natural health providers and moreso seemingly Chiropractors specifically, I completely understand and respect the intent of these recommendations and the logic behind them. As such, we have complied on all accounts. Further I applaud the CCO for helping members by proactively recommending such preventive measures. Thank you.

That said, I would like it to be made clear to the College that our compliance to this request is not because I believe that the studies referenced and others that reference chiropractic and immunity don't exist or aren't valid. On the contrary.

There is a growing body of science over a number of years that support the premise that chiropractic care has a positive or beneficial effect on immune parameters. Would the chiropractic profession and the public benefit from much more research in this arena? Absolutely. But at the same time we can't discount what is already available to us and building as time goes forward. Beyond that, after 25 years in very busy practice and communication with hundreds of my peers over that quarter century, I would contend it would likely be very difficult to find a practicing chiropractor with any significant amount of clinical experience dealing with anything more than very short term symptom relief care, that could deny they've heard significant numbers of unsolicited patient reports of marked or greatly improved immunity while under chiropractic care. They tell us they get sick less often. They tell us they recover faster when they do. Some even tell us they go seasons or in some cases even years without immune challenges they used to get much more frequently prior to care. I would expect that a number of you reading this have frequently heard the same things from your patients.

All that said, I'm not herein trying to say that volumes of corroborating patient reports would constitute 100% proof that chiropractic is the be all and the end all for immunity, but at the same time they can't be ignored.

I would like to present not all, but some of the more prevalent scientific studies that show a positive and I believe in some cases compelling link between chiropractic care and improved immune status or performance. Again I believe there is room for further scientific validation when it comes to chiropractic and immunity. I'm certain most of my like minded peers would agree.

While I do believe it would be irresponsible to say that we already have 100% conclusive proof that chiropractic boosts immunity, I believe it would be far more irresponsible to discount what's already available in the literature and real life patient experience and say that there is none.

I encourage you on the College to either review these studies yourselves, or to commission an 'unbiased' committee to do so on your behalf and present their findings to the College. I believe that would be responsible action on the part of a regulator before they make a cart blanche recommendation that all immune related posts by chiropractors are unsubstantiated or unverifiable and as such not allowed. Again, I know the climate is

very different right now, so I understand your current recommendations, but when things change out there, I believe we need to again adapt.

I will preface the study references given to say some of these studies show a strong link between neurological health/function (which Chiropractic beneficially impacts) and immune strength. Others, show positive either short or longer term improvements in immune parameters following chiropractic interventions. Other studies yet, show an improvement in the stress response (sympathetic/parasympathetic balancing) which also has been linked to improved immunity. All I believe are quite instrumental in building a case to say that our care can have a positive impact on immunity.

Finally, I feel it should be noted that although the WFC has rendered their own biased opinion on chiropractic and immunity after looking at a small subset of the literature, this should not be seen as the end of the discussion. Interestingly, the International Chiropractic Association took a much more comprehensive look at the topic of chiropractic and immunity as well, including a number of the same studies, and they came to quite a different conclusion. The pdf of the ICA position paper on Chiropractic and immunity is linked here...

<http://www.chiropractic.org/wp-content/uploads/2020/03/2nd-Edition-Immune-Function-Report-3-28-2020-715-pm.pdf>.

It should also be noted that the Foundation for Vertebral Subluxation, Dr. Matt McCoy and Dr. Christopher Kent (2 brilliant minds in our field) analyzed the WFC document and their critical review of it can be found here...

http://www.mccoypress.net/docs/fvs_rebuttal_wfc_booklet.pdf?fbclid=IwAR14Mt75MLUOdZDtns8JPHtI22dK4GXeXOZLjBexzxyImFspqfumvohtIU

We tend to see the world through the lenses of the glasses that we're wearing. I think that that is especially true among Chiropractors. That would be very clear comparing the WFC and ICA documents. I don't think any of us would argue there is great diversity in our profession. I believe that diversity can be a large part of our strength. That is if we respect this diversity and not use it to cause infighting. I applaud the CCO for past efforts that have respected some of this diversity. I humbly suggest however that CCO has more work to do to respect it fully. We Chiropractors no matter how we practice have a tonne of good to offer the public of Ontario. I believe we're much better off accepting and even celebrating our differences, and then standing together and linking arms for the greater good of the people we serve.

Thank you for your time in review this and these studies. And thank you for all you do for this great profession.

Sincerely,

Dr. Mark Foullong,
Chiropractor.

ARTICLE CITATIONS FOR REVIEW

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Ontario Regulators and COVID-19

March 30, 2020

By Debbie Tarshis

This bulletin is intended to provide a few highlights of some of the steps the province has taken in the face of COVID-19.^[1] It also provides some general comments to assist Ontario regulatory bodies that regulate professions.

Undoubtedly, you are all aware of the Premier's order for the closure of all non-essential businesses effective 11:59 pm on March 24, 2020. The closure will be in effect for a minimum of 14 days and can be extended. [Here is a link to the news release from the Office of the Premier.](#)

The list of essential workplaces is posted on the [government's website](#).

The list has 74 types of businesses grouped in 19 categories. These categories include research, health care and seniors care and social services, the justice sector, and business regulators and inspectors, among others. The regulation which orders closure of places of non-essential business (the "Closure Regulation") is now also available [here](#) (O. Reg. 82/20). Please note that the list of essential businesses is Schedule 2 to the Closure Regulation.

Here are a few comments on the Closure Regulation. It states that it does not preclude any business from operating remotely, without attending at the place of business, to provide services online, by telephone or other remote means. It also states that it does not preclude operations or delivery of services in Ontario by any government or by any person or publicly-funded agency or organization that delivers or supports government operations and services, including operations and services of the health care sector.

For those of you that regulate health care professions, you will also be aware of directives being issued by Ontario's Acting Chief Medical Officer of Health under the *Health Protection and Promotion Act*. One such directive was issued on March 19, 2020 (COVID-19 #2) to regulated health professionals and persons who operate a group practice of regulated health professionals ("health care providers"). [Attached is a copy of that Directive.](#)

It required certain steps to be taken immediately by health care providers. The first was that all non-essential and elective services were to cease or be reduced to minimal levels, subject to allowable exceptions, until further notice. It provided guidance on how to make decisions regarding the reduction or elimination of non-essential and elective services.

For health care providers, there appears to be inconsistency and possible conflict between the Directive (COVID-19#2) made under the *Health Protection and Promotion Act* and the Closure Regulation made under the *Emergency Management and Civil Protection Act*, but one must understand that the Directive predated the Closure Regulation. For example, under Schedule 2 of the Closure Regulation, health care professionals providing emergency care including dentists, optometrists and physiotherapists are listed as an essential business (No. 58). Based on the Closure Regulation, it appears that their offices must be closed except for emergency care. Some regulators have been communicating to their members whose offices are closed that care can continue to be provided if it is done online, by telephone or other remote means (which appears to be permitted under the Closure Regulation) so long as it is

performed in accordance with the standards of practice of the profession and in a manner that ensures patient/personal health information confidentiality.

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One of the orders under the *Emergency Management and Civil Protection Act* (O. Reg. 73/20) does the following:

- suspends limitation periods for the duration of the emergency
- subject to the discretion of the court, tribunal or other decision-maker responsible for a proceeding, suspends any period of time within which a step must be taken in any proceeding in Ontario.

Here is a [link to O. Reg. 73/20](#).

There is also a new Act, the *Hearings in Tribunal Proceedings (Temporary Measures) Act, 2020*, which came into force on March 25, 2020. Among other things, it permits a tribunal to conduct a hearing in person, electronically, in writing or by a combination of any of them, as the tribunal considers appropriate. It applies to a proceeding commenced before, on or after the day the Act came into force. Here is a [link to that Act](#).

Comments for Regulators

Here are some comments to assist regulators during this very difficult and challenging time:

1. Take the steps necessary so that your staff can work remotely. For some of you, this will be more challenging than for others.
2. Consider what your core services and programs are. You will likely have to examine these on a program by program basis. For example, processing applications for registration may raise issues that are different from processing complaints and reports.
3. Consider how to triage within program areas. For example, can you identify, prioritize and investigate the complaints and/or reports that pose the most serious risk of harm to the public?
4. Consider whether certain programs or elements of certain programs can be postponed or suspended; for example, postponing elements of a quality assurance program.
5. Consider the authority of the regulator (including its Council, committees, Registrar and staff) to take certain steps and whether there is legal authority to delegate the performance of certain processes through policy.
6. Consider how to communicate with the Council and committees and whether there is authority and if so, how to hold Council and committee meetings remotely.
7. Consider whether hearings can be conducted electronically or in writing and how to do so.
8. Consider what advice to give to your registrants regarding government orders and directives.
9. Consider your responsibility as employers and how to support your employees as they adjust to working remotely.

This is not intended to be an exhaustive list and we anticipate that there are many questions that arise from each comment on the list. You may be interested in the resources on COVID-19 posted on our website, located [here](#).

Please do not hesitate to [contact us](#) if we can be of assistance. We are open for business.

[1] This article was prepared on March 27, 2020. This is a rapidly changing environment and each day there appears to be a new development regarding COVID-19. Please keep this reality in mind as you read the article.

The information and comments herein are for the general information of the reader and are not intended as advice or opinion to be relied upon in relation to any particular circumstances. For particular application of the law to specific

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Raising the Bar

by Rebecca Durcan
May 2020 - No. 246

Regulators have struggled for years balancing the concepts of parity and changing societal expectations. The principle of parity says that the sanction for a particular type of misconduct should be consistent with that imposed in prior decisions. However, changing societal expectations suggests that some sanctioning ranges are no longer suitable. Attempts to go above the previous range for sanctions, especially in the area of sexual abuse, have resulted in bumpy roads for regulators: *College of Physicians and Surgeons of Ontario v Peirovy*, 2018 ONCA 420, <http://canlii.ca/t/hrt0r>, *Horri v The College of Physicians and Surgeons*, 2018 ONSC 3193, <http://canlii.ca/t/hs8sz>, *Abrametz v The Law Society of Saskatchewan*, 2018 SKCA 37, <http://canlii.ca/t/hs7tk>.

However, the recent decision of the Supreme Court of Canada in *R. v Friesen*, 2020 SCC 9, <http://canlii.ca/t/j64rn> may advance this debate. Mr. Friesen was initially sentenced to six years in jail for sexual interference with a four year old girl. The Manitoba Court of Appeal reduced the sentence to 4 ½ years because the trial Judge had used a four to five year “starting point” from cases where there had been a breach of trust (before considering aggravating factors). The Court of Appeal found this to be an error because there was no breach of trust found in the case.

The Supreme Court of Canada restored the trial Judge’s sentence in a lengthy discussion of the relevant principles.

To begin with, the Court viewed the principle of parity of sentences for similar conduct as part of the broader principle of proportionality:

“All sentencing starts with the principle that sentences must be proportionate to the gravity of the offence and the degree of responsibility of the offender. The principle of proportionality has long been central to Canadian sentencing.... Parity and proportionality do not exist in tension; rather, parity is an expression of proportionality. A consistent application of proportionality will lead to parity.

The Court went on to state “sentencing ranges and starting points are guidelines, not hard and fast rules”. In some cases it may be possible to determine a suitable, individualized sentence without reference to the range at all. Appellate courts should not use their reviewing authority to enforce or impose a sentencing range. Having said that, the Court also declined to “suggest that starting points are no longer a permissible form of appellate guidance”.

The Court went on to engage in a lengthy discussion of the “wrongfulness of sexual offences against children and the profound harm that they cause.” Much of this discussion resonates with the concepts underlying the sexual abuse of clients, including adults, by professionals.

In this discussion the Court said that such offence provisions protect the “the personal autonomy, bodily integrity, sexual integrity, dignity, and equality of children.” The Court said:

As Professor Elaine Craig notes, “This shift from focusing on sexual propriety to sexual integrity enables greater emphasis on

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WANT TO REPRINT AN ARTICLE

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violations of trust, humiliation, objectification, exploitation, shame, and loss of self-esteem rather than simply, or only, on deprivations of honour, chastity, or bodily integrity (as was more the case when the law's concern had a greater focus on sexual propriety)".... This emphasis on personal autonomy, bodily integrity, sexual integrity, dignity, and equality requires courts to focus their attention on emotional and psychological harm, not simply physical harm.

This led the Court to apply the principles of proportionality to the sexual abuse of children. The conduct is both clearly wrong and extremely harmful. These considerations, particularly where they are accompanied by legislative changes addressing the concern, mean that sentencing must prioritize denunciation and deterrence. As such "it is no longer open to the judge to elevate other sentencing objectives to an equal or higher priority" although other objectives, such as rehabilitation, may be given some weight.

The Court then went on to discuss factors that assist in determining a fit sentence in child sexual abuse cases including:

- Likelihood to re-offend;
- Abuse of a position of trust and authority;
- Duration and frequency; and
- Age of the victim, partially as an indicator of their degree of vulnerability.

The Court acknowledged that a degree of physical interference could be an aggravating factor in that it was an indicator of the degree of violation of the child. However, the Court was concerned that this consideration could be misapplied because:

- It could resurrect traditional notions of sexual impropriety (e.g., prioritizing penile penetration as the key aggravating factor);
- It assumes that the harm to the child correlates to the physical act;
- It can de-emphasize the inherent wrongfulness of sexual abuse of children in general; and
- It can lead to a false hierarchy of physical acts.

The Court also indicated that a victim's participation in the conduct was irrelevant and should not be considered when coming up with a fit sentence. In fact, grooming behaviour by the offender, which can lead to victim participation, is an aggravating factor.

In the circumstances of this case, the Court afforded less weight to the guilty plea and expression of remorse than it might otherwise have received because they did not result in achieving a "change in attitude that reduced his likelihood of further offending".

The Court also pointed out that the six year sentence should not be viewed as the upper end of the range for these types of offences. Unfortunately, in the Court's experience this was not a "worst case".

The Court went on to discuss three aggravating factors in the case that could have been considered, but were not:

- The potential harm to the mother from the extortion that accompanied the sexual offence;
- The fact that the defendant committed the offences in the home of the child's mother; and

Grey Areas

A COMMENTARY ON LEGAL ISSUES AFFECTING PROFESSIONAL REGULATION

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- The evidence of misogynistic attitudes on the part of the defendant.

Many of the principles of this case could be applied to the sanctioning of practitioners who engage in the sexual abuse of their clients. The wrongfulness of the acts and the potential harm to clients are enormous.

The case also gives guidance to considerations that may allow for the raising of the range of sanctions from its previous, perhaps too low, position. For example, social science evidence about the nature and potential harm, including long-term harm, to clients can be used. Legislative measures to address the issue, including amendments to the sanctions that can be imposed, is an indicator of changing societal views. Distinguishing older precedents that were based on a different understanding of the nature of the misconduct is also helpful. Finally, focussing the on the aggravating factors mentioned above is important.

This case illustrates that raising the bar, for some forms of professional misconduct, is possible.

From: Jo-Ann Willson
Sent: Monday, June 1, 2020 1:13 PM
To: Rose Bustria
Subject: Fwd: Grey Areas – When Should Regulators Enforce “Someone Else’s Law”?

Council.

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From: Steinecke Maciura LeBlanc <info@sml-law.com>
Date: June 1, 2020 at 12:08:32 PM EDT
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Reply-To: Steinecke Maciura LeBlanc <info@sml-law.com>

For past issues of *Grey Areas*, please visit our website at <http://www.sml-law.com/resources/newsletters-2/>.

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Grey Areas

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A COMMENTARY ON LEGAL ISSUES AFFECTING PROFESSIONAL REGULATION

When Should Regulators Enforce “Someone Else’s Law”?

by Erica Richler
June 2020 - Issue no. 247

Practitioners are expected to obey the law. Especially laws that apply to their practice or reflect on their integrity. However, a recurring issue arises as to how involved regulators should become in enforcing the laws of other entities (e.g., government, other regulatory bodies). Typically, they enforce their own laws.

The issue is simple where the primary enforcement body makes a finding about conduct that is clearly improper for a member of the profession. But what about situations where someone is attempting to involve the regulator rather than the primary enforcement body? This could occur for various reasons including: a lower cost to the complainant, a desire to avoid having to gather the evidence, the promise of a ready appeal mechanism or the goal of causing damage to the livelihood of the practitioner.

Regulators could be asked to enforce “someone else’s law” in many circumstances:

1. An upset client complains that a practitioner breached their privacy by disclosing sensitive personal information about them, despite the fact that the Information and Privacy Commissioner is the principal enforcement body.
2. An employee of a practitioner asserts that the practitioner harassed them based on gender and race despite the availability of remedies through the Human Rights Tribunal.
3. A third party insurer reports that a practitioner gave in-person treatments during the pandemic for routine matters despite the emergency order to close establishments for everything but urgent care.

It is fairly clear that the regulator generally need not await the outcome of the primary enforcement body: *Berge v College of Audiologists and Speech-Language Pathologists of Ontario*, 2016 ONSC 7034, <http://canlii.ca/t/gvtpb>; *Dufault v British Columbia College of Teachers*, 2002 BCSC 618, <http://canlii.ca/t/4vzn>. Even where an argument could be made that the regulator has no jurisdiction to enforce the statute (e.g., a federal offence provision), the conduct will often have aspects of integrity or ethical implications that make it relevant to the practice of the profession: *Law Society of Saskatchewan v Abrametz*, 2016 SKQB 320, <http://canlii.ca/t/gv5r4>.

There are a number of arguments supporting the involvement of regulators in the enforcement of “someone else’s law”, including:

1. Often the conduct is quite relevant to the suitability of the practitioner to be a member of the profession. The reputation and credibility of the profession would be damaged if no action were taken. For example, respect for women, children, people with disabilities and for Indigenous peoples, racialized or religious groups is essential to the

effectiveness of the profession and the regulator should act even if there is another available enforcement mechanism.

2. Regulators need to be “good citizens” and should be part of the solution for significant societal issues. For example, during the pandemic, leaving enforcement of physical distancing measures solely to the police is insufficient and often counter-productive. All societal organizations need to help communicate (and, in some cases, even help enforce) the nature and rationale for the provisions.
3. Regulators which routinely refer conduct concerns to other enforcement bodies become irrelevant. Who needs a regulator who ducks responsibility for behaviour by their members because someone else can also deal with it?
4. Regulators often are obligated by their enabling statutes to process complaints and concerns. Exceptions are often limited (e.g., where a complaint is frivolous or vexatious). Members of the public who have a concern often choose to approach the regulator because they do not wish to pursue other options. For example, some people deliberately bring sexual abuse concerns to a regulator rather than the police because they may wish to avoid participating in the criminal justice system.

Of course there are countervailing considerations as well, including:

1. For some matters, regulators of professions may not be best suited to enforce the requirements. The primary enforcement body may have special investigative powers (e.g., to require the employer of the practitioner to provide information), added expertise (e.g., workplace safety, employment relations) and extra enforcement options (e.g., immediate compliance orders) that the regulator may not possess.
2. The issue may be of marginal relevance to the practice of the profession or public confidence in the regulator. It may even distract the regulator from its core mandate. For example, is it appropriate for

a regulator to expend resources on investigating and dealing with a practitioner who has had several by-law infractions because their loud dog has bothered the practitioner's neighbours? The concern may be legitimate, especially to the neighbours, but the regulator's involvement may not be warranted.

3. The issue may involve delicate judgment calls or interpretation questions that are best left to the primary enforcement body, otherwise, inconsistent results may occur. For example, regulators may not be the best option for interpreting a client's entitlement to a benefit or funding under a specialized social assistance program.
4. In some, usually rare, cases the person raising the issue is unhappy with the decision of the primary enforcement body and is searching for another enforcement body hoping for a different outcome. Similarly, a party to a dispute, for example, in an employment setting, may wish to involve the regulator in a dispute in order to put pressure on the other party or as a means for obtaining evidence for their case.

Given these competing considerations, regulators should carefully consider when it should get involved in enforcing "someone else's law". A principled approach should facilitate a consistent, public interest and practical approach to such complaints and concerns. Those principles might involve the following:

- a. As a starting point, processing those concerns where the regulator is obliged to do so under the terms of its enabling statute.
- b. Where the regulator has discretion, lean towards taking action on concerns that impact public safety, reflect on the integrity or ethics of the practitioner, or otherwise fit within the public interest mandate of the regulator.
- c. In appropriate cases where the regulator has discretion, providing information about their options to the person raising the concern without actively discouraging the individual from using the regulator's

process. Many regulators are already doing this where it appears that the complainant is under the misapprehension that the regulator can award monetary damages.

- d. Where the regulator has discretion, lean towards declining to take action on the concerns where there is a compelling reason for not doing so, such as where the regulator cannot deal with the issue effectively, where the concern has little impact on the suitability of the practitioner, or where it would be an abuse of process to deal with the concern.

A thoughtful approach to this issue will help protect the public and enhance the relevance and reputation of the regulator without imposing an undue burden on practitioners or the regulator itself.

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Information and Privacy Commissioner of Ontario
Commissaire à l'information et à la protection de la vie privée

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Impact of COVID-19

Mar 16 2020

Summary:

Notice to the Public and Institutions

To protect the health of our employees and to do our part to slow community transmission of the COVID-19 virus, the IPC has closed its physical office.

While most tribunal services will not operate as usual while the office is closed, we continue to provide limited services to the public, public sector organizations, and the health and child and family services sectors.

We remain available to public organizations for consultation and discussions on access and privacy matters during this time.

We continue to update our FAQs as we get more information. You can also reach us by emailing info@ipc.on.ca (<mailto:info@ipc.on.ca>).

If you've made a request for general or personal information from a public-sector organization, you should expect delays. Because of the COVID-19 outbreak, many public sector staff are working remotely and may not be in a position to search for the records you are asking for until they are back in the office.

Tips for Working from Home

We understand that these are exceptional circumstances. The reasonableness of security and privacy measures has to take into account time-limited, urgent needs.

Many organizations are striving to manage service disruptions and continue to provide essential services, especially in the health and child and family services sectors.

Here are some tips for dealing with personal information when working from home:

Mobile devices

- password protect your device
- lock your device when not in use
- if using portable storage devices, such as USBs and portable hard drives, if possible, ensure they are encrypted and password protected
- keep your software up-to-date

Emails

- if possible, use work email accounts rather than personal ones for work-related emails involving personal data
- before sending an email, check that you're sending it to the correct recipient, particularly for emails involving personal data

Paper copies and files

- only remove personal information from the office if it is necessary to carry out your job duties
- securely store any paper files when not in use – lock files away and do not leave files in your car

Frequently Asked Questions

When will the IPC reopen?

We will continue to evaluate this evolving situation and provide regular updates here and on Twitter @IPCinforprivacy (<https://twitter.com/IPCinforprivacy>).

What essential services will be provided by the IPC during this time?

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While most tribunal services will not operate as usual while the office is closed, we continue to provide limited services to the public, public sector organizations, and the health and child and family services sectors.

We remain available to public organizations for consultation and discussions on access and privacy matters during this time.

Will institutions be required to respond to requests for access to or correction of information during this time?

UPDATED MARCH 25 – The expectation to comply with Ontario's access laws remains in effect, however this is an exceptional circumstance and we understand that many organizations will be unable to meet the 30-day response requirement. As such, we will consider these circumstances when evaluating appeals relating to deemed refusals.

What will happen with my appeal?

The Ontario government has issued a suspension order, effective March 16, under the *Emergency Management and Civil Protection Act* that 'freezes' the time limits for initiating complaints or appeals to the IPC set out in Ontario's access laws, health privacy law, and child and family services law.

Most tribunal services will be on hold while the office is closed.

These steps are subject to any additional rules the Ontario government may establish in the interim and when lifting the suspension order.

Our top priority is keeping the public and all IPC staff safe during the COVID-19 outbreak. We will make every effort to get back to regular business quickly once this crisis is over.

What if my privacy is breached? Will the IPC be taking complaints?

Anyone with a complaint should submit it to the IPC using our online complaint forms (<https://www.ipc.on.ca/guidance-documents/forms/>). We will make every effort to respond to urgent matters in a timely way, but may not be able to address your complaint until the office reopens. We appreciate your patience during this difficult time.

Can I still reach the IPC to consult or ask questions about matters related to access and privacy at my organization?

While most tribunal services will not operate as usual while the office is closed, we continue to provide limited services to the public, public sector organizations, and the health and child and family services sectors.

We remain available to public organizations for consultation and discussions on access and privacy matters during this time.

We continue to update our FAQs as we get more information. You can also reach us by emailing info@ipc.on.ca (<mailto:info@ipc.on.ca>).

How will I comply with the requirement to report privacy breaches to the IPC?

Institutions, health information custodians and child and family service providers should continue to report breaches at their organizations using the online breach report form (<https://www.ipc.on.ca/guidance-documents/forms/>). We will make every effort to respond to urgent matters in a timely way, but may not be able to address your report until the office reopens. We appreciate your patience during this difficult time.

I am sending in an important piece of mail. Will it be received?

No, all mail is being held until the office reopens and is not being opened. Also, if you sent any mail on or after March 9, 2020, or any courier packages on or after March 11, 2020, we may not have received them yet and they will not be opened, either. If the communication was urgent, you may email info@ipc.on.ca (<mailto:info@ipc.on.ca>).

How do I get in touch with the IPC during the closure?

While most tribunal services will not operate as usual while the office is closed, we continue to provide limited services to the public, public sector organizations, and the health and child and family services sectors and we remain available to public organizations for consultation and discussions on access and privacy matters.

Members of the public can email info@ipc.on.ca (<mailto:info@ipc.on.ca>). We will make every effort to respond to urgent matters in a timely way, but may not be able to address your email until the office reopens.

Should organizations tell staff who are working at home to avoid accessing and collecting personal information of patients/clients? Home computers may not have the same level of security as the devices in the office, which are on a secure network.

We understand that these are exceptional circumstances. The reasonableness of security and privacy measures has to take into account time-limited, urgent needs. Many organizations are striving to manage service disruptions and continue to provide essential services, especially in the health and child and family services sectors.

If your organization believes that staff (or agents working on the behalf of the organization) should be allowed to handle personal information from home, in order to provide necessary services in an effective and efficient way, you should permit them to do so. You should guide any staff working from home on how to do their work within as privacy-protective an environment as they can, given the realities of our current situation.

In a public health crisis, it is also understandable that service professionals, especially in the health and child protection sectors, may need to send or receive information by phone, text, email or other messaging services. The above applies to the use of technologies not normally used for business, during this crisis.

We remain available to public organizations for consultation and discussions on access and privacy matters during this time.

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Council Member Terms as at June 10, 2020 ¹

Name	District	Date First Elected/Appointed	Date Re-elected/ Reappointed	Date of Expiry of Current Term
Elected Members				
Dr. Janet D'Arcy	4 (Central)	April 2019	NA	April 2022
Dr. Colin Goudreau ²	6 (Western)	April 2020	NA	April 2023
Dr. Sarah Green	5 (Central West)	April 2020	NA	April 2023
Dr. Paul Groulx	2 (Eastern)	April 2019	NA	April 2022
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	April 2020	April 2021
Dr. Janit Porter	4 (Central)	April 2020	NA	April 2021
Dr. David Starmer	7 (Academic)	April 2014	April 2017 April 2020	April 2023
Appointed Members ³				
Ms Georgia Allan	Smiths Falls	September 8, 2014	September 8, 2017	September 7, 2020
Ms Karoline Bourdeau	Toronto	July 17, 2017	NA	July 17, 2020
Mr. Gagandeep Dhanda	Mississauga	April 9, 2020	NA	April 9, 2021
Ms Robyn Gravelle	Burlington	May 16, 2019	May 16, 2020	May 16, 2023
Mr. John Papadakis	Scarborough	June 30, 2019	N/A	June 30 2022
Mr. Rob MacKay	Thunder Bay	November 28, 2018	N/A	November 27, 2021

¹ Please advise Ms Rose Bustria a.s.a.p. if you aware of aware of any discrepancies.

² Dr. Goudreau served as a noncouncil committee member of the Discipline Committee prior to being elected to Council (the by-laws provide for a nine consecutive year maximum as either a council or noncouncil committee member).

³ CCO requires at least 6 public members to be properly constituted.