COLLEGE OF CHIROPRACTORS OF ONTARIO

ELECTRONIC PUBLIC INFORMATION PACKAGE FOR
COUNCIL VIRTUAL MEETING
WEDNESDAY, APRIL 14, 2021 – 8:30 – 12 NOON
COMPENDIUM VOLUME

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

COUNCIL MEETING

Tuesday, April 14, 2021 *(8:30 a.m. – 1:00 p.m.)* [1]

Compendium Volume (Public) [2]

SECTIONS OF THE *CODE* FOR IN-CAMERA SESSIONS *IF* DIRECTED BY COUNCIL	Page No.	ITEM	Action Required	Action By	Priority Level [3]	Time [4]
		4. Committee Reports				
		4.1 Executive Committee Report Compendium Documents	FYI			***9:00 a.m.***
		Communications/Strategic Planning [5]				
	527	4.1.36 Vice-President's Message (Friday, March 5, 2021)				
		Miscellaneous Communications from Members/Stakeholders [6]	FYI			

[1] Subject to Council's direction.
[2] The Compendium Volume contains background information and items for review relevant to Council's agenda. The information is primarily FYI. The Main Agenda includes those matters requiring *action or review* by Council.
[3] Subject to Council's direction.
[4] Approximate (subject to Council's direction).
[5] Strategic planning deferred until CCO Council and staff can safely meet in person. Previous possible topics include emergency preparedness plan, CCO's Position Statement on Chiropractic and the Immune System (public interest lens), Core Competencies for Council Members/Evaluation (follow up to January 24, 2020 training session), and learnings from conducting business during COVID-19 (SWOT analysis). Please forward any recommended topics to Dr. Mizel and Ms Willson.
[6] Subject to questions/discussion.

SECTIONS OF THE *CODE* FOR IN-CAMERA SESSIONS *IF* DIRECTED BY COUNCIL	Page No.	ITEM	Action Required	Action By	Priority Level [3]	Time [4]
	540	4.1.37 Various Communications with Dr. Harald Simon				
		Other Chiropractic/Health Related Stakeholders-Environmental Scan				
		Federation of Canadian Chiropractic (FCC)				
	559	4.1.40 Call for Nominations [7]				
	567	4.1.41 Request for feedback re: consultation document on the regulation of Osteopaths in Quebec (March 15, 2021)				
		Ontario Chiropractic Association (OCA)				
	608	4.1.42 Communication dated March 16, 2021 re: Evidence Based Framework Advisory Council – Request for Meeting				
	635	4.1.43 Bulletin dated March 29, 2021 re: last day to vote in CCO elections				
		Canadian Chiropractic Association				
	645	4.1.45 CCGI Stakeholder Report September 2020				
		Canadian Chiropractic Protective Association				
	652	4.1.46 Communique dated February 24, 2021 re: Social Media Caution				
		Health Profession Regulators of Ontario (HPRO)				

[7] Dr. Mizel and Ms Willson will be attending the upcoming meetings (April 16, 24, 2021).

SECTIONS OF THE *CODE* FOR IN-CAMERA SESSIONS *IF* DIRECTED BY COUNCIL	Page No.	ITEM	Action Required	Action By	Priority Level [3]	Time [4]
	656	4.1.47 Communication dated March 1, 2021 to Health Regulatory College Registrars/Executive Directors re: Consultation on Proposed Exemptions Under the *Police Record Checks Reform Act, 2015* (_ CCO feedback)				
		6. For Your Information [8]	FYI (subject to questions)			
		College of Chiropractors of British Columbia [9]				
	693	6.1 College of Chiropractors of British Columbia – *Amendments to the PCH: Routine and Repeat Imaging* (dated February 8, 2021)				
	695	6.2 Related articles in the Chronicle of Chiropractic (dated February 26, 2021 and March 20, 2021)				
	700	6.3 CBC article dated March 22, 2021 entitled "*Battle over chiropractors' ability to do routine X-rays headed for B.C. court*"				
	707	6.4 Canadian Lawyer article (dated March 30, 2021) entitled "*Battle over*				

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

[9] Information to be reviewed by the Quality Assurance Committee.

SECTIONS OF THE *CODE* FOR IN-CAMERA SESSIONS *IF* DIRECTED BY COUNCIL	Page No.	ITEM	Action Required	Action By	Priority Level [3]	Time [4]
		chiropractors' ability to do routine X-rays headed for B.C. court"				
	713	6.5 Injunction application dated March 10, 2021				
		College of Physicians and Surgeons of Ontario				
	732	6.6 Information dated January 15, 2021 re: requirement for candidates for election to participate in an orientation program before being eligible				
		College of Respiratory Therapists of Ontario				
	738	6.7 Caution re: Posting Vaccination on Social Media				
		College of Teachers of Ontario				
	739	6.8 Timothy Bradley v Ontario *College of Teachers,* July 9, 2020 (Div. Court) [10]				
		Media				
	746	6.9 Various articles re: investigation/potential discipline of health professionals during COVID-19 pandemic				
	755	6.10 Article received March 8, 2021 entitled "*The Value of Case Reports as Clinical Evidence*"				
	771	6.11 Grey Areas dated March 2021 – *Is Irremediable Becoming the New Ungovernable*				
	774	6.12 Council Members Terms				

[10] The Divisional Court emphasized the stringent nature of the public interest test that applies to discipline panels that consider rejecting a joint submission.

SECTIONS OF THE *CODE* FOR IN-CAMERA SESSIONS *IF* DIRECTED BY COUNCIL	Page No.	ITEM	Action Required	Action By	Priority Level [3]	Time [4]

From: "College of Chiropractors of Ontario" <cco.info@cco.on.ca>
Sent: Friday, March 5, 2021 9:02:59 AM
Subject: Message from the CCO Vice-President - Friday, March 5, 2021

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

Message from the CCO Vice-President - Friday, March 5, 2021

Typically, these messages to members and the public are written by the CCO President. However, the current president is standing for re-election to council, and in the interest of not affording any one candidate any perceived advantage over any other, I have undertaken to provide this update letter.

Mr. Robert MacKay
Vice-President

COVID-19 Vaccine Rollout

As you will no doubt be aware, Ontario is in the midst of the rollout of COVID-19 vaccines. While there is obviously great interest and daily discussion of the subject in the media, here is what you need to know as a valued member of the health care community in the province.

The Ministry of Health has identified a set of guidelines for prioritizing access to COVID-19 vaccines for healthcare providers and others working in healthcare settings in accordance with the province's phased vaccine distribution plan. The guidelines are used by Ontario's Public Health Units, the agency responsible for administering vaccines within the areas they serve.

According to the Ministry's guidance, chiropractors are together with other practitioners of "Non-acute rehabilitation and therapy" in the group identified as "high priority", the third category of provider after the "highest priority" and "very high priority" groups which include hospital-based critical care, emergency and COVID-19 unit care, and other surgical specialties, pharmacists, dentists, midwifes, etc. respectively. It follows that chiropractors will get access to the vaccine after people in those groups have been offered it, as determined and managed by the local public health unit.

Websites and contact information for each local public health unit can be found at the following link. Members are advised to continue to visit your local public health unit's website, for the most up-to-date information and for registration for the COVID-19 vaccine, when available.

CCO will continue to publish timely information on its COVID-19 page under the heading "COVID-19 Vaccine Information" regarding the distribution of COVID-19 vaccines to regulated health professionals including chiropractors as soon as we receive it from the Ministry of Health and Ontario public health units.

Updates to Policy P-058: Policy on Considering Applications for Registration During the COVID-19 Pandemic

CCO continues to innovate and adapt to the needs of members and new applicants in light of the ongoing pandemic response.

CCO Council has approved amendments to its well-regarded Policy P-058: Policy on Considering Applications for Registration During the COVID-19 Pandemic to allow for the registration of candidates under the General (Provisional) class of registration as a result of the cancellation of the CCEB Part C examination in January 2021. New applicants to whom this applies should visit the following link for updated policy information and the application form.

Social Media Review Pilot Project

As has been shared previously, at the request of Council Dr. Gauri Shankar was tasked to design and undertake a pilot project to ascertain the feasibility of a program for ongoing review of member social media and online content.

Dr. Shankar has now completed his review of the social media of all Council members, peer assessors and non-Council committee members who were included in the scope of the pilot project, and is preparing an executive summary of his findings for presentation to Council.

The review was a qualitative and quantitative analysis of these Council members' content across all social media platforms that assessed compliance with CCO's social media and advertising policies and guidelines, identifying any exceptions. A comprehensive scoring system was used to evaluate when corrective action, if any, was required.

Council Elections Reminder

As a public member of CCO Executive Committee I know first-hand the privilege and serious responsibility shared by both public and elected members of Council to regulate chiropractic in Ontario in the public interest. CCO members, the Ministry of Health and the public have legitimate expectations that excellent candidates will stand for Council positions and be elected to serve.

I congratulate all the candidates who have allowed their name to go forward, and urge all members to note the following important dates related to the elections to Council.

Your vote matters!

March 8, 2021: CCO will post on its website and distribute by email to eligible voters in each district, relevant biographical information on the candidates.

March 15, 2021, 4 pm: **Voting opens**. CCO will distribute an electronic ballot to eligible voters in each district via email, and voting instructions.

March 29, 2021, 4 pm: **Voting closes**. CCO will post unofficial election results at the following link.

Sincerely,

Robert MacKay, Vice-President CCO

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Tel: 416-922-6355
Toll Free: 1-877-577-4772
Fax:416-925-9610
cco.info@cco.on.ca
www.cco.on.ca

March 16, 2021

ITEM 4.1.37

540

Via E-mail (hfsimon@amtelecom.net)

Dr Harald Simon BA, BEd, DC
2208 Hwy 551, PO Box 128
Mindemoya, ON
CANADA P0P 1S0
M (249) 777 – 0077

Dear Dr. Simon:

I understand you that you have made multiple enquires of CCO staff recently by voicemail and email, in particular wishing to discuss CCO financial reports, and again in conjunction with the CCO pilot social media analysis undertaken by Dr. Gauri Shankar.

With all due respect I refer you to my letter of December 11, 2020, in which I clearly stated that CCO staff do not take direction from members of the College in terms of prioritizing and managing their work loads. This is even more the case when working remotely as part of the pandemic response, while still delivering seamlessly on the mandate of the College. Again, I remind you that correspondence about the business of the CCO should be directed to the President, cc me.

With regard to CCO's financial reports, as you may know these are reviewed exhaustively before being submitted to a 3rd party auditor, and once that audit is completed, they are then presented to the membership as part of the annual report, and are posted on the CCO website. Thus once finalized and widely disseminated, they are considered to be 'stand-alone' documents akin to say the Discipline Decisions of the College, and as such they are not re-opened for discussion.

As pertains to the pilot project undertaken by Dr. Shankar at the request of CCO Council, and about which I have corresponded to you on several occasions, I point you to the most recent update provided by CCO Vice-President Rob Mackay in his letter to members dated March 5, 2021. To wit: "Dr. Shankar has now completed his review of the social media of all Council members, peer assessors and non-Council committee members who were included in the scope of the pilot project, and is preparing an executive summary of his findings for presentation to Council."

Sincerely,

Jo-Ann Willson
Registrar and General Counsel

College of Chiropractors of Ontario
L'Ordre des Chiropraticiens de l'Ontario
59 Hayden Street
Suite 800
Toronto, Ontario
M4Y 0E7
Tel: 416-922-6355
Toll Free: 1-877-577-4772
Fax:416-925-9610
cco.info@cco.on.ca
www.cco.on.ca

December 11, 2020

541

Dr. Harald Simon
2208 Hwy 551, PO Box 128
Mindemoya, ON
CANADA P0P 1S0
M (249) 777 – 0077

Via e-mail (hfsimon@amtelecom.net)

Re: Your Inquiry dated December 5, 2020 (attached)

Dr. Simon:

Thank you for your email of December 5, 2020, requesting that CCO staff add the matter of publishing the minutes of CCO Council & Executive meeting minutes on CCO's public website to the agenda of the upcoming February Council meeting.

Please note that CCO staff do not set the agenda of the Council meeting, nor do they take direction from individual members of the College. Suggestions concerning the Council agenda should be directed to me and CCO President Dr. Denis Mizel, who as Chair of the meetings of Council and Executive Committee, ultimately manages any given meeting's agenda upon consideration of the needs and requests of the elected and appointed members of Council and its Committees, and a consideration of CCO's priorities, consistent with CCO's public interest mandate, and within the context of the extraordinary times in which we all find ourselves.

With respect to the posting of meeting minutes, you are correct in noting the public correspondence between CCO and the MOHLTC about this feature of the new College Performance Management Framework. CCO embraces the intent of this measure as a demonstration of transparency. I encourage you to follow Council's next steps as they relate to this initiative. Thank you.

Sincerely,

Jo-Ann Willson,
Registrar and General Counsel

Rose Bustria

From: Harald Simon <hfsimon@amtelecom.net>
Sent: Saturday, December 5, 2020 5:14 PM
To: Rose Bustria
Subject: Posting CCO Council & Executive meeting minutes on the CCO public website

Dear Ms Bustria,

Could you please ensure that all council members receive a copy of my following letter?

I would kindly request confirmation of this request at your convenience.

Thank you.

Harald Simon

Dear Council Members,

Re: Posting CCO Council & Executive meeting minutes on the CCO public website

At the Nov 26/20 council meeting correspondence about the new College Performance Management Framework (CPMF) between the registrar and Ms Allison Henry, Director, Health Workforce Regulatory Oversight Branch, MOHLTC, was mentioned. Specifically, Ms Willson's Oct 13/20 letter to Ms Henry asked in numbered paragraphs 2 & 3 on page 2 about the CPMF Standard 3, Measures 4 (b) (ii) & (iii) about details of required posting of Executive committee meeting minutes and stated that "CCO embraces the intent of this measure to demonstrate greater transparency".

I attended the Nov 28/19 CCO council meeting where Dr Starmer moved to have all CCO council meeting minutes posted on the CCO public website as has been the practice with the College of Chiropractors of British Columbia (CCBC) since Oct 2010. After a cursory two minute discussion, Drs Mizel & Amlinger moved to table this item for further consideration and that motion passed. Notwithstanding the president's various pronouncements in multiple president's messages since, touting aligning CCO with best practices for greater transparency shared with other Canadian chiropractic regulatory colleges ensuing from multi-jurisdictional meetings, no further mention from CCO about posting minutes has occurred until the recent positive messaging from the registrar dictated by the MOH CPMF initiative.

It would therefore seem incumbent on council to have a quasi-proactive discussion and decision about posting minutes at the next scheduled council meeting on Feb 26/21 especially because council is not fully constituted. Can one assume that council is already in agreement with the registrar's above referenced comments to the MOH? With the executive committee currently being the only quorum CCO can muster, greater transparency should be voluntarily demonstrated as opposed to being forced into it by the MOH. Although ten years behind more progressive regulators, as the CCBC, a decision to post council and executive meeting minutes forthwith would be a sign of good faith to all CCO stakeholders, not least being its registrants.

Thanking you for your kind attention to this important overdue matter, I remain

Sincerely,

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Dr Harald Simon BA, BEd, DC
2208 Hwy 551, PO Box 128
Mindemoya, ON
CANADA P0P 1S0
M (249) 777 – 0077
hfsimon@amtelecom.net

Jo-Ann Willson **544**

From: Harald Simon <hfsimon@amtelecom.net>
Sent: Tuesday, March 16, 2021 1:30 PM
To: Jo-Ann Willson
Subject: FW: Correspondence dated, December 11, 2020 from Ms Willson
Attachments: 20Dec11SimonL.PDF

Dear Ms Willson,

Although your Mar 16/21 email didn't mention it, I assume you are writing in response to my Feb 22/21 query to CCO staff member Dr Walton in regards to the pilot social media analysis of Dr Shankar. In your Dec 21/20 memo posted in the public meeting package for the Feb 26/21 council meeting you directed Dr Walton to answer any queries about this project. Since this memo was public, it is not unreasonable to ask Dr Walton to carry out your request to answer feedback.

I have not ever engaged CCO *staff* to discuss financial reports, as you again allege.

Our previous email exchange on Dec 11/20 in the attachment above, where you obfuscated my comments and allege I asked CCO staff to carry out my requests was unwarranted, as you will recall from my reply below. In fact, our correspondence appearing in the Feb 26/21 public meeting package conveniently for you and unfairly to me omitted my email below.

I respectfully request that you please refrain from repeatedly misrepresenting my comments.

Sincerely,

Harald Simon

From: Harald Simon [mailto:hfsimon@amtelecom.net]
Sent: Friday, December 11, 2020 1:16 PM
To: 'Rose Bustria'
Subject: RE: Correspondence dated, December 11, 2020 from Ms Willson

Dear Ms Bustria,

Please forward my Dec 11/20 email reply to Ms Willson.

With thanks.

Harald Simon

Dear Ms Willson,

Re: Posting CCO Council & Executive meeting minutes on the CCO public website

Thanks for your Dec 11/20 (above attachment) response to my Dec 5/20 email to all CCO council members (elected and non-elected) with above subject, sent to Ms Bustria with a request to confirm

that all council members would receive a copy. ***N***either you **n**or Ms Bustria have confirmed that my email has been circulated to all council members.

Nowhere in my Dec 5/20 email did I ask CCO ***staff*** to add the matter of publishing CCO and Executive committee meeting minutes on CCO's public website to the agenda of the Feb 26/21 council meeting, as you allege in your Dec 11/20 email! I challenge you to demonstrate where you imagine I made such a statement.

In the first sentence of paragraph 3 on Dec 5/20, I infer that it would seem incumbent on council to have this topic on the agenda of the Feb 26/21 meeting and make arguments supporting this assertion. My Dec 5/20 correspondence was to all council members, who, as you correctly explain on Dec 11th, are empowered to request council meeting agenda items. Dr Mizel, being the council member having, as you state, ultimate management of agenda setting upon consideration of the requests of council members, was included in my email.

"CCO encourages all stakeholders to forward inquiries relating to CCO to CCO directly" is the welcoming message on the CCO website homepage. I again respectfully ask for confirmation that my Dec 5/20 correspondence to all CCO council members has been directly communicated to them.

Best regards.

Sincerely,

Dr Harald Simon BA, BEd, DC
2208 Hwy 551, PO Box 128
Mindemoya, ON
CANADA P0P 1S0
M (249) 777 – 0077
hfsimon@amtelecom.net

From: Rose Bustria [mailto:RBustria@cco.on.ca]
Sent: Friday, December 11, 2020 9:55 AM
To: Harald Simon
Subject: Correspondence dated, December 11, 2020 from Ms Willson

Please see attached. Thank you.

Rose Bustria
Administrative Assistant
*Note Address Change
College of Chiropractors of Ontario
59 Hayden Street, Suite 800
Toronto, ON M4Y 0E7
Tel: (416) 922-6355 ext. 101
Toll Free: 1-877-577-4772
Fax: (416) 925-9610
E-mail: rbustria@cco.on.ca
Web Site: www.cco.on.ca

From: Jo-Ann Willson
Sent: Tuesday, March 23, 2021 3:44 PM
To: Rose Bustria
Subject: Fwd: FCC Regulatory Council - 2021 Call for Nominations
Attachments: image002.jpg; FCC 2021 Call for Nominations for Chair and Vice Chair.docx

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: jpwillson@cco.on.ca
Web Site: www.cco.on.ca

Begin forwarded message:

> **From:** Greg MacDonald <gmacdonald@pathfinder-group.com>
> **Date:** March 23, 2021 at 3:39:09 PM EDT
> **To:** chrisprior35@hotmail.com, Denise Gerein <denise@saskchiro.ca>, deputyregistrar@chirobc.com, Doug.shatford@cshlaw.ca, drmichellemac@gmail.com, drmitzel@stcatherineschiropractic.com, drnshea@gmail.com, fleblanc@nbchiropractic.ca, "Janis Noseworthy (drjanisdc@gmail.com)" <drjanisdc@gmail.com>, jfhenry@ordredeschiropraticiens.qc.ca, Joel Friedman <JFriedman@cco.on.ca>, jjsuchdev@hotmail.com, John Sutherland <jsutherland@pathfinder-group.com>, Jo-Ann Willson <jpwillson@cco.on.ca>, Lara.Zaluski@gov.yk.ca, mackayrob@tbaytel.net, nlcbregistrar@gmail.com, "Philippe Lariviere, DC" <plariviere@ordredeschiropraticiens.qc.ca>, registrar@chirobc.com, registrar@mbchiro.org, thalowski@albertachiro.com
> **Subject: FCC Regulatory Council - 2021 Call for Nominations**
>
> Dear Members of the FCC Regulatory Council,
>
> Please find attached the 2021 Call for Nominations for the Regulatory Council. This year, both the Chair and Vice-Chair positions are open for nominations.

If you wish to nominate someone for one of these two positions, please use the attached form and return to Mr. John Sutherland, CEO, Federation of Canadian Chiropractic by April 9, 2021.

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Have a great day,

Greg

Greg MacDonald
Associate Executive Director, Federation of Canadian Chiropractic
604-5657 Spring Garden Road, Lobby Box 142
Halifax, NS, B3J 3R4
T 902-406-4351
W www.chirofed.ca

THE FEDERATION
FEDERATION OF CANADIAN CHIROPRACTIC
LA FÉDÉRATION
FÉDÉRATION CHIROPRATIQUE CANADIENNE

2021 Call for Nominations
ELECTION OF FCC REGULATORY COUNCIL COMMITTEE CHAIR AND VICE CHAIR

Dedicated leadership and involved membership have been essential in the successful work of The Federation of Canadian Chiropractic (FCC) Regulatory Committee. Your help is needed to continue our progress into the future. If you want to be a part of collaborating with and guiding chiropractic in Canada, get involved!

The role of the Regulatory Committee is to bring together regulatory board representatives from across Canada and internationally to discuss and decide on matters of mutual concern.

The FCC Regulatory Committee is composed of the following:

a) Chair
b) Vice-Chair
c) One or two representative(s) from each regulatory board in Canada

1. **Vacancies**

The following positions are open for nominations:

- Chair
- Vice-Chair

The terms of appointment for each position are two years or until their successor is elected.

2. **Nomination process**

Please complete a Nomination Form (attached) and submit by email to Mr. John Sutherland, CEO, at jsutherland@pathfinder-group.com on or before April 9, 2021

3. **Election Details**

If there is only one candidate nominated for a position, then that candidate will automatically be appointed by acclamation.

If there are several candidates for one or more positions, elections will be held at the Regulatory Council Committee Meeting on Friday, April 16, 2021.

Mission of the FCC

The Federation of Canadian Chiropractic serves the public interest by promoting excellence in regulatory and accreditation practice.

Duties of Positions

Chair shall be responsible for the activities of the Regulatory Council Committee as identified in Section 12.1c.

Vice Chair shall be responsible for the activities of the Regulatory Council Committee as identified in Section 12.1c if the Chair is not available.

THE FEDERATION
FEDERATION OF CANADIAN CHIROPRACTIC
LA FÉDÉRATION
FÉDÉRATION CHIROPRATIQUE CANADIENNE

NOMINATION FORM FOR ELECTION OF FCC REGULATORY COMMITTEE CHAIR AND VICE CHAIR POSITIONS

Please ensure the nominator has contacted the nominee in advance to ascertain his/her concurrence to permit this nomination.

****

I DO HEREBY NOMINATE _____ (PRINT NAME)

FOR THE FOLLOWING POSITION: (CHECK ONE)

_____ **CHAIR**

_____ **VICE-CHAIR**

SUBMITTED BY: _____ (PRINT NAME)

_____ (SIGNATURE)

****

Please return this form by April 9, 2021 to:

Mr. John Sutherland, Chief Executive Officer
Federation of Canadian Chiropractic
jsutherland@pathfinder-group.com

THE FEDERATION
FEDERATION OF CANADIAN CHIROPRACTIC
LA FÉDÉRATION
FÉDÉRATION CHIROPRATIQUE CANADIENNE

2021 Call for Nominations
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THE FEDERATION
FEDERATION OF CANADIAN CHIROPRACTIC
LA FÉDÉRATION
FÉDÉRATION CHIROPRATIQUE CANADIENNE

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NOMINATION FORM FOR ELECTION OF FCC REGULATORY COMMITTEE CHAIR AND VICE CHAIR POSITIONS

Please ensure the nominator has contacted the nominee in advance to ascertain his/her concurrence to permit this nomination.

****

I DO HEREBY NOMINATE _____ (PRINT NAME)

FOR THE FOLLOWING POSITION: (CHECK ONE)

_____ **CHAIR**

_____ **VICE-CHAIR**

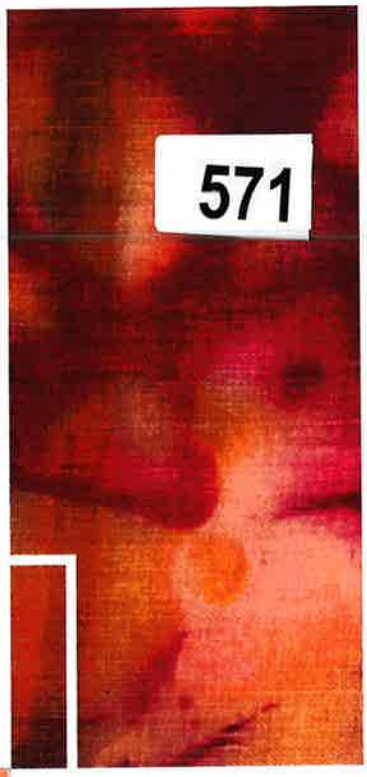
SUBMITTED BY: _____ (PRINT NAME)

_____ (SIGNATURE)

****

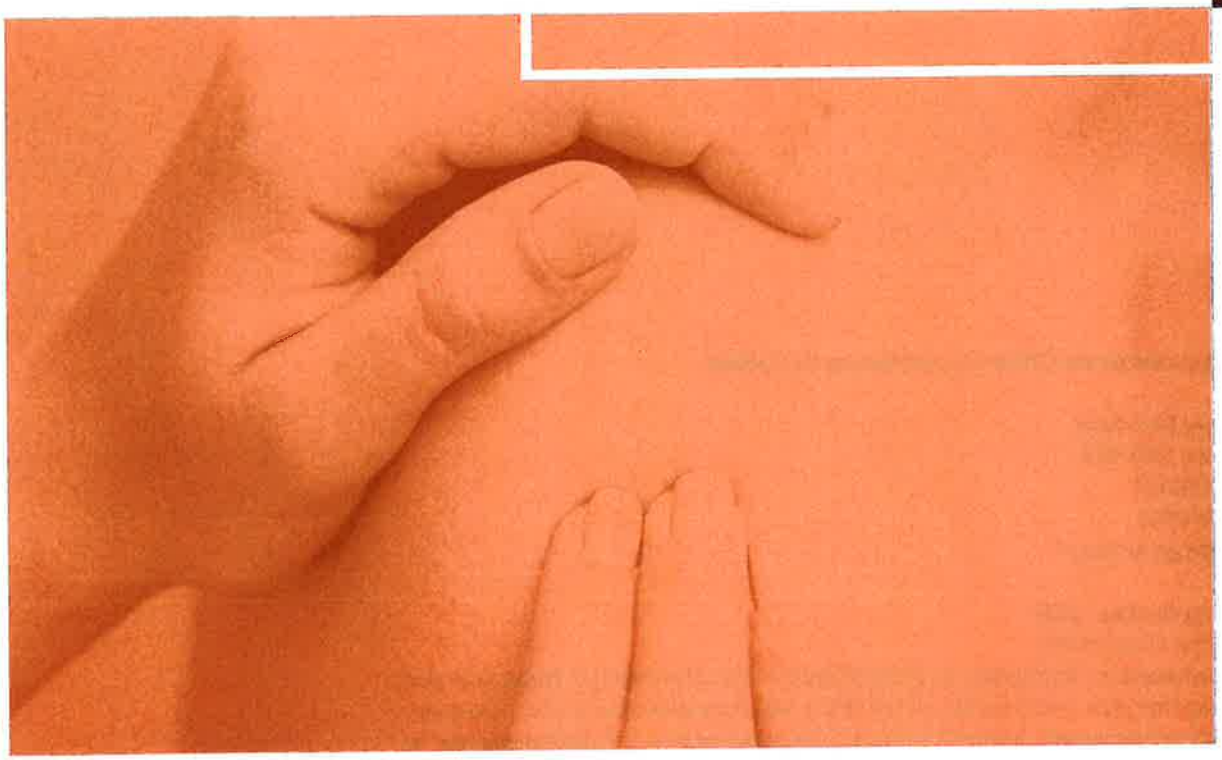
Please return this form by April 9, 2021 to:

Mr. John Sutherland, Chief Executive Officer
Federation of Canadian Chiropractic
jsutherland@pathfinder-group.com



Office des professions du Québec

Professional Regulation of Osteopaths



Consultation Document

October 2020

Québec

572

This report was produced by the Office des professions du Québec.

800 D'Youville Place, 10th floor
Quebec City, Quebec G1R 5Z3
Telephone: 418-643-6912
Toll free: 1-800-643-6912
Email: courrier@opq.gouv.qc.ca

573

Office des professions du Québec

Professional Regulation of Osteopaths

Consultation Document

October 2020

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Introduction

The Office des professions du Québec (hereafter referred to as the "Office") is an oversight body commissioned by the government to ensure that each professional order safeguards public protection in its area of activity. Under its mandate, the Office advises the government on the laws and regulations governing this mission to protect the public, as well as on the creation of new orders or the integration of new groups within existing orders.

Starting in 2003, as part of this mandate, the Office began developing a portrait of the practice of osteopathy in Quebec, following a request for professional regulation filed by the now defunct Registre des ostéopathes du Québec. To assist with this process, the Office was able to rely on the collective expertise of various committees set up to study the relevant aspects of the practice of osteopathy (the history of the work carried out by the Office or on its initiative is provided in Appendix 1).

The aim of this document is to present all the information collected as part of the work carried out by the Office, report any findings and allow interested groups and individuals to respond. The Office hopes to enhance and clarify its current portrait, with a view to making recommendations to the government regarding the regulation of osteopaths.

This document is divided into two parts. The first part provides a portrait of the current practice of osteopathy and presents regulatory models in effect in places where the practice is regulated, for information purposes. The second part summarizes the recommendations made as part of the work carried out by the Office to regulate Quebec osteopaths, in particular with regard to the title that could be reserved to them, their scope of practice and the activities that could be reserved to them or shared with other professionals.

The document concludes with a series of findings and questions to which readers are invited to respond. The response form provided should be emailed no later than May 1, 2021, to the following address: consultation.osteopathie@opq.gouv.qc.ca.

Part 1: The current situation

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1. What is osteopathy?

Osteopathy emerged in the U.S. in 1874, when Andrew Taylor Still set out the basic principles of the practice; he founded the first school of osteopathy in Kirksville, Missouri, in 1892. Several schools were subsequently established, and the practice of osteopathy became increasingly popular in the U.S. The osteopathy programs in these schools gradually incorporated a large part of the medical curriculum. Today, American osteopaths bear the title of osteopathic physician and have the right to practise medicine, prescribe drugs and perform surgery.[1]

In the early 1900s, osteopathy developed in the U.K. and France according to the original model, but without the medical component. As a result, the form of osteopathy that developed in Europe is part of what the World Health Organization (WHO) refers to as "alternative medicine," "traditional medicine" or "complementary medicine." This approach to osteopathy has expanded elsewhere in the world since the 1980s, and is currently the prevailing approach in Quebec.

Canada's National Occupational Classification reflects the difference between the American and European approaches. Osteopathy is classified both in a group related to medical professions and in a group related to alternative medicine. The first group (3125 – Other professional occupations in health diagnosing and treating) includes doctors of osteopathy, who are presented as performing mainly the following activities:

- Diagnose disorders and injuries of the musculoskeletal, circulatory and nervous systems
- Treat patients with manipulative therapy, medications or surgery

The second group (3232 – Practitioners of natural healing) includes osteopathic manual therapists, who are presented as performing mainly the following activities:

- Diagnose, treat and manage musculoskeletal and other related disorders of the body's structure by moving, stretching, and massaging a patient's muscles and joints to correct biomechanical dysfunctions

This latter form of non-medical osteopathy, which is a so-called "alternative" or "complementary" approach, is the subject of the Office's analysis. It was defined by the WHO in a document aimed at setting out alternative, traditional and complementary medicine training standards, as follows:

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1 See section 4.3 for more details.

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> ***Osteopathy (also called osteopathic medicine) relies on manual contact for diagnosis and treatment. It respects the relationship of body, mind and spirit in health and disease; it lays emphasis on the structural and functional integrity of the body and the body's intrinsic tendency for self-healing. . . .***
>
> ***Osteopathic practitioners use their understanding of the relationship between structure and function to optimize the body's self-regulating, self-healing capabilities. This holistic approach to patient care and healing is based on the concept that a human being is a dynamic functional unit, in which all parts are interrelated and which possesses its own self-regulatory and self-healing mechanisms. One essential component of osteopathic health care is osteopathic manual therapy, typically called osteopathic manipulative treatment (OMT), which refers to an array of manipulative techniques that may be combined with other treatments or advice, for example on diet, physical activity and posture, or counselling. The practice of osteopathy is distinct from other health-care professions that utilize manual techniques, such as physiotherapy or chiropractic, despite some overlap in the techniques and interventions employed.*** [2]

To summarize, according to the WHO document, osteopathy is based on the following three principles:[3]

- *The human being is a dynamic functional unit, whose state of health is influenced by the body, mind and spirit*
- *The body possesses self-regulatory mechanisms and is naturally self-healing*
- *Structure and function are interrelated at all levels of the human body*

Moreover, according to the documentation consulted,[4] osteopathy proposes a conceptualization of the human body based on three systems: the neuromusculoskeletal system, the visceral system (related to the internal organs) and the cranial system. In light of the definition proposed by the WHO, the interrelations between these systems are central to osteopathic practice.

It is, however, important to note that the definition of osteopathy continues to be the subject of discussion. For example, a literature review conducted in the U.K. indicates that the definition in use in that country differs from the one proposed by the WHO,[5] which promotes a holistic approach, presenting osteopathy as "a complete 'system of medicine.'" The definition in use in the U.K. puts osteopathy in the field of manual therapies, with an increased focus on the neuromusculoskeletal system.[6] A survey conducted in the U.K. in 2011 showed that a majority of

2 World Health Organization, *Benchmarks for Training in Traditional/Complementary and Alternative Medicine* (Geneva: 2010), p. 1. [Online] https://www.osteopathe-syndicat.fr/medias/page/6374-Benchmark-for-Training-in-Osteopathy.pdf.

3 *Ibid.*, p. 3.

4 See in particular: *Rapport du comité d'experts sur l'encadrement professionnel de l'ostéopathie*, Office des professions du Québec, May 2011, p. 22-23, and *Appendix 1: A Review of Literature on the Osteopathic Profession, Osteopathic Practice and Osteopathic Regulation in the UK, Report to the General Osteopathic Council* (Warwick Business School, February 2015), p. 18.

5 *Appendix 1: A Review of Literature on the Osteopathic Profession, Osteopathic Practice and Osteopathic Regulation in the UK, Report to the General Osteopathic Council* (Warwick Business School, February 2015), p. 20.

osteopaths reported using mainly techniques involving the neuromusculoskeletal system in their practice. Moreover, nearly 50% of respondents reported never or rarely using visceral or cranial techniques.[7]

In short, the definition of osteopathy has yet to be fully formalized and can be subject to variations, depending on the authorities responsible and where it is practised.

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6 See the example of the definition proposed by the General Osteopathic Council in section 4.2.3.

7 KPMG, *Report A: How Do Osteopaths Practise?*, March 2011, p. 10. [Online] https://www.osteopathy.org.uk/news-and-resources/document-library/continuing-fitness-to-practise/kpmg-report-a-how-do-osteopaths-practise-ozone/. It should be noted, however, that some survey respondents emphasized that it was difficult to distinguish between the use of these various techniques.

2. What knowledge is required to practise osteopathy?

Practising osteopathy requires extensive, internationally recognized knowledge. In several countries, the bodies responsible for regulating osteopathy are also responsible for recognizing the education programs that make this knowledge acquisition possible.[8]

A great deal of the knowledge required to practise osteopathy is common to a specific group of healthcare professionals, including knowledge related to basic sciences (e.g., anatomy, physiology, pathology, biomechanics, pharmacology, radiology) and clinical sciences (e.g., psychology, ethics and professional conduct, health promotion, practice management). In the case of osteopathy training, however, knowledge is acquired through the principles and foundations of osteopathy.

Osteopathy also shares several assessment and treatment tools with other healthcare professionals, such as physiotherapists, chiropractors and physicians working in manipulative therapy fields. These tools are nevertheless used as part of an intervention plan based on osteopathy principles. In that regard, the WHO guidelines specify the following:

> ***Although manual techniques are used by various manipulative therapy professions, the unique manner in which osteopathic manipulative techniques are integrated into patient management, as well as the duration, frequency and choice of technique, are distinctive aspects of osteopathy. Osteopathic manipulative treatment employs many types of manipulative techniques, including spinal thrust and impulse techniques, as well as gentle techniques.***[9]

To develop the overall knowledge and skills required to practise osteopathy, the WHO recommends two education curricula:

- The first involves a minimum of 4,200 hours, including at least 1,000 hours of supervised clinical practice, and is intended for those who have no prior healthcare training.
- The second is intended for professionals already working in healthcare. The duration of this training can vary depending on the initial training of the professionals in question.[10]

8 This is the case for the Osteopathy Board of Australia and the General Osteopathic Council in the U.K.

9 World Health Organization, *Benchmarks for Training in Traditional/Complementary and Alternative Medicine*, p. 3.

10 *Ibid.*, p. 7.

In Quebec, no educational institution recognized by the ministère de l'Éducation et de l'Enseignement supérieur (MEES) offers initial training in osteopathy. Various private schools, however, offer osteopathy training. The Office identified nine of these schools following a survey of osteopathy schools and associations conducted in 2013. The results of this survey should be approached with caution given the time that has since elapsed. They nevertheless constitute the Office's most recent data.

This survey made it possible to observe that the number of hours of training in the programs offered and the eligibility requirements can vary considerably from one school to the next. Using different educational approaches, the nine schools whose programs were analyzed cover basic

biological sciences and the study of major systems (anatomy, physiology, pathology and medical semiology), embryology, biomechanics and various osteopathic techniques (structural, functional, cranial and visceral). The number of hours of training varies from 500 to 2,000, and the duration of the programs ranges from three to six years. In this context, it cannot be stated with certainty that those practising osteopathy in Quebec have received training that meets the guidelines set out by the WHO.

Given this situation, in the past several years, the Office commissioned experts to make recommendations regarding the training required to practise osteopathy in such a way as to safeguard public protection.[11]

Consequently, in 2011, the committee of experts on the professional regulation of osteopathy recommended the implementation of training involving 3,480 to 3,510 hours of theoretical and practical instruction, corresponding to "a minimum of five years of university education." Moreover, the committee recommended that this training be offered only to those with a Diploma of College Studies.

According to the committee, the training should be divided into four blocks: basic sciences, clinical sciences, osteopathic sciences and professional development. The following table summarizes the proposal put forward by the committee in 2011.

Osteopathy training proposed by the committee of experts in 2011

Blocks	Fields	Hours of instruction
Basic sciences	Anatomy, physiology, pathology, embryology, biomechanics, radiology/medical imaging/laboratory analysis, pharmacology	720 to 735
Clinical sciences	Psychology, ethics and professional conduct, health and hygiene, practice management	195
Osteopathic sciences	History, philosophy and principles of osteopathy, osteopathic assessment and intervention, gynecology/obstetrics, pediatrics, practical training	2,250
Professional Development	Research, integration activity	315 to 330

11 Appendix 1 provides a history of the work carried out by the Office with regard to the regulation of osteopathy in Quebec.

In 2017, the Groupe de travail pour la création de l'Ordre professionnel des ostéopathes du Québec recommended that specific training components be required for those already practising osteopathy and wanting to obtain a licence to practise osteopathy, based on their diploma. Appendix 2 summarizes the proposals of the working group on the subject.

3. What is the practice profile of osteopaths?

The Office estimates that approximately 1,500 people currently practise osteopathy in Quebec. It is, however, difficult to obtain reliable data on their practice environment given the lack of a regulatory framework for this practice. According to summary research, it appears that osteopaths most often work in private practice, either alone in their own clinic or as self-employed workers within multidisciplinary teams.

This portrait seems to be the same in the U.K., according to the results of a survey conducted by the firm KPMG in 2011.[12] According to the data collected for that survey, a large percentage of osteopaths reported that they worked mainly in private practice or as part of a group of practitioners. Moreover, a small percentage of osteopaths reported practising in hospitals or doing home visits.

In addition, according to the results of a survey of osteopathy schools and associations conducted by the Office in 2013, many trained osteopaths were either members of an existing professional order or had earned a diploma that would allow them to obtain a licence issued by such an order. More specifically, the data collected showed that, among the members of the associations identified:

- 78% had earned a diploma that would allow them to obtain a licence issued by the Ordre professionnel de la physiothérapie du Québec
- 9% had earned a diploma that would allow them to obtain an occupational therapy licence
- 8% had earned a diploma that would allow them to obtain a nursing licence
- 2% had earned a dimploma that would allow them to obtain a psychologist's licence
- 1% had earned a doploma that would allow them to obtain a physician's licence
- 1% had earned a diploma that would allow them to obtain a chiropractor's licence
- Fewer than 1% had earned a diploma that would allow them to obtain a veterinarian's licence
- Fewer than 1% had earned a dipoma that would allow them to obtain a dentist's licence

12 KPMG. *Report A: How Do Osteopaths Practise?* (See note 7.)

4. What are the current regulatory models for osteopathy?

4.1 In Quebec

The practice of osteopathy is not currently subject to any regulatory framework in Quebec. In particular, the use of the title osteopath is not reserved and is frequently used by practitioners of osteopathy.

However, if the practice of osteopathy were to be regulated in Quebec, it would be necessary, given the provisions of the *Professional Code* (CQLR, c. C-26), that a title, an abbreviation and initials, if appropriate, be reserved to osteopaths. Only those with a licence issued by the professional order to which osteopaths belong and members on the roll of that order could use the title, abbreviation and initials.

In Quebec, American training in medical osteopathy is recognized by the Collège des médecins du Québec (CMQ). Section 14 of the *Règlement sur les conditions et modalités de délivrance du permis et des certificats de spécialiste du Collège des médecins du Québec* (RLRQ, c. M-9, r. 20.1) provides the following:

> ***14. The degree of doctor of osteopathy awarded by a school of osteopathic medicine in the U.S. is equivalent to a medical degree, provided that the school is certified by the Commission on Osteopathic College Accreditation of the American Osteopathic Association on the date that the degree is awarded*** **[free translation].**

The holder of this degree is issued a licence to practise medicine and is authorized to bear the title of doctor in Quebec.

4.2 Elsewhere in Canada

Elsewhere in Canada, non-medical osteopathy is not currently subject to any regulatory framework. However, several provinces reserve the use of the titles of osteopath, osteopathic physician and other, related titles to those authorized to practise osteopathic medicine.[13] Consequently, those who practise non-medical osteopathy in these provinces generally refer to themselves as osteopathic manual practitioners, osteopathic practitioners or osteopathic therapists. These practitioners are often members of a provincial association.

The regulation of a profession or an activity, and the establishment of rules governing that profession are specific to each province or territory, within the limits of the law.

13 That is the case, for example, in Alberta, British Columbia and Ontario.

4.3 In the U.S.

In the U.S., osteopaths are physicians or surgeons. They hold a licence for full medical or surgical practice. The medical legalization of osteopathy has been in effect across the entire U.S. since 1974, and American osteopaths enjoy the same medical prerogatives as physicians (MDs). They bear the title of osteopathic physician (DO) and have the right to practise medicine, prescribe drugs and perform surgery. American osteopaths receive training exclusively in one of the 19 educational institutions of osteopathic medicine that are members of the American Association of Colleges of Osteopathic Medicine. This training is recognized throughout several territories by regulatory bodies that oversee the practice of medicine.

4.4 In the U.K.

In the U.K., the *Osteopath Act 1993*[14] regulates the profession of osteopath. This law provides for the creation of the General Osteopathic Council (GOsC), which is responsible for overseeing the profession. This body is responsible for keeping registers of osteopaths who practise in the U.K., and overseeing the recognition of qualifications and professional conduct. As of March 31, 2019, over 5,300 osteopaths were registered with the GOsC. They are the only individuals authorized to bear the title of osteopath in the U.K.

The scope of practice of osteopaths is not specified in the *Osteopath Act 1993*. However, the GOsC provides the following definition of osteopathy:

> ***Osteopathy is a system of diagnosis and treatment for a wide range of medical conditions. It works with the structure and function of the body and is based on the principle that the well-being of an individual depends on the skeleton, muscles, ligaments and connective tissues functioning smoothly together.***
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> ***To an osteopath, for your body to work well, its structure must also work well. So osteopaths work to restore your body to a state of balance, where possible without the use of drugs or surgery. Osteopaths use touch, physical manipulation, stretching and massage to increase the mobility of joints, to relieve muscle tension, to enhance the blood and nerve supply to tissues, and to help your body's own healing mechanisms. They may also provide advice on posture and exercise to aid recovery, promote health and prevent symptoms recurring.***[15]

Activities performed by osteopaths are not specified in the *Osteopath Act 1993*.

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14 Available online: http://www.legislation.gov.uk/ukpga/1993/21/contents.

15 General Osteopathic Council: https://www.osteopathy.org.uk/visiting-an-osteopath/about-osteopathy/.

4.5 In France

In France, section 75 of *Loi n° 2002-303 du 4 mars 2002 relative aux droits des malades et à la qualité du système de santé*[16] provides that the conditions regarding the reservation of the title of osteopath, as well as the list of acts that these practitioners are authorized to perform, are established by decree.

Between 2007 and 2014, various decrees pertaining to the acts and conditions regarding the practice of osteopathy, the training of osteopaths, the accreditation of educational institutions and mandatory civil liability insurance were adopted. In particular, *Décret n° 2007-435 du 25 mars 2007 relatif aux actes et aux conditions d'exercice de l'ostéopathie*[17] describes the practice of osteopathy as follows:

> ***Section 1***
>
> ***Practitioners bearing the title of osteopath are authorized to perform manipulations with the sole aim of preventing or treating functional disorders of the human body, with the exception of organic pathologies that require therapeutic, medical, surgical or drug-related intervention, or the use of a physical agent. These manipulations are musculoskeletal and myofascial in nature, and exclusively manual and external. Practitioners can perform these acts only when symptoms that justify the use of paraclinical examinations are present.***
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> ***To manage these functional disorders, osteopaths perform unforced direct and indirect non-instrumental manipulations and mobilizations, in accordance with the recommendations for best practices established by the Haute Autorité de santé*** **[free translation].**

Moreover, section 3 of this decree specifies that a practitioner bearing the title of osteopath is authorized to perform manipulations of the skull and cervical spine following a diagnosis by a physician who certifies the absence of any contraindications. The practitioner cannot, however, perform any gyneco-obstetrical manipulations or pelvic touch.

Any candidates wishing to practise osteopathy must register with the director general of the appropriate regional health agency. Today, there are slightly more than 29,000 individuals authorized to bear the title of osteopath in France.

4.6 In Australia

In Australia, the profession of osteopath is regulated under the *Health Practitioner Regulation National Law Act 2009*.[18] This law does not define the scope of practice of osteopathy, but specifies that only those registered can use the title of osteopath or registered osteopath. In addition, it specifies that, along with chiropractors, physicians and physiotherapists, osteopaths

16 Available online: https://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000000227015.

17 Available online: https://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000000462001.

18 Available online: https://www.legislation.qld.gov.au/view/html/inforce/current/act-2009-045.

are among the healthcare professionals authorized to perform cervical spine manipulations,[19] which are a reserved activity.

Under this law, the body responsible for regulating osteopathy is the Osteopathy Board of Australia. In particular, it is responsible for keeping a register of osteopaths and establishing standards of practice and a code of conduct for registered osteopaths. According to the data provided by this organization, some 2,400 osteopaths currently practise in Australia.

4.7 In New Zealand

In New Zealand, osteopathy has been regulated since 2004 by the *Health Practitioners Competence Assurance Act 2003*.[20] This law specifies that the Osteopathic Council of New Zealand (OCNZ) is the regulatory body responsible for overseeing osteopathy. This organization is responsible, in particular, for keeping a register of osteopaths and managing the mechanism for disciplinary complaints. The OCNZ has also identified seven scopes of practice for osteopaths, adapted to the type of practice involved.[21]

Moreover, the *Health Practitioners Competence Assurance (Restricted Activities) Order 2005* specifies that performing cervical manipulations is a reserved activity.[22] The OCNZ has published a position paper that specifies the framework that applies to this activity.[23] It has also established guidelines regarding the use of internal techniques or techniques regarding sensitive areas, such as the genitalia.[24]

According to the information available on the OCNZ website, approximately 550 individuals practise osteopathy in New Zealand.

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19 This manipulation is described as follows: "Manipulation of the cervical spine means moving the joints of the cervical spine beyond a person's usual physiological range of motion using a high velocity, low amplitude thrust." (*Health Practitioner Regulation National Law Act 2009*, art. 123).

20 Available online: http://www.legislation.govt.nz/act/public/2003/0048/latest/DLM203312.html.

21 Available online: https://osteopathiccouncil.org.nz/Public/Registerd-Osteopaths/Scope-Of-Practice/Public/Registered-Osteopaths/Scope-Of-Practice.

22 The law describes these manipulations as follows: "Applying high-velocity, low-amplitude manipulative techniques to cervical spinal joints (SR 2005/182)," [Online]: http://www.legislation.govt.nz/regulation/public/2005/0182/latest/whole.html#DLM336025.

23 Available online: https://www.osteopathiccouncil.org.nz/images/stories/pdf/new/Pstn_Stmnt_HVLA_Aug20161.pdf.

24 Practice Guidelines—*Examination and Treatment of Genitalia, Sensitive Areas and Internal Techniques in Osteopathic Practice,* [Online]: https://www.osteopathiccouncil.org.nz/images/stories/pdf/new/Guidelines_Genitalia_Sep13.pdf.

Part 2: The regulation of osteopathy in Quebec

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1. The need to regulate osteopathy

The Office quickly recognized the need to regulate the practice of osteopathy, mainly for the following reasons:

- The factors specified in section 25 of the *Professional Code* to determine whether or not a professional order should be constituted or whether a group of people should be integrated into an existing order were deemed satisfactory.
- In particular, the Office determined that the acts performed by osteopaths were potentially harmful for the public, mainly because, on the one hand, the front-line procedures were often performed without any prior diagnosis and, on the other hand, osteopaths used spinal and joint manipulations that were reserved to three professions, namely physicians, chiropractors and physiotherapists.
- In this context, it seemed vital to ensure that osteopaths had the skills needed to safely practise osteopathy.

Osteopaths are regularly consulted as front-line healthcare providers, which requires a high degree of autonomy on their part. Following an assessment, an osteopath can decide to administer an osteopathic treatment or determine that a patient's condition requires the treatment of another healthcare professional. Someone who does not have the skills to ensure that osteopathy is practised safely could, on the basis of an erroneous assessment, administer a treatment that could lead to a deterioration in the patient's health. For example, a news story in April 2012[25] described the case of an osteopath who failed to detect the signs and symptoms of a blood clot in a patient. The osteopath in question chose to treat the patient instead of referring her to her doctor. As a result, the woman's left arm had to be amputated.

Moreover, some manipulations are contraindicated under particular circumstances and, if incorrectly performed, can cause serious injuries. In general, the complex techniques used in osteopathy are potentially as harmful as the techniques used by other healthcare professionals.

Lastly, although it may not lead to a deterioration in the patient's health, an osteopathic treatment may be ineffective and result in a financial loss for the patient.

The practice of osteopathy requires particular skills and can lead to different types of harm (e.g., physical, financial) that are serious enough to require the practice to be regulated.

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25 "Amputée, elle poursuit son ostéopathe," [Online]: https://www.tvanouvelles.ca/2012/04/23/ amputee-elle-poursuit-son-osteopathe.

2. What model is best suited to the regulation of osteopathy?

The committees established by the Office to reflect on the regulation of osteopathy, the main recommendations of which are provided in Appendix 1, contemplated which model would be best suited to the regulation of osteopathy.

2.1 Reserved title

Each province or territory is responsible for determining the rules surrounding the practice of a profession.

With regard to the reserved title, the experts consulted recommended reserving the use of the title "osteopath" and the abbreviation "ost." for those recognized as competent to practise osteopathy.

Some reservations were issued with regard to these proposals. On the one hand, some considered that the use of the title of osteopath should be reserved for osteopathic physicians, that is, those trained in osteopathic medicine. As specified previously, this is an avenue taken by some Canadian provinces. In Alberta, for example, the *Health Professions Act* (RSA 2000, c. H-7) reserves the following titles and initials for members of the Alberta College of Physicians and Surgeons who practise osteopathy: osteopath, osteopathic practitioner, Doctor of osteopathy, Doctor of osteopathic medicine, Osteopathic medical practitioner, DO.

On the other hand, the Quebec osteopathic environment is intent on preserving the initials DO, which refers to "diplômé en ostéopathie" (graduate of osteopathy). The Office, however, cannot support this proposal because of the confusion that it could create. Given that this abbreviation could also be interpreted as "doctor of osteopathy," using it could lead to misunderstandings and would prevent the public from easily identifying the skill level of the professional to whom it refers.

With regard to this matter, it is important to remember that the pertinent sections of the *Professional Code* specify that no individual can use a title or an abbreviation reserved for a member of a professional order identified in Schedule 1 of the *Professional Code* or use initials that could lead someone to believe that he or she is such a professional, unless he or she holds a licence issued by the order and is entered on the roll. Consequently, the use of the initials "DO" could lead someone to believe that the osteopath has a doctoral degree in a specific field or that he or she is a physician, dentist or veterinarian, which the *Professional Code* prohibits.[26]

2.2 Regulatory models

With regard to the preferred regulatory models for the regulation of osteopaths, the experts consulted at the various stages of the work carried out by the Office recommended either that a separate professional order be created or that osteopaths be integrated into an existing order.

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26 *Professional Code*, s. 58.1.

This recommendation was based in particular on the fact that osteopathy is considered to be a healthcare profession with its own scope of practice, and not a treatment approach or method that could be used by other professionals within their respective scopes of practice. Following this consultation, the Office will have to rule on the issue and recommend that the government either create a separate professional order or integrate osteopaths into an existing order.

3. What scope of practice best describes the practice of osteopaths?

The committees created by the Office to reflect on the regulation of osteopathy, the main recommendations of which are provided in Appendix 1, recommended different wording in reference to osteopaths' scope of practice.

In its 2011 report, the committee of experts composed of seven osteopaths trained in a regulated healthcare profession recommended the following scope of practice:

- The practice of osteopathy consists in assessing dysfunctions in the mobility[27] and motility[28] of the neuromusculoskeletal, visceral and craniosacral systems in order to determine their interrelations, develop a treatment plan and perform any acts of palpation and manipulation with a view to correcting the dysfunctions and promoting self-regulation and self-healing.

In 2017, the Groupe de travail pour la création de l'Ordre professionnel des ostéopathes du Québec composed of eight osteopaths selected to represent the associations known to the Office recommended the following wording:

- Assess dysfunctions in mobility and motility of the structures of the human body, determine a manual treatment plan and perform interventions with a view to correcting the dysfunctions and promoting the body's capacity for self-regulation.

Finally, in 2018, the joint committee composed of osteopath members of the working group and representatives of professional orders recommended the following wording:

- Assess osteopathic dysfunctions in mobility and motility of the structures and supporting tissues of the human body. Develop and perform manual interventions with a view to correcting the osteopathic dysfunctions.

The Office noted major differences between the various proposals for scopes of practice put forward over the years. It also noted a major discrepancy in some of the wording and the wording used in the *Professional Code* to describe professionals related to osteopathy in one way or another, such as physiotherapy and occupational therapy, to name just a few.

The scopes of practice of the Ordre professionnel de la physiothérapie du Québec (OPPQ) and the Ordre des ergothérapeutes du Québec (OEQ) read respectively as follows:

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27 "The quality of that which can move or be moved, or change places or position. Mobility of a member, an organ. → motility." *Petit Robert de la langue française* (ed. 2019)[free translation].

28 "Capability of movement. Overall movements specific to an organ, a system. Intestinal motility. → peristalsis." *Petit Robert de la langue française* (ed. 2019) [free translation].

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37. Every member of one of the following professional orders may engage in the following professional activities in addition to those otherwise allowed him by law:

. . .

n) the Ordre professionnel de la physiothérapie du Québec: assess physical function limitations and disabilities related to the neurological, musculoskeletal and cardiopulmonary systems, determine a treatment plan and apply treatment in order to obtain optimal functional performance;

o) the Ordre professionnel des ergothérapeutes du Québec: assess functional abilities, determine and implement a treatment and intervention plan, develop, restore or maintain a person's skills, compensate disabilities, reduce handicapping situations and tailor the environment to needs with a view to fostering the optimal autonomy of the person in interaction with his environment[29];

. . .

Moreover, the Office questioned whether the use of the term "osteopathic dysfunctions" made it possible to define the practice of osteopathy in a way that was sufficiently clear and understood by everyone. For information purposes, it is important to bear in mind that the Groupe de travail ministériel sur les professions de la santé et des relations humaines[30] had recommended specific guidelines when developing scopes of practice, in particular:

The scope:

- Is descriptive
- Recognizes the existence of possible overlaps with other professions
- Specifies the context within which professional activities are carried out

In addition, the working group said that it was opting for a description of each of the scopes of practice that was as precise and distinctive as possible. For the working group, the scope of practice set out the main activities of a profession in order to capture its nature, spirit and purpose.

For the Office, the description of the scope of practice for osteopathy had to follow specific criteria that ensure the intelligibility and consistency of the descriptions generally used to describe the other professional scopes of practice.

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29 *Professional Code*, s. 37, par. *n* and *o*.

30 "Une version renouvelée du système professionnel en santé et en relations humaines, rapport d'étape du Groupe de travail ministériel sur les professions de la santé et des relations humaines" (Rapport Bernier), November 2001, p. 240 and 241. [Online]: https://www.opq.gouv.qc.ca/fileadmin/documents/Systeme_professionnel/01_premier%20rapport%20Bernier.pdf.

4. What activities could osteopaths be authorized to carry out?

The committees formed by the Office to reflect on the regulation of osteopathy also examined the activities that osteopaths could be authorized to carry out and under what circumstances. To answer these questions, they considered the knowledge and skills that osteopaths would require to safely carry out the activities in question.

The Office retained the following based on the various recommendations made.

4.1 Assessment activities

Firstly, the Office holds that the practice of osteopathy involves conducting assessment activities, although there is no consensus on the wording.

The following activity is already reserved to members of the OPPQ and members of the OEQ:[31]

- Assess neuromusculoskeletal function in a person having a physical function limitation or disability.

Some of the experts consulted also suggested reserving this assessment activity to osteopaths, as well as physiotherapists and occupational therapists. The professional orders concerned expressed strong reservations regarding this proposal.

Given these reservations, the joint committee suggested wording the assessment activity that could be reserved to osteopaths differently, and made the following proposal:

- Assess the osteopathic dysfunctions impacting the mobility and motility of the structures or supporting tissues of the body of a person presenting physical signs or symptoms.

4.2 Activities involving manipulations

Secondly, the Office holds that osteopaths perform various types of manipulations as part of their practice. Some of these manipulations are already among the activities reserved within the professional system. The following activity is reserved to members of the OPPQ:

- Perform spinal and joint manipulations, provided a training certificate has been issued to the member by the Order pursuant to a regulation made under paragraph *o* of section 94 of the *Professional Code*.[32]

31 *Professional Code*, s. 37.1, par. 3, sub-par. *a*, and par. 4, sub-par. *b*.

32 *Règlement sur les activités de formation des physiothérapeutes pour procéder à des manipulations vertébrales et articulaires* (RLRQ, c. C-26, r. 192.1), [Online]: http://legisquebec.gouv.qc.ca/fr/ShowDoc/cr/C-26,%20 r.%20192.1/.

Moreover, some of the experts consulted recommended that osteopaths be authorized to perform internal manipulations. This type of manipulation is already an activity reserved by the professional system, since it is an invasive activity.[33] In particular, the following activity is reserved to members of the OPPQ:

- Introduce an instrument or a finger in the human body beyond the labia majora or anal margin.[34]

Based on the recommendations of the various committees, the Office considers that the following wording takes into account the manipulations performed by osteopaths and the conditions needed to ensure that they are performed safely:

- Perform joint and spinal manipulations, including the sacrococcygeal joint, by introducing a finger beyond the anal margin, provided a training certificate has been issued to the member by the Order pursuant to a regulation made under paragraph *o* of section 94 of the *Professional Code*.

4.3 Visceral and cranial techniques

Thirdly, some of the experts consulted suggested reserving the following activity for osteopaths:

- Apply manual visceral or cranial techniques.

However, the professional orders consulted expressed strong reservations regarding the suggestion that this activity be reserved. In particular, they indicated that there was limited scientific evidence and conclusive data to support it.

The Office considers that, according to the WHO document referred to earlier, visceral and cranial techniques are included in the skills that osteopaths acquire during the course of their training. The Office notes, however, that these techniques are generally not mentioned in the scopes of practice of osteopaths or the activities reserved to them in countries or territories in which osteopathy is already regulated.[36]

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33 "The term invasive refers to an exploratory or treatment method that goes beyond physiological barriers or into an artificial opening in the human body, or that causes a more than superficial lesion to the body. The physiological barriers specifically identified in the Act are as follows: the pharynx, nasal vestibule, labia majora, urinary meatus and anal margin" [free translation]. *Cahier explicatif, Loi modifiant le Code des professions et d'autres dispositions législatives dans le domaine de la santé* (Loi 90).

34 *Professional Code*, s. 37.1, par. 3, sub-par. c.

35 World Health Organization. *Benchmarks for Training in Traditional/Complementary and Alternative Medicine* (Geneva, 2010), p. 9. [Online]: https://www.osteopathe-syndicat.fr/medias/page/6374-Benchmark-for-Training- in-Osteopathy.pdf.

36 See section 5 of this document.

5. Findings and questions

Based on this brief portrait, the Office retained the following findings that raised various questions about osteopathy, including its definition, scope of practice and activities, as well as the knowledge required to practise osteopathy and the regulation of the profession.

5.1 Findings

Definition, scope of practice and activities pertaining to osteopathy

- Osteopathy is a practice that has not yet been clearly defined. In its non-medical form, it is practised mainly through manual techniques used to correct dysfunctions related to the structure of the human body.
- Although it is related to the practice of such professions as physiotherapy and chiropractic, osteopathy is characterized in particular by its emphasis on the interrelations between the different systems of the human body.
- The proposal to reserve the practice of visceral and cranial techniques to osteopaths was not well received by the professional orders consulted, which pointed to the lack of conclusive data to support the effectiveness of this practice.

Knowledge required to practise osteopathy

- The content and duration of training offered in private osteopathy schools in Quebec vary considerably from one school to the next, as do the eligibility requirements. In this context, it cannot be concluded that all osteopaths trained in Quebec have equivalent skills that prepare them to practise osteopathy safely.

Regulation of osteopathy

- Osteopathy is currently not subject to regulation in Quebec.
- At an international level, osteopathy is regulated by bodies in several countries, in particular with regard to the reserved title of osteopath. Moreover, several countries reserve the practice of cervical manipulations to osteopaths and other professionals.

5.2 Questions

1. In general, what do you think of the portrait of osteopathy outlined in this document? Does it appear to comply with current practice?
2. In your opinion, what key elements could enhance this portrait?

3. Which scope of practice among those mentioned (p. 24) seems most appropriate and why?

4. Which aspects of these scopes of practice seem to best represent the practice of osteopathy?

5. In your opinion, are there any distinctive elements that are absent from the proposed scopes of practice? If so, which ones?

6. More specifically, how does the use of the term "osteopathic dysfunction" in the scope of practice (p. 25) help clearly define the practice of osteopathy?

7. In what way does the assessment activity conducted by osteopaths differ from or resemble the assessment conducted by physiotherapists or occupational therapists (p. 26)?

8. Is it appropriate to use the term "osteopathic dysfunction" to describe the assessment activity conducted by osteopaths (p. 26)?

9. To what extent do Quebec osteopaths use visceral and cranial techniques within their practice?

10. To what extent is the use of these techniques based on conclusive data and scientific evidence?

11. Does the use of these techniques pose a high risk of harm?

12. If so, what is the nature of the risks involved?

13. In your opinion, what regulatory model among those specified in this document (p. 22) seems especially well suited to the situation in Quebec, and why?

14. In your opinion, what other elements should be considered as part of this consultation?

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Appendix 1

History of the work done by the Office des professions du Québec regarding the regulation of osteopathy in Quebec

1. Opinion of the Office regarding the opportunity to create a professional corporation in the field of alternative medicine (1992)

The first request to create a professional order for osteopaths was submitted to the Office by the Registre ostéopathique du Québec (ROQ) in 1990. The Office responded to the request in its 1992 opinion regarding the opportunity to create a professional corporation in the field of alternative medicine. This opinion concerned osteopathy, as well as massage therapy and other manual approaches that were not regulated, such as homeopathy, naturopathy, phytotherapy and reflexology.

When it drafted its opinion, the Office estimated that 85 individuals were practising osteopathy in Quebec. Almost all of them were members of a professional order in the musculoskeletal field.

Following an analysis, the Office found that the factors specified in section 25 of the *Professional Code* applied to osteopathy. Consequently, the Office proposed specific measures to regulate the practice. In particular, it recommended that:

- The title of certified osteopath be reserved
- The professional orders concerned, namely those of physicians and physiotherapists, ensure through regulation that only members who had demonstrated their skills in the field could use the title of certified osteopath

However, these recommendations were never implemented.

2. Examination undertaken following the modernization of healthcare professions (2003)

In 2003, following a request by the ROQ, the Office re-examined the situation regarding the practice of osteopathy. This process was part of the adoption of Bill 90 – *An Act to amend the Professional Code and other legislative provisions as regards the health sector* (SQ 2002, c. 33) – which emphasized the possible interfaces between the practice of osteopathy and the activities henceforth reserved for healthcare professionals.

In light of the newly adopted legislative provisions, the Office updated the data pertaining to the practice of osteopathy, and made the following observations:

- The acts performed by osteopaths pose risks of harm, mainly because they are front-line procedures often performed without a prior diagnosis.
- Osteopaths perform spinal and joint manipulations, which are reserved to three groups of professionals, namely physicians, chiropractors and physiotherapists.
- The practice of osteopathy can no longer be considered marginal. When the Office examined the request submitted by the ROQ, it was estimated that over 500 individuals were practising osteopathy, and the data available suggests a considerable increase in the numbers prepared to offer services in this field.

Consequently, in 2007, the Office decided to form a committee of experts on the professional regulation of osteopathy (hereafter referred to as the "expert committee"). The committee began its work in 2008, which concluded with the publication of a report in 2011.

3. Expert committee (2008)

The mandate of the expert committee, which was composed of seven osteopaths with training in a regulated health profession, was to advise the Office on the definition of osteopathy, the training required to safely practise osteopathy and the type of professional regulation of the practice. Following three years of work, the expert committee developed a series of preliminary guidelines that were initially shared with the osteopathic community in the course of meetings organized with osteopathy schools and associations. The expert committee then presented its report, whose recommendations can be summarized as follows.

With regard to the description of the field of osteopathy, the expert committee recommended the following formulation:

- The practice of osteopathy consists in assessing the dysfunctions in mobility[37] and motility[38] of the neuromusculoskeletal, visceral and craniosacral systems in order to determine their interrelations, develop a treatment plan and perform any acts of palpation and manipulation with a view to correcting the dysfunctions and promoting self-regulation and self-healing.

The expert committee also recommended reserving four professional activities to osteopaths, namely:

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37 "The quality of that which can move or be moved, or change places or position. Mobility of a member, an organ. → motility." *Petit Robert de la langue française* (ed. 2019) [free translation].

38 "Capability of movement. Overall movements specific to an organ, a system. Intestinal motility. → peristalsis." *Petit Robert de la langue française* (ed. 2019) [free translation].

- Assess dysfunctions in mobility and motility of the neuromusculoskeletal, visceral or cranial systems of a person presenting physical symptoms or disorders.
- Introduce a finger in the human body beyond the labia majora or anal margin.
- Perform spinal or joint manipulations.
- Perform visceral or cranial manipulations.

With regard to the training required to practise osteopathy safely, the expert committee specified that appropriate training in the field should include between 3,480 and 3,510 hours of theoretical and practical instruction divided into four blocks: basic sciences, clinical sciences, osteopathic sciences and professional development. The report presented a detailed description of the content of each of these blocks. The expert committee also recommended, as part of the instruction, 315 hours of training focused specifically on spinal and joint manipulations. Within the framework of the Quebec education system, this training would correspond to at least five years of university studies.

The expert committee also made detailed recommendations regarding "grandfathered provisions." The committee identified four training profiles,[39] indicating the conditions to be met for each one so that candidates would have the skills needed to practise osteopathy safely.

The expert committee also suggested that individuals who enrolled in an osteopathy training program once the regulatory measures were in place should be subject to a theoretical and practical exam once they completed their program.

Lastly, with regard to the recommended professional regulation of the practice of osteopathy, the expert committee recommended reserving the title of "osteopath" to those who would ultimately earn a degree recognized by the government attesting to training that takes the specified recommendations into account, or who benefited from the "grandfathered provisions" described in the report.

The expert committee recommended that these individuals be regulated by a newly created professional order, or be integrated into an existing order. This recommendation was based in particular on the fact that the expert committee considered osteopathy not as a treatment approach or method that could be used by other professionals in their scope of practice, but as a

39 They include the following categories: category 1) those with a university degree in the field of physical health; category 2) those with a university degree that includes a minimum of 12 credits in the field of physical health in at least two areas (anatomy, physiology, pathology or semiology) and those with a Diploma of College Studies in physical rehabilitation techniques, nursing techniques or acupuncture techniques; category 3) those with a Diploma of College Studies or a university degree other than those mentioned previously; category 4) candidates who do not fall under any of the three previously mentioned categories (see pages 44-47 of the expert committee report).

healthcare profession with its own scope of practice.

4. The advisory committee (2012)

Following the publication of the expert committee's report, the Office formed an advisory committee in 2012 made up of representatives of each of the orders concerned with the practice of osteopathy.[40] This committee's mandate was to comment on, validate and enhance the proposals made by the expert committee. The advisory committee was also mandated to measure the impacts of the expert committee's recommendations on the professional system.

Once its work was completed, the advisory committee, like the expert committee, confirmed the need for the professional regulation of osteopathy. However, the advisory committee recommended a different regulatory approach than the expert committee: it wanted the Office to examine the possibility of regulating osteopathy using the model developed to regulate psychotherapy. However, this avenue was not adopted by the Office.

The advisory committee also expressed concerns about other aspects of the expert committee's report. In particular, it questioned:

- The scientific bases of the activity that involved performing visceral or craniosacral manipulation, which the expert committee suggested reserving
- The training recommended by the expert committee to perform spinal and joint manipulations

5. The Groupe de travail pour la création de l'Ordre professionnel des ostéopathes du Québec (2014)

In fall 2014, the Office requested the help of the osteopathy associations to create a working group that would begin the process of regulating the practice of osteopathy.

This working group made up of eight osteopaths from different associations began its work in February 2015. As part of its mandate, it was required to examine several aspects of the regulation of the practice, namely the reserved title, scope of practice and professional activities reserved to osteopaths, the requisite training, temporary provisions, and the administration of a possible order, as well as its budget and viability.

In fall 2017, the working group presented an information document intended for the osteopathic community. The document recommended defining the scope of practice of osteopathy as follows:

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40 The CMQ, OPPQ, Ordre des infirmières et infirmiers (OIIQ), OEQ and Ordre des chiropraticiens du Québec (OCQ).

Assess dysfunctions in mobility and motility of the structures of the human body, establish a manual treatment plan and perform interventions with a view to correcting the dysfunctions and promoting the body's capacity for self-regulation. **600**

Moreover, the working group recommended that the following activities be reserved to osteopaths:

- Assess the neuromusculoskeletal function of a person with a physical function limitation or disability.
- Assess the mobility and motility of the structures of the human body of a person presenting physical symptoms or disorders.
- Perform joint, spinal or peripheral manipulations, provided a training certificate has been issued to the member by the Order pursuant to a regulation made under paragraph *o* of section 94 of the *Professional Code*.
- Apply manual visceral or cranial techniques.
- Introduce a finger in the human body beyond the labia majora or anal margin.

Lastly, the working group suggested identifying the four conditions for issuing an osteopathy licence, namely (i) temporary provisions for osteopaths who are already practising, (ii) training equivalency, (iii) temporary provisions for students and new graduates and (iv) basic conditions for students planning to enrol in an osteopathy program once the practice is regulated by a professional order.

6. The consultation held by the Groupe de travail pour la création de l'Ordre professionnel des ostéopathes du Québec (2017)

In November 2017, the document that was created served as a basis for a consultation with osteopathy schools and associations in Quebec. This consultation was held by the working group in conjunction with the Office. It generated more than 230 responses from individuals, schools and associations involved in osteopathy.

The comments pertained mainly to the temporary provisions proposed by the working group. In general, the individuals and schools whose profiles matched the proposed conditions were satisfied with the proposals, while those that did not satisfy the conditions wanted them to be changed. Moreover, some osteopathy schools and associations questioned the composition of the working group, its representativeness and the independence of its members.

In April 2018, a consultation of the professional orders concerned with the regulation of osteopathy was also held.[41] This consultation was based on an information document similar to

41 The CMQ, OPPQ, OIIQ, OEQ and OCQ.

the one presented to the osteopathic community in 2017, and addressed the reserved title of osteopath, the scope of practice, the reserved and shared professional activities, and the conditions for issuing an eventual licence.

During this consultation, the professional orders reaffirmed the importance of regulating the practice of osteopathy, in particular given the high risk of harm that it posed for the public. They also reiterated the concern expressed in 2012 about the lack of consistency with regard to the training offered in osteopathy schools, and the lack of scientific evidence to support the practice of osteopathy. In this context, it was once again recommended that the regulation of osteopathy be based on the model used in psychotherapy.

7. The joint committee (2018)

Relying on the cooperation of professional orders and members of the working group in osteopathy, the Office formed a joint committee on osteopathy in June 2018 made up of representatives of the professional orders consulted and eight members of the working group.

The joint committee's mandate was to define osteopathy as accurately and distinctly as possible, and describe the professional activities that could be reserved to osteopaths. Lastly, the committee was mandated to discuss the regulatory provisions surrounding the practice of osteopathy.

Once the discussions were over, the joint committee recommended defining the scope of practice of osteopathy as follows:

> **Assess the osteopathic dysfunctions in mobility and motility of the structures or supporting tissues of the human body. Develop and perform manual interventions with a view to correcting the osteopathic dysfunctions.**

With regard to the activities that could be reserved to osteopaths, the committee's discussions converged towards the following activities:

- Assess the osteopathic dysfunctions in mobility and motility of the structures or supporting tissues of the human body of a person presenting physical signs or symptoms.
- Perform joint and spinal manipulations, including the sacrococcygeal joint, by introducing a finger beyond the anal margin, provided a training certificate has been issued to the member by the Order pursuant to a regulation made under paragraph *o* of section 94 of the *Professional Code*.

However, the professional orders expressed strong reservations regarding the proposal to reserve the following activities to osteopaths:

- Assess the neuromusculoskeletal function and its interrelations with other physiological functions of a person with a functional disorder.
- Apply manual visceral and cranial techniques.
- Introduce a finger in the human body beyond the labia majora, provided a training certificate has been issued to the member by the Order pursuant to a regulation made under paragraph *o* of section 94 of the *Professional Code*.

The professional orders were especially concerned with the lack of conclusive data to support the performance of some of these activities. They also wondered what repercussions reserving these activities to osteopaths could have on other professionals. The professional orders, however, reaffirmed the need to regulate the practice of osteopathy in Quebec, and said that they hoped that it would happen quickly.

Appendix 2

Proposals of the 2017 working group regarding the training elements required of candidates already practising osteopathy and wanting to obtain a licence to practise based on their degree

1	2	3
Hold a university degree, which, once issued, allows candidates to obtain a licence to practise the profession of: - Physiotherapist - Occupational therapist - Physician - Chiropractor - Nurse Hold a diploma of osteopathy from a Quebec school offering a program of a minimum of 1,200 hours of classroom instruction	**Hold a bachelor's degree in exercise science/athletic therapy** Hold a diploma of osteopathy from a Quebec school offering a program of a minimum of 1,200 hours of classroom instruction Be a member of the Canadian Athletic Therapists Association (CATA) or meet CATA's criteria and have completed a minimum of 1,000 hours of clinical practice in osteopathy in the past year, working with a clientele with a variety of issues Within the first year of being entered on the roll of the Order, complete a training session on ethics and professional conduct organized by the Order	**Hold a college diploma that allows candidates to obtain a licence to practise the profession of:** - Physical rehabilitation therapist - Acupuncturist - Nurse Complete upgrade training involving at least 450 hours of classroom instruction to acquire basic knowledge of: - Anatomy - General physiology/pathology - Neurophysiology - Biomechanics - Neuromusculoskeletal assessment Hold a diploma of osteopathy from a Quebec school offering a program of a minimum of 1,200 hours of classroom instruction After obtaining a diploma, have completed a minimum of 1,000 hours (1,500 hours in the case of an acupuncturist) of clinical practice in osteopathy in the past year, working with a clientele with a variety of issues

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4	5	6
Hold a bachelor's degree in kinesiology Complete upgrade training involving at least 450 hours of classroom instruction to acquire basic knowledge of: - Anatomy - General physiology/pathology - Neurophysiology - Biomechanics - Neuromusculoskeletal assessment Hold a diploma of osteopathy from a Quebec school offering a program of a minimum of 1,200 hours of classroom instruction After obtaining a diploma, have completed a minimum of 1,500 hours of clinical practice in osteopathy within the past 18 months, working with a clientele with a variety of issues Within the first year of being entered on the roll of the Order, complete a training session on ethics and professional conduct organized by the Order	**Hold a bachelor's degree in physical education and health instruction** Complete upgrade training involving at least 450 hours of classroom instruction to acquire basic knowledge of: - Anatomy - General physiology/pathology - Neurophysiology - Biomechanics - Neuromusculoskeletal assessment Hold a diploma of osteopathy from a Quebec school offering a program of a minimum of 1,200 hours of classroom instruction After obtaining a degree, have completed a minimum of 2,000 hours of clinical practice in osteopathy within the past three years, working with a clientele with a variety of issues Within the first year of being entered on the roll of the Order, complete a training session on ethics and professional conduct organized by the Order	**Hold a Diploma of College Studies (DCS) in natural, health or pure and applied science** Hold a diploma in osteopathy from a Quebec school offering a minimum of 3,100 hours of classroom instruction, including a minimum of 1,000 hours of supervised clinical practice Have completed a minimum of 700 hours for the thesis option or the clinical internship and essay option After obtaining a diploma, have completed a minimum of 2,000 hours of clinical practice in osteopathy within the past three years, working with a clientele with a variety of issues Within the first year of being entered on the roll of the Order, complete a training session on ethics and professional conduct organized by the Order

From: Jo-Ann Willson
Sent: Wednesday, March 24, 2021 12:17 PM
To: Rose Bustria
Subject: FW: FCC Regulatory Council - consultation document on the regulation of Osteopaths in Quebec - 1st reminder
Attachments: Quebec review of Osteopathy English translation January 2021.pdf

Importance: High

Council.

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From: Jean-François Henry, chiropraticien D.C. <jfhenry@ordredeschiropraticiens.qc.ca>
Sent: Wednesday, March 24, 2021 12:04 PM
To: 'Dr. Janis Noseworthy (drjanisdc@gmail.com)' <drjanisdc@gmail.com>; thalowski@albertachiro.com; fleblanc@nbchiropractic.ca; drnshea@gmail.com; nlcbregistrar@gmail.com; registrar@chirobc.com; denise@saskchiro.ca; Jo-Ann Willson <jpwillson@cco.on.ca>; registrar@mbchiro.org; Lara.Zaluski@gov.yk.ca
Cc: Philippe Larivière <PLariviere@ordredeschiropraticiens.qc.ca>; John Sutherland <jsutherland@pathfinder-group.com>; Greg MacDonald <gmacdonald@pathfinder-group.com>
Subject: FCC Regulatory Council - consultation document on the regulation of Osteopaths in Quebec - 1st reminder
Importance: High

Hello dear fellow regulators,

I thought it would be a good idea to provide you with a few key points illustrating the OCQ's stance with respect to this consultation.

- The OCQ recognizes that it is necessary to regulate the practise of osteopathy
- The OCQ establishes that there needs to be an accredited and governmentally recognized academic institution which sets the training standards prior to regulating osteopathy
- The OCQ will oppose to the reservation of the act of performing manipulation (high velocity-low amplitude) of the spine and/or peripheral joints, including the cranium

If you would need to discuss further the matter, please do not hesitate to contact me. I provide you with the translated consultation document again to simplify things. Please see background, action and timeline below.

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Your comments should be submitted to Greg MacDonald at the FCC office at gmacdonald@pathfinder-group.com no later than April 1, 2021, in order to meet submission deadlines.

Please accept my best regards,

Dr Jean-François Henry, chiropraticien, D.C., B.Sc., M.Sc. | Président

ORDRE DES CHIROPRATICIENS DU QUÉBEC

COVID-19 : veuillez noter que nos bureaux sont temporairement fermés, mais que nos activités sont maintenues. Contactez-nous par courriel!

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De : Alex MacDonald <amacdonald@pathfinder-group.com>
Envoyé : 15 mars 2021 09:41
À : 'Dr. Janis Noseworthy (drjanisdc@gmail.com)' <drjanisdc@gmail.com>; Jean-François Henry, chiropraticien D.C. <jfhenry@ordredeschiropraticiens.qc.ca>; thalowski@albertachiro.com; fleblanc@nbchiropractic.ca; drnshea@gmail.com; nlcbregistrar@gmail.com; registrar@chirobc.com; denise@saskchiro.ca; jpwillson@cco.on.ca; registrar@mbchiro.org; Lara.Zaluski@gov.yk.ca
Cc : Philippe Larivière <PLariviere@ordredeschiropraticiens.qc.ca>; John Sutherland <jsutherland@pathfinder-group.com>; Greg MacDonald <gmacdonald@pathfinder-group.com>
Objet : RE: FCC Regulatory Council - consultation document on the regulation of Osteopaths in Quebec - 1st reminder

Regulatory council members:

A reminder that comments are requested not later than April 1, 2021, in order to meet submission deadlines. NEW Please remit your response to Greg MacDonald at the FCC office at gmacdonald@pathfinder-group.com

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From: Alex MacDonald
Sent: February 2, 2021 12:48 PM
To: Dr. Janis Noseworthy (drjanisdc@gmail.com) <drjanisdc@gmail.com>; Jean-François Henry, chiropraticien D.C. <jfhenry@ordredeschiropraticiens.qc.ca>; thalowski@albertachiro.com; fleblanc@nbchiropractic.ca; drnshea@gmail.com; nlcbregistrar@gmail.com; registrar@chirobc.com; denise@saskchiro.ca; jpwillson@cco.on.ca; registrar@mbchiro.org; Lara.Zaluski@gov.yk.ca
Cc: Philippe Lariviere, DC <plariviere@ordredeschiropraticiens.qc.ca>; John Sutherland <jsutherland@pathfinder-group.com>
Subject: FCC Regulatory Council - consultation document on the regulation of Osteopaths in Quebec

Sent on behalf of the co-chairs of Regulatory Council

BACKGROUND

The Office des professions du Quebec has produced a consultation document on proposed regulation of Osteopathy and Osteopaths in Quebec. This consultation document is the result of a request for regulation first put forward in 2003 by Osteopaths in that jurisdiction. The purpose of the consultation document is to gather all of the necessary background information on the regulation of the profession of Osteopathy, and to allow interested groups and individuals to respond. Regulatory Council of the FCC intends to provide comment. The consultation document (translated) is attached to this email.

ACTION

Regulators are requested to review the attached document and to provide comment to FCC staff in order to prepare a consolidated Regulatory Council response to The Office des professions du Quebec. The due date for the final FCC response to the Office des professions du Quebec is May 1, 2021, and as a result, the due dates for regulator review/comment are as follows:

February 1, 2021	translated document released to chiropractic regulators through Regulatory Council
April 1, 2021	**final returns from regulators due to FCC office for consolidation**
April 16, 2021	first draft of consolidated report completed
April 23/24, 2021	FCC response (final) approved by Regulatory Council
April 30, 2021	FCC submission to Office des professions du Quebec

Thank you

Alex

Jo-Ann Willson

From: Jo-Ann Willson
Sent: Friday, March 19, 2021 8:04 AM
To: Rose Bustria
Subject: FW: Ontario Chiropractic Association - Evidence Based Framework Advisory Council - Request for Meeting
Attachments: OCA Evidence-based Framework Advisory Council members.pdf

Exec and Council.

Jo-Ann Willson, B.Sc., M.S.W., LL.B.
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From: Deborah Gibson <dgibson@chiropractic.on.ca> **On Behalf Of** Caroline Brereton
Sent: Tuesday, March 16, 2021 1:26 PM
To: Jo-Ann Willson <jpwillson@cco.on.ca>; Dennis Mizel <drmizel@stcatharineschiropractic.com>
Cc: Caroline Brereton <cbrereton@chiropractic.on.ca>
Subject: Ontario Chiropractic Association - Evidence Based Framework Advisory Council - Request for Meeting

Dear Dennis and Jo-Ann,

As an important stakeholder in the chiropractic profession, I would like to set up a meeting to gather input and feedback on the first deliverable of the Evidence Based Framework Advisory Council-Patient Preference.

Background

In conversation with members and stakeholders, the adoption of the evidence-based framework by the OCA and other associations across Canada was done with strategic intent however no change management strategy was part of the implementation plan in Ontario. Adopting a framework for a well-established profession is a big change. Without this change management plan many OCA members do not see that we have the best interests of the profession in mind and question the value of membership and the future of the profession. In addition, the adoption of this framework almost simultaneously with the launch of the marketing strategy focussed on MSK has resulted in confusion and frustration among members who believe we are working to narrow scope of practice and that we are focussed on low back pain only.

OCA Board and leadership understand that enabling Ontarians to have access to evidence-based chiropractic care is key. We know that members need tools to continuously integrate new knowledge in to practice. This will support a strong profession as well.

The first step in the initiative was the launch of the *OCA Evidence-based Framework Advisory Council*. It is a diverse panel that represents the demographics of the chiropractic profession across Ontario – see attached.

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Despite the COVID-19 pandemic, the advisory council has been dedicated to advancing its mandate to help the OCA develop a comprehensive and inclusive understanding and definition of chiropractic care in Ontario through the application of the evidence-based practice framework.

That work is based on the universally accepted three pillars of the evidence-based framework:

1. Patient Preference
2. Best Available Evidence
3. Clinical Expertise

From the beginning all advisory council members recognized that the three pillars of the framework, Patient Preference, Best Available Evidence and Clinical Expertise are not separate, parallel paths, but are inter-dependent.

Principles guiding the work of council are refined as the work progresses.

Council will work to support chiropractors to:

- Practice according to the full scope of practice of chiropractors approved by the College of Chiropractors of Ontario and the government of Ontario.
- Provide care that is consistent with the College of Chiropractors of Ontario's standards, guidelines, and policies.
- Empower patients to make decisions about their care and respect their preferences.
- Apply best available external clinical evidence.
- Apply their individual clinical expertise.
- Fulfill their duty of care to their patients.

Examining the element of Patient Preference is the first output. The Council reviewed and accepted research on the universal expectations of patients from their health providers, in support of Patient Preference. They discussed how the voice of patients has evolved since the inception of the evidence-based framework. In Ontario, the voice of patients has been instrumental in shaping health care policy in the public and private pay systems.

Council members reviewed three areas of focus of patient expectations:

1. **Partnership**: mutual respect, choice and personalization
2. **Active listening**, genuine interest and clarity
3. **A Human Touch:** compassion, connection and empathy.

Council recommended to the OCA Board of Directors that the first output should be a white paper on Patient Preference, recognizing the significant research supporting the correlation between applying patient preference in care planning and patients' compliance with their chiropractic care plan.

Council members also supported the Getting to Outcomes (GoT) methodology to guide the work of the OCA in supporting members to enhance their practice by applying the Patient Preference principles. This research-based change management methodology will address the gap

between research and practice by ensuring the OCA has sustainable processes and program supports in place for members.

When a time has been identified for our meeting, we will share the document a week in advance with specific questions. We are engaging with several stakeholders and will consolidate feedback as the consultations progress.

We understand that CCO has a unique mandate in the Chiropractic profession so please let us know what the best mechanism is to gather input on the draft document.

Members of the OCA Board of Directors and /or the Advisory Council may also join the meeting also.

We look forward to meeting with you on this important initiative for Ontario chiropractors.

Regards,
Caroline

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Ontario Chiropractic Association

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Introducing the *OCA Evidence-based Framework Advisory Council*

Dr. Sean Batte (Logan University graduate; practicing in London area)

Fast facts: Dr. Sean Batte is a graduate of Logan University's Chiropractic program. He earned an undergraduate and Master of Science degree in Medical Biophysics from the University of Western Ontario and a second undergraduate degree from Logan University. Dr. Batte has been practicing in the London, Ontario area for 19 years.

Dr. Batte is also a member of the Royal Canadian Navy with several command qualifications and is a graduate of the Canadian Forces Staff College.

Question: Why are you joining the ***OCA Evidence-based Framework Advisory Council***?

Dr. Batte: I think there is a real opportunity to unite the profession and make it stronger. This work belongs to the entire profession and we can see it made stronger if we all learn how use evidence and research to our profession's and patient's advantage. That's why I want to participate on this council. My hope is it will give chiropractors more social credibility as evidence is the currency of credibility when paired with an appropriate strategy. Existing and new research, when deployed with a comprehensive implementation plan is vital part of a larger vision to help better serve our communities and patients, inclining more to seek chiropractors out as their first choice for health care.

Question: As a leader in the profession, can you please share any other involvement, whether that is volunteering or mentoring others?

Dr. Batte: I volunteer with the Salvation Army Centre of Hope's chiropractic clinic. I have volunteered for the London Chiropractic Society and organized seminars. I also served as a chiropractor at the Canada Summer Games and serve as a chiropractic trainer at local amateur sporting events. I have had the pleasure to care for members of Team Canada's rowing team. I also enjoy mentoring students and new graduates from Logan University who have completed their externships in my clinic or shadowed me. I've been a guest lecturer at the University of Western Canada School of Medicine on several occasions to speak about chiropractic to medical students.

Outside the profession, I have raised money for the Soldier On organization for wounded veterans. A few years ago, I led the way to build the multi-million-dollar Battle of the Atlantic Memorial in London Ontario.

I serve in the Royal Canadian Navy Reserves part time. In 2017, I was appointed to Chief of Staff for Central Region (Ontario). In this role, I have 1500 sailors whose readiness and training I am responsible for to the Central Region Captain (Navy). In my ships' squadron I have seven Naval Reserve Divisions whose sailors must be operationally ready to serve domestically and overseas. The main focus of my mentorship is in 'leadership' and 'command.'

Question: Can you also share your involvement and experience with other parts of the of the broader health system?

Dr Batte: In addition to my work with the University, I am the Vice Chair of the WKY Viking Foundation, which is a multidisciplinary research foundation of health professionals from a number of fields, including chiropractors, physicians, naturopaths and others. Our aim is to conduct research that will demonstrate the benefits of including complementary and alternative health disciplines at a national level.

Dr. Ken Brough: (Palmer College of Chiropractic graduate and practices in Ottawa)

Fast facts: Dr. Ken Brough has been involved in the Ontario Chiropractic Association for 12 years in various roles, including his most recent position as Chair of the Board of Directors for the last two years. Dr. Brough was also involved with the Canadian Chiropractic Association (CCA) and the Canadian Chiropractic Clinical Guidelines Initiative (CCGI) as Chair of the Government and Inter-Professional Relations Committee and as a Steering Committee member respectively. Dr. Brough has practiced for 28 years in the Ottawa area, leading his clinics in collaborative care models of practice including chiropractors, physiotherapists and registered massage therapists. As the owner of CURAVITA, he employs a team of over 30 professionals in two locations.

Question: Why are you joining the ***OCA Evidence-based Framework Advisory Council***? What is your motivation?

Dr. Brough: As a member, I did not have a strong understanding of the concepts of evidence-based care; it was an emerging concept for me until I became more involved in the Canadian Chiropractic Association (CCA). I became very familiar when I sat on the committee for Canadian Chiropractic Guidelines Initiative (CCGI). When I fully understood Dr. Sackett's work in articulating the three pillars of evidence-based care: best available evidence, clinical expertise and patient preference, I saw how that framework was selectively applied. There is not a strong understanding of how the framework relates to daily clinical practice. *Dr Sacketts intention was for all of the pillars of the framework to be applied and we need to support the application of all 3 pillars in patient care.*

Question: As a leader in the profession, can you please share any other involvement, whether that is volunteering or mentoring?

Dr. Brough: I was involved with CCA for nine years, largely as a Board member. I've served on the OCA Board of Directors for 13 years and have held executive positions, namely Chair, which is the position I hold now.

For four years, I served on the CCGI Steering Committee as the new guidelines initiative was being redeveloped. I was involved in the initial strategic planning for the initiative and helped lay the groundwork for where CCGI is today.

I operate two multidisciplinary practices. All of us work in full wellness-based model. I employ five chiropractors and we all work in a collaborative model. Mentoring my team is very important; I work with them to practice in the framework of the three pillars of evidence-based care. For our younger practitioners, we established a mentoring program in my clinics to leverage the experience of more established chiropractors; this is of great value to the younger associates who feel supported to grow and thrive.

Question: Can you also share your involvement and experience with other parts of the of the broader health system?

Dr. Brough: In clinical practice, we work with a spectrum of professionals, including the medical profession. Through my work with the CCA, I contributed to the foundational work with the Canadian Armed Forces to launch the chiropractic initiative. I presented to the Parliamentary Defence Committee about the potential involvement of chiropractic care for the military. I also worked with the Royal Canadian Mounted Police (RCMP) when it was re-aligning its health policy and utilization for employees.

Also, while working with the CCA, I participated in its efforts to launch a chiropractic program in Nunavut at one Community Health Centre. That work enabled the creation of a legal framework to enable chiropractors to practice legally in the territory.

Introducing the *OCA Evidence-based Framework Advisory Council*

Dr. Anita Chopra (New York Chiropractic College graduate and practices in Brampton, Oakville and Etobicoke)

Fast facts: Dr. Anita Chopra has been serving the Brampton, Oakville, and Etobicoke area since 2011 after graduating from the New York Chiropractic College. Dr. Chopra received her Bachelor of Arts in Psychology from the University of Western Ontario and is a certified Webster Technique and Rocktape practitioner. Dr. Anita Chopra actively engages her community through guest speaking events with various groups in the Peel region.

Question: Why are you joining the ***OCA Evidence-based Framework Advisory Council***?

Dr. Chopra: I believe that it's time to have good representation of the profession at hand. We are all busy in our practices, but we need to make time to shed light on what is going on our profession. With a lot of media coverage of our profession, it is important to understand what we do and how we do it.

Question: As a leader in the profession, can you please share any other involvement, whether that is volunteering or mentoring?

Dr. Chopra: I am a regular speaker on injury prevention at The Running Room and speak to pregnant and postpartum women on the importance of chiropractic care. I also have spoken to classes on what chiropractic care is.

Question: Can you also share your involvement and experience with other parts of the of the broader health system?

Dr. Chopra: I have tried setting up referral practices with other health care professionals. It is something that takes time and effort; but it does pay off. Establishing trust and competency is very important when building these practices.

Introducing the *OCA Evidence-based Framework Advisory Council*

Dr. Marco De Ciantis (CMCC Graduate and practices in North York)

Fast facts: Dr. Marco De Ciantis has served the North York area for seven years practicing with his twin Dr. Paolo De Ciantis at Sports Specialist Rehab Centre. Dr. Marco De Ciantis has an interest in working with both amateur and professional athletes and provides his services to local football, soccer, and rugby teams regularly as well as both youth and adult Taekwondo athletes at national competitions. Dr. De Ciantis also volunteered his services with the 2015 Pan Am/ParaPan Am games in Toronto.

Dr. Marco De Ciantis was recognized for his outstanding work with the Patient Care award from the Ontario Chiropractic Association in 2018. Dr. De Ciantis has worked to build a collaborative and patient-centred model of care in his career and has attempted to spread this model of care within his community. Dr. De Ciantis also actively engages his community by volunteering within hospitals, local social clubs, charity campaigns, and community health initiatives.

Question: Why are you joining the OCA Evidence based Framework Advisory Council?

Dr. De Ciantis: I've spent years since graduating in 2012, speaking with colleagues about potential changes I and we felt could help to steer the profession towards a direction of unification; unification between all the different "factions" so-to-speak in the various practice styles found under the chiropractic umbrella. Joining this Advisory Council is, on one level, putting foot to pavement and actively contributing to such a process. Moreover, this is a journey to help consolidate all the practice philosophies in our profession, improving professional cohesion and enhancing inter-professional collaborations.

Question: As a leader in the profession, can you please share any other involvement, whether that is volunteering or mentoring others?

Dr. De Ciantis: Last year, I joined the Toronto-based humanitarian group, Bridge to Health. I travelled to Uganda back in January/February of this year for two weeks where I worked in the field, in isolated villages in rural Uganda with medical doctors, speech pathologists, a dentist, dental hygienists, researchers, pharmacist and many local support staff delivering MSK (musculo-skeletal) care to individuals who have never received any care, whatsoever. Furthermore, I and another chiropractor worked, side-by-side, with local clinical officers (Uganda's version of medical doctors), teaching them how to perform proper histories, physical and neurological examinations for MSK conditions and how to treat them. On November 4 of this year, I presented research gained from this experience and previous trips at the American Public Health Associations (APHA) Conference in Philadelphia. We were the only Canadian representatives.

In my personal practice, I mentor undergraduate (chiropractic, naturopathic, kinesiologist) and secondary (high school) students. My clinic acts as a co-op learning facility with local high schools where grade 11-12 students come in and observe multiple days of the week for hours, earning credits. Moreover, I and other chiropractors at the clinic have established interprofessional networks with various physiatrists, medical doctors, personal trainers, pharmacists (local Shoppers Drug Mart), with orthopaedic surgeons in UHN and with private facilities (Pain & Wellness Centre) where interprofessional collaborations and rounds occur every month, bolstering patient-centred health care.

Introducing the *OCA Evidence-based Framework Advisory Council*

Dr. Peter Emary (New York Chiropractic College graduate and practices in Cambridge)

Fast facts: Dr. Peter Emary has served the Cambridge, Ontario region for 16 years after graduating from the New York Chiropractic College. Dr. Emary has also received a Master of Science in Clinical Sciences degree from Bournemouth University and has a special interest in clinical research and radiology.

Dr. Emary served as the President of the Waterloo Regional Chiropractic Society from 2011 to 2013, during which time the organization was awarded the Ontario Chiropractic Association's Society of the Year award in both 2011 and 2012. Dr. Emary has also been recognized for his community involvement with the Rotarian of the Year award in 2005 by the Rotary Club of Cambridge (Preston-Hespeler) of which he was a member of for 10 years.

Question: Why are you joining the ***OCA Evidence-based Framework Advisory Council***?

Dr. Emary: I've been wanting to get more involved in our profession for years but have often lacked the time to properly do so. However, I couldn't pass up the chance to be involved in this OCA initiative. Aligning the chiropractic profession with the principles of evidence-based practice is something I've been wanting to see happen for a very long time. I'm enthusiastically looking forward to getting involved and participating in the advisory council.

Question: As a leader in the profession, can you please share any other involvement, whether that is volunteering or mentoring?

Dr. Emary: I served on the Executive Board of the Waterloo Regional Chiropractic Society from 2007 to 2013. I served as President of the Society from 2011 to 2013. I worked with a fantastic group of Board Members and am proud that we were awarded the OCA's 'Society of the Year' during my two years as president. We built upon the successes of our previous society Presidents and I am pleased that the Waterloo Regional Chiropractic Society is still as strong today as ever.

Question: Can you also share your involvement and experience with other parts of the broader health system?

Dr. Emary: This past year, I started teaching part-time in the chiropractic department at D'Youville College and am thoroughly enjoying it. I'm teaching a course in evidence-based practice to third-year students; and am helping them to learn how to critically appraise research literature and apply it, combined with clinical experience and patient preference, to managing an individual patient. This year I've also started participating in the ISAEC program through Grand River Hospital. This has been a tremendous experience so far and my clinical skills are being greatly enhanced through this program.

We have a really great practice leader and a highly-skilled group of chiropractors on the ISAEC team here; I'm excited to see the impact that this program will have, not only in our region, but across Ontario, in terms of streamlining care and reducing referrals for advanced imaging and spine surgery.

This program is an evidence-based program and is placing Ontario chiropractors on the front line of primary interdisciplinary spine care.

In addition to my clinical practice at the Langs Community Health Centre (CHC) in Cambridge, I'm also fortunate to be working on a Ph.D. at McMaster University. For my thesis, I will be investigating the impact of chiropractic integration on opioid use among chronic back pain patients within the CHC setting.

Introducing the *OCA Evidence-based Framework Advisory Council*

Dr. Brian Gleberzon: (CMCC graduate and practices in Toronto)

Fast facts: Dr. Brian Gleberzon is a researcher, professor, and Chair of the Department of Chiropractic Therapeutics at the Canadian Memorial Chiropractic College in Toronto. Dr. Gleberzon was involved with the College of Chiropractors of Ontario from 2007 to 2016 and the Ontario Chiropractic Association since 2016 where he currently holds the position of Secretary-Treasurer and serves on the Finance and Audit Committee and the Research Committee

Dr. Gleberzon has a Master of Health Sciences from the University of Sydney and is completing his Ph.D. from the University of New South Wales. Dr. Gleberzon has practiced in the Toronto area for 30 years. He has also been recognized for his work in the profession and received the OCA's Professional Service in Research in Chiropractic Award, now known as Researcher of the Year and the OCA's Professional Service awards in Public Relations Award 2001 and 2008 respectively.

Question: Why are you joining the ***OCA Evidence-based Framework Advisory Council***?

Dr. Gleberzon: I want to ensure the voice of the patient and the voice of the clinician is heard, not just clinical research. I see it as a three-legged stool; we need to remember all three pillars. I want to resolve the friction at the researcher-practitioner interface. I'm a non-linear thinker who wants to deconstruct dogma. I speak truth to power and that is partly why I want to contribute as a member of the Council. I'm not afraid to address difficult conversations.

Question: As a leader in the profession, can you please share any other involvement, whether that is volunteering or mentoring others?

Dr. Gleberzon: I'm President and a founding member of local CUPE union at CCMC. I'm a strong advocate for natural justice and procedural fairness.

One of the small groups I work with is clinical education, deconstructing guidelines and looking at its content. I'm an advocate for challenging dogma. It is how I work and what I am interested in. This is the topic of my Ph.D. triangulation to understand what is really fair and just. To the individual patient, we must be responsible.

There are two areas of research I pioneered. I was the lead author of a study on student injuries. Initially, I received a lot resistance; now other professions are starting to publish similar articles. The second area of research concerns women chiropractors. I surveyed CMCC women whether they were ever sexually harassed by patients. For women, this is an issue. I was the first to publish data for the chiropractic profession. It is an important issue and I'm not afraid to ask the questions; get the data and publish. We learned that most of the harassment occurs in the first five years by male patients.

Question: Can you also share your involvement and experience with other parts of the of the broader health system?

Dr. Gleberzon: I teach at CMCC and run my practice, which is focused mainly on back pain and sports injuries; most of my patients are older adults.

I've published many research papers and contributed to various textbooks; I speak at scientific conferences globally. In 2008, I designed the Best Food Forward program for the Canadian Chiropractic Association and presented the program to members of Parliament and senior advisors of the Public Health Agency of Canada.

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Sheila Gregory (patient member)

Fast facts: Sheila Gregory has been a chiropractic patient for more than 30 years. She lives in Newmarket, Ontario.

She has been treated by many different practitioners in the Greater Toronto Area, and has experienced diverse practice styles. Sheila started visiting a chiropractor because of neck and lower back pain experienced at work. She has maintained consistent and ongoing treatment over the years.

Sheila describes her experience with chiropractors as excellent. Their care and expertise has helped her reduce pain and maintain an active lifestyle. Throughout the years, Sheila's chiropractic needs have evolved and changed, therefore making her an excellent candidate to discuss her diverse set of experiences with chiropractic care. Sheila is motivated to provide insightful and meaningful input into the ***OCA Evidence-based Framework Advisory Council***.

Question: Why are you joining the ***OCA Evidence-based Framework Advisory Council***?

Ms. Gregory: When I learned about the Council from OCA, I realized how many chiropractors I have been treated by over the years (about six or seven) and, for the most part, how much they've helped me. I've a great respect for chiropractors. I've been exposed to a range of treatments and think I can offer an understanding of the patient's point of view. My personal motivation to contribute to the Council is related to my background in physical education and health promotion/community health.

Question: As our patient member, can you please share any other involvement in chiropractic or any other organizations, whether that is volunteering for an association or mentoring others? Specifically, have you served as a patient or representative with other organizations?

Ms. Gregory: I've not been involved in the chiropractic profession or as patient representative in any other organization. Past volunteer activities include serving as a board director for a homeless shelter and serving on the executive of my professional association.

Question: Can you also share your involvement and experience with other parts of the of the broader health system, for example, as a patient or as a health advocate for a family member or friend?

Ms. Gregory: As a health care advocate for my parents going through the aging process and the end of their lives, I'm familiar with the excellence and the challenges patients experience when navigating the health care system. As a former employee of Dying With Dignity Canada (DWDC), I worked with health care professionals who served as board directors and/or members of the Physicians Advisory Council. My experience at DWDC gave me an understanding of how, sometimes, health care provider beliefs, professional codes, institutional policies, and legislative restrictions can be in direct conflict with patients' desires and/or rights.

Dr. Glen M. Harris (CMCC Graduate and practices in mid-town Toronto)

Fast facts: Dr. Glen M. Harris has been active in the chiropractic sports care community after graduating from the Canadian Memorial Chiropractic College with his Doctor of Chiropractic and the Royal College of Chiropractic Sports Sciences (Canada)

Dr. Harris served on the Executive Board of the Royal College of Chiropractic Sports Sciences (Canada) from 2002 to 2016 and is also a past President of the organization from 2010 to 2012. Dr. Harris has also been the North American (Canada) representative on the International Federation of Sports Chiropractic /Fédération Internationale de Chiropratique du Sport (FICS) since 2012. Dr. Harris is an Assistant Professor at the Canadian Memorial Chiropractic College in the Division of Clinical Education where he supervises clinical interns Dr. Harris continues to practice in Toronto and is the President of MSK+, a continuing education company for chiropractors and allied health professionals.

Question: Why are you joining the ***OCA Evidence-based Framework Advisory Council***?

Dr. Harris: I'm committed to the advancement of the chiropractic profession. I've served in leadership positions at the national and international level through the Royal College of Chiropractic Sports Sciences (RCCSS Canada). I have served in leadership positions at the national and international level through the International Federation of Sports Chiropractic /Fédération Internationale de Chiropratique du Sport (FICS).

I've supervised chiropractic interns for twenty years; now this is an opportunity to assist and serve the profession at the provincial level.

Question: As a leader in the profession, can you please share any other involvement, whether that is volunteering or mentoring?

Dr. Harris: I've been involved with a significant amount of teaching in my clinician role at the CMCC. I've mentored and supervised over forty sets of interns, ranging in sizes of 7 to 9 interns per set. In that role, I supervise fourth-year students for six-month clinical internship rotations at the South Riverdale clinic where we have an inter-referral process with the clinic's physicians, nurse practitioners and others. I've been in this role for ten years.

I've been a supervisor on student research projects; I also served on the Research Ethics Board (REB) at CMCC.

I'm proud to volunteer as a member of the host medical services at the Canada Games with the Team Ontario men's softball team. For the 2010 Paralympic Winter Games, held in Vancouver, I served in the clinic for the duration of the games so that all athletes had access to healthcare services. I performed the same role for the 2015 Pan American and Para Pan American Games, held in Greater Toronto Area.

Question: Can you also share your involvement and experience with other parts of the of the broader health system?

Dr. Harris: In my work with the Canada Games, Vancouver 2010 Paralympic and Toronto 2015 Pan Am and Para Pan Am games, I worked in polyclinics with a full range of health professionals.

In my private practice, I work in an integrated multidisciplinary practice, alongside physiotherapists and registered massage therapists. I have a private company called, MSK+, which provides continuing education to physicians, nurses and all health professionals, specifically on manual therapy, soft tissue, therapeutic exercises and education. The company has been in operation for 10 years.

Introducing the *OCA Evidence-based Framework Advisory Council*

Dr. Deborah Kopansky-Giles (CMCC graduate working in Greater Toronto Area)

Fast facts: Dr. Deborah Kopansky-Giles, DC, FCCS(C), FICC (Hons), M.Sc., is a Professor at the Canadian Memorial Chiropractic College (CMCC), an Assistant Professor in the Faculty of Medicine, University of Toronto and a staff chiropractor at Unity Health Toronto (St. Michael's Hospital), Department of Family and Community Medicine.

Dr. Kopansky-Giles attained her Fellowship in Chiropractic Clinical Sciences in 1993 and completed her M.Sc. in 2010. She has served on the organizing committees for numerous conferences including, the World Federation of Chiropractic (WFC) 10th Biennial Congress in Montreal (2009) as conference Co-Chair, the *Bone and Joint Decade* World Network meetings in Vietnam (2012), Brazil (2013), London (2014) and Berlin (2017) in addition to her role as a member of the Health Services Committee, the XVI International AIDS Conference in Toronto in 2006 which attracted over 28,000 delegates.

Question: Why are you joining the ***OCA Evidence-based Framework Advisory Council***?

Dr. Kopansky-Giles: I've been involved for many years being on the policy/political side for my profession, including nine years on the OCA Board of Directors, six years on the CCA Board and 15 years on the World Federation of Chiropractic (WFC) as the Canadian representative. So, I bring provincial, national and international experience to the Council.

As an clinician, educator and researcher, I am motivated to help ensure that our profession is evidence-based, integrated into the health system and accessible to all Ontarians. I'm driven by how we can best serve people because I believe it is all about the patient. I want to continue to bring that perspective to this work. For me, it always comes down to helping people who are suffering and not about my profession's or my own motivation.

Question: As a leader in the profession, can you please share any other involvement, whether that is volunteering or mentoring?

Dr. Kopansky-Giles: I'm highly motivated to advance the profession believe in the importance of contributing to our communities through my work and through volunteerism.

In 2000, the United Nations declared 2000-2010 the Bone and Joint Decade to shine a light on this global issue and to seek specific attention to those areas. With the UN declaration, the World Health Organization (WHO) encouraged the development of the international Bone and Joint Decade (BJD), comprised of expert health professionals working to create an agenda and build momentum around advocacy for bone and joint conditions. For the past 15 years, I've been involved in this BJD work – (now known as the Global Alliance for Musculoskeletal Health) as a member of the International Coordinating Council and on the Executive Committee since 2010. In that capacity, I've had the privilege of working with global leaders from many professions and patient organizations. This has enabled me to broaden my perspective significantly with respect to global health issues and the integral role that chiropractors can have locally and around the world as primary spine care providers.

Over the past 35 years, I've had the privilege of being involved in a wide diversity of organizations (local, provincial, national and international), participating on various boards and committees. As a few examples: a research agenda council for the AIDS Bureau of Canada, The Ontario HIV Treatment Network,, the Ontario Rehabilitation Council, various Ministry of Health and Long-Term Care (MOHLTC) quality committees, the Financial Services Commission of Ontario Accident Benefits Advisory Committee, the World Spine Care (WSC) Canada board, the Global Spine Care Initiative Scientific Secretariat, and many others. Down the road, I am looking at 'retirement' plans for continuing work with WSC with our programs in Botswana, India, Ghana and Dominican Republic.

Question: Can you also share your involvement and experience with other parts of the of the broader health system?

Dr. Kopansky-Giles: I'm deeply involved in the education of chiropractors and other learners. As a Professor at CMCC; I supervise our CMCC graduate chiropractic training program at St. Michael's Hospital. I also teach in the Department of Family and Community Medicine at the University of Toronto (UoT) where my teaching involves educating family medince learners, teaching medical faculty (faculty development) and also international students in the Global Health Program.

For four years, I was privileged to co-chair a national working group for the College of Family Physicians Canada; where we developed teaching and assessment tools for the CanMEDS Collaborator Role competency. These tools are available open access on the CFPC website for all health professional educators.

Over the past 15 years, I've been actively engaged in the evolution of our integrative model of care in family medicine at St. Michael's Hospital. The St. Michael's Hospital program was the first time in Canada that chiropractors were integrated as clinicians and educators into an academic health science centre. This program was identified by the federal government as a exemplar for primary care innovation in 2012 and by the World Health Organization in 2016 as a global leading practice. I was honoured to co-lead a national webinar for Canada Human Health Resources about our model, reaching 65 ministry of health-related organizations across Canada. Our model of care is team-based and non-hierarchical, patient centred and continuing to evolve through a social determinants of health lens.

The St. Michael's Hospital model continues to evolve in creative ways; chiropractors are fully integrated team members, collaborating on an innovative primary care team which also includes dentists, psychologists, legal literacy services, income security services to help people navigate the our complex social support system and so forth; structured to minimize barriers to accessing care, including economic barriers.

I am fortunate to work with the WHO Global Health Workforce, Healthy Ageing and Integrated, People-Centred Health Services programs on behalf of the WFC and G-MUSC; to advocate for priority of musculoskeletal health and to ensure that chiropractors are seen as essential contributors to the global health workforce and in helping to reduce the burden of spine and musculoskeletal disorders on people around the world.

In the decades since my graduation, I have seen incredible advancement of chiropractic in Canada and I'm very excited to see this continue to evolve with the good work that chiropractors do every day in their practices, with the excellent education and research our profession contributes to and with the leadership that the OCA has given in strengthening chiropractic in Ontario.

Introducing the *OCA Evidence-based Framework Advisory Council*

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Dr. Keshena Malik (CMCC Graduate and practices in the Hamilton area)

Fast facts: Dr. Keshena Malik has been in practice for 10 years in the Greater Hamilton area in a multidisciplinary, collaborative clinical setting, including chiropractors, physiotherapists and registered massage therapists.

Dr. Malik is an Advanced Practice Provider with the Low Back Pain Rapid Access Clinic (formerly ISAEC). Dr. Malik also completed her Master of Science in Rehabilitation Sciences from McMaster University. Dr. Malik is also the Co-chair of the McMaster Chiropractic Working Group and is a regular guest speaker with McMaster's Program for Interprofessional Practice, Education and Research. Dr. Malik is involved in the Ontario Chiropractic Association as a member of the Board of Directors, serving on the Research Committee, Strategic Planning Task Force and volunteering as a Chiropractic Educator for the OCA's Community Engagement and Leadership Program.

Question: Why are you joining the ***OCA Evidence-based Framework Advisory Council***?

Dr. Malik: I endorse evidence-based chiropractic care. I am motivated by and passionate about disseminating knowledge of this evidence-based framework to our colleagues, stakeholders and patients, as well as aiding in providing an inclusive understanding of this framework in support of its application to and shaping of our profession.

Question: As a leader in the profession, can you please share any other involvement, whether that is volunteering or mentoring?

Dr. Malik: For the past six years, I have been involved in mentoring through McMaster University's Program for Interprofessional Practice, Education and Research (PIPER) as a guest speaker, educating students (including medical, physiotherapy, occupational therapy, midwifery, nursing) about the chiropractic profession. I also volunteer as a group facilitator at Interprofessional Education (IPE) events, which include sessions facilitating students from the McMaster University Faculty of Health Sciences programs to learn from and about their colleagues training and scope of practice in each program.

Question: Can you also share your involvement and experience with other parts of the of the broader health system?

Dr. Malik: In my clinical practice, I have developed referral relationships with allopathic, allied and complementary and alternative health professionals in order to provide the most effective patient-centred care. I feel it is imperative to understand each profession's scope of practice while considering patient preferences to ensure the most appropriate care.

In terms of new approaches to interprofessional practice, in addition to guest speaking at various IPE events, I also have training in the Canadian Interprofessional Health Collaborative (CIHC) Competency Framework. I feel that interprofessional collaboration should be the hallmark of every profession.

Dr. Bernadette Murphy (CMCC Graduate and practices in the Greater Toronto Area)

Fast facts: Dr. Bernadette Murphy is involved in patient care and the advancement of the chiropractic profession in both Canada and New Zealand. Dr. Murphy received her BA in Life Sciences from Queen's University and Doctor of Chiropractic from the Canadian Memorial Chiropractic College before heading to New Zealand to complete her Master of Science and Ph.D. in Human Neurophysiology from the University of Auckland. While in New Zealand, Dr. Murphy was the Director of Research at the New Zealand College of Chiropractic and then accepted a lectureship in the Department of Sport and Exercise Science at the University of Auckland. Dr. Murphy developed a Master of Science in Exercise Rehabilitation at the University of Auckland. Throughout this time, Dr. Murphy maintained a clinical practice.

In 2008 Dr. Murphy returned to Ontario as a faculty member at the University of Ontario Institute of Technology to expand its Bachelor of Health Science degree with a Kinesiology program.

Question: Why are you joining the ***OCA Evidence-based Framework Advisory Council?***

Dr. Murphy: As a clinician, I have a firm commitment to evidence-based practice. As a basic science researcher, I understand the challenges of running the studies to collect the data to create the evidence. It's important to understand that "absence of evidence" is not "*evidence of absence.*" I bring that dual expertise to my work with the ***OCA Evidence-based Framework Advisory Council.***

Question: As a leader in the profession, can you please share any other involvement, whether that is volunteering mentoring?

Dr. Murphy: Over the years, I have mentored a number of chiropractors and future chiropractors as a research supervisor. Ensuring that the chiropractic profession has clinicians with strong backgrounds in critical thinking and interpreting research evidence is an important part of the profession "*coming of age.*"

Question: Can you also share your involvement and experience with other parts of the of the broader health system?

Dr. Murphy: Over the years, in both Canada and New Zealand, I have taught students from chiropractic, medicine, nursing, physiology and kinesiology. What always strikes me is that, regardless of discipline, students struggle with the same concepts. I think that interprofessional education is an important part of breaking down stereotypes. I am privileged that my work is recognized globally; I am a recipient of the WFC best scientific paper award in 1995 and 2015. I was the New Zealand Chiropractor of the Year (2004); I received the 2010 OCA award for most significant contributions to research; I was honoured with the Earl Homewood CMCC Professorship in 2013 and 2014, and the UOIT Research Excellence Award in 2014 for excellence in research acknowledged as being of international calibre.

Dr. Paul Nolet (CMCC graduate and practices in Guelph)

Fast facts: Dr. Paul Nolet has provided chiropractic services in both Ontario and Harare, Zimbabwe for 36 years and is currently practicing in Guelph, Ontario. Dr. Nolet's practice emphasizes pain relief and functional restoration within an interprofessional setting in the Ontario ISAEC program and at Wellington Ortho and Rehab where he works with chiropractors, physiotherapists, massage therapists, orthopedic surgeons and a physical medicine specialist as the Director of Chiropractic Services.

Dr. Paul Nolet received a Master of Science in Sports Health Science from Life University, a Master of Public Health in Health Studies from Lakehead University, is a Fellow of the Royal College of Chiropractic Sports, an Internationally Certified Chiropractic Sports Practitioner, and a non-surgical member of the Canadian Spine Society. Dr. Nolet is completing his Ph.D. in Forensic Medicine from the Care and Public Research Institute at Maastricht University in the Netherlands. Dr. Nolet's research focuses on the risk factors of back and next pain from the view of musculoskeletal epidemiology. Dr. Paul Nolet has served on the Board of Directors of the Canadian Chiropractic Examining Board since 2013.

Question: Why are you joining the ***OCA Evidence-based Framework Advisory Council***?

Dr. Nolet: We've known for a while that many conditions like back pain, neck pain and headaches for instance, have a large burden of illness on the health system. With our profession's growing research and clinical guideline initiatives that show that many of the treatments chiropractors do to be effective for the treatment of many musculoskeletal conditions, it is time for the profession to move toward playing a more significant role in the provinces health system. I would like to be involved in moving our profession in that direction.

Question: As a leader in the profession, can you please share any other involvement, whether that is volunteering for a sports team or mentoring others?

Dr. Nolet: Early in my chiropractic career, I practiced for almost five years in Harare, Zimbabwe. I practiced in one of the main medical centres and was able to spend time observing surgery with orthopaedic and neurosurgeons. I was also able to get involved in the local community. I understand culturally sensitivity and the complexity of what is in front of you. I joined another Canadian chiropractor and his family and we practiced together.

Question: Can you also share your involvement and experience with other parts of the of the broader health system, for example, teaching, establishing referral practices with other health professionals or new approaches to interprofessional practice?

Dr. Nolet: I volunteered for several years on a committee with the Waterloo Wellington Local Health Integration Network (LHIN). For the last few years, I chaired the Health Professions Advisory Committee and was able to get a glimpse of what the health system has to provide for Ontarians. I was involved in the Pan Am games 2015, supporting cyclists; I've also worked at the Pre-Pan American games at both the national and international levels.

I completed my Master of Public Health on neck injuries in car accidents. My thesis was completed at Toronto Western Hospital at the Centre for Research Expertise for Improved Disability Outcomes (CREIDO) that was funded by the WSIB.

When I am not practicing, I am working on my Ph.D. in Forensic Medicine through Maastricht University. I have been able to publish my research in journals such as Physical Medicine and Rehabilitation, European Spine Journal and The Spine Journal. I've published 15 articles and counting.

Dr. Antonio "Tony" Ottaviano (Life University graduate and practices in the Niagara area)

Fast facts: Dr. Antonio Ottaviano received his Doctor of Chiropractic from Life University and has been involved in the chiropractic profession in Ontario for much of his career. Dr. Ottaviano has contributed content for orienting new graduates to OCA materials, organized chiropractic seminars in the Niagara area, and is a former President of the Niagara Chiropractic Society. Dr. Ottaviano has practiced in both Alberta and Ontario and has been servicing the St. Catherine's region for the last 36 years, the last 10 of which he has been joined by his son. Dr. Antonio Ottaviano was actively involved with local soccer clubs and was the coach for a team for many years.

Question: Why are you joining the OCA Evidence based Framework Advisory Council?

Dr. Ottaviano: My personal motivation for volunteering for the Advisory Council is my concern about some of the disturbing trends being propagated by members of our own profession that are taking hold in our profession both outside Canada and most recently within Canada and our province.

Specifically:

1. The trend in Britain and Australia of prohibiting chiropractors from adjusting children and, closer to home, the recent moratorium by the British Columbia College of Chiropractors prohibiting the adjusting of children below the age of two.
2. The trend of disparaging and discouraging the use of x-ray in the overall assessment of a chiropractic patient
3. The trend toward the abandonment of the term subluxation and minimizing the essence of our care, the chiropractic adjustment and its effect on the nervous system.
4. The trend toward minimizing and disparaging the second and third pillars of the evidence-based practice framework which are clinical expertise and patient values and preferences over the first pillar, best available evidence.
5. The trend toward members of our profession disparaging fellow members in the press versus dealing the issue amongst ourselves.

I'm entering my 40th year in practice. Having practiced for that period of time and having seen changes in patients' health and wellbeing that could not always be backed up by a double-blind controlled study, I am concerned that a strictly evidence-based first-tier agenda to determine what chiropractors can and can't do undermines what I have witnessed firsthand in patients. Research should be directed towards understanding why we see the results we do and how we can improve on those outcomes further. I understand that making outlandish claims is damaging to the profession in the public's eye; but by the same token we cannot look to push for regulatory castration of our services because research may not have caught up with what I have seen improve in my patients with a regular program of chiropractic care, which has at its core the spinal adjustment.

My goal is that, with respectful discussion, we can forge a clear plan forward that incorporates the evidence- based framework to strengthen and empower our profession, not weaken it for the future generation of chiropractors in our province.

Question: As a leader in the profession, can you please share any other involvement , whether that is volunteering or mentoring?

Dr. Ottaviano: In the past, I served as president of the Niagara Chiropractic Society for two terms, at which time my focus was on bringing together the members in our district, regardless of their practice styles or philosophical leanings. My personal approach was, *"what can I do to help my fellow chiropractors become more successful in practice and provide better care for our patients?"* I organized diverse monthly speakers for our luncheon meeting, as well as quarterly evening seminars, bringing in high-profile speakers in our profession with the goal of empowering the members with speakers on science, philosophy and art, including practice management, technique, x-ray and motivation. Those seminars were attended by over 100 chiropractors and staff and were extremely well received.

I was involved with the James Carter Associates practice management program as a lecturer and also served in helping members in the assessment of their practices and the incorporation of practice management procedures and staff training. I was on the executive of a minor soccer association in our city and coached a competitive boys' team for 10 years, travelling across Canada the U.S. and Europe for competitive showcase tournaments.

Dr. Rod Overton (CMCC Graduate and practices in the London area)

Fast facts: Dr. Rod Overton has been serving the London area for 27 years with a wide variety of techniques and is actively involved with the community as a guest speaker with various groups, businesses, and schools. Dr. Overton has studied many chiropractic adjusting techniques over his career, including diversified, Talsky tonal technique, MC2, and has most recently been witnessing great changes with OTZ chiropractic technique. Dr. Overton's activities have been recognized by the Ontario Chiropractic Association for his work with the Professional Service Award in Public Relations in 2011.

Question: Why are you joining the ***OCA Evidence-based Framework Advisory Council***?

Dr. Overton: I had no idea what chiropractic was really about when I started chiropractic college. A good friend of ours was a chiropractor and he helped our family with some injuries. He was a kind and gentle man with a strong passion for what he was doing. When he suggested that I should become a chiropractor, I thought that it seemed like a good way to help people and make a living. I didn't know that it would change my life.

I was shocked when I began to learn how much your health could benefit through chiropractic care. During my teens, I suffered with a seemingly endless series of colds. Mononucleosis, strep throat and pneumonia were an unpleasant part of my university experience. When I started receiving regular chiropractic care, I stopped getting sick all the time. I still suffered the occasional cold but not nearly as often as before. Even more importantly, I began to realize that my new profession offered me a brand new perspective on health, and how the body works.

I hope that the work of the council will have a great effect on how the public, the government and industry, perceives the chiropractic profession. That makes it extremely important and I'm excited to be a part of that."

Question: As a leader in the profession, can you please share any other involvement, whether that is volunteering or mentoring others?

Dr. Overton: I organize chiropractic events and run a volunteer chiropractic clinic at the Salvation Army Centre of Hope that has operated for eight years. I've also given back to the chiropractic profession as the president of the London Chiropractic Society from 1994 to 1995, as well as from 2008 to 2012.

Question: Can you also share your involvement and experience with other parts of the of the broader health system?

Dr. Overton: I really enjoy being involved in organizing chiropractic events and bringing various speakers to London. I served as president of the London Chiropractic Society in 1994/1995 and from 2008 – 2012. I have inspired and educated many people through presentations on various health-related topics, at many schools, organizations and businesses. I've run a volunteer chiropractic clinic for people in need at the Salvation Army Centre of Hope since 2011. I'm proud that more than 20 chiropractors have been involved with the Salvation Army Centre of Hope clinic over the years.

From: Jo-Ann Willson
Sent: Monday, March 29, 2021 11:41 AM
To: Rose Bustria
Subject: FW: Important: Last day to vote in CCO elections

Council.

Jo-Ann Willson, B.Sc., M.S.W., LL.B.
Registrar & General Counsel
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From: Ontario Chiropractic Association (OCA) <OCA@chiropractic.on.ca>
Sent: Monday, March 29, 2021 11:39 AM
To: Jo-Ann Willson <jpwillson@cco.on.ca>
Subject: Important: Last day to vote in CCO elections

Important: Last Day to Vote in CCO Elections

Ontario Chiropractic Association

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Important Update

Important: Last day to vote in CCO elections

District 4 | District 5 | District 7

"There's no such thing as a vote that doesn't matter."
– Barack Obama, former president of the United States

We congratulate all candidates running for the College of Chiropractors of Ontario (CCO)'s 2021 Election.

Elections to CCO Council are being held in **Districts 1, 4 and 5** and byelections are being held in **Districts 4 and 7**. Eligible voters in each district should have received an email to vote, with voting instructions and a link to an electronic ballot with the candidates in their district. **Voting closes today, Monday, March 29, 2021 at 4 p.m. (EST).**

Please find the list of candidates by district here. On each district page, you'll find a list of candidates with links to their biographical information.

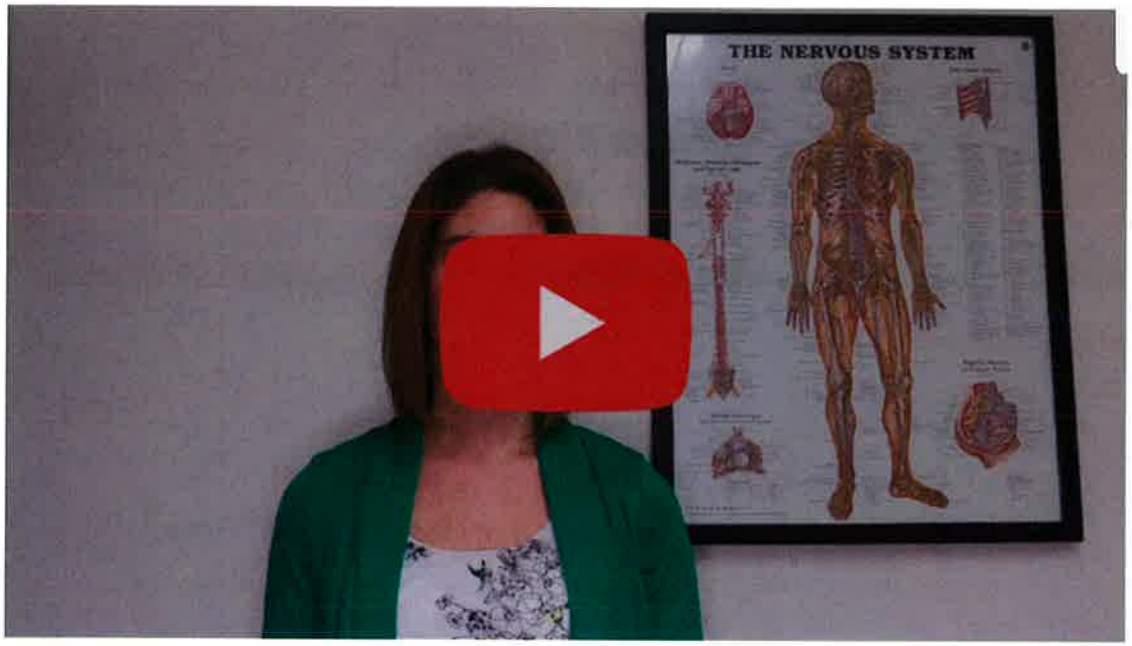
In District 1, congratulations to **Dr. Angelo Santin** who was elected by acclamation.

District 4: Central

Two CCO Council positions are available. Click here to access all candidates' biographical statements.

- **Dr. Kyle Grice**
  - Click here for Dr. Grice's biographical statement
  - Click here or watch below for a message from Dr. Grice

- **Dr. Barbara Smith**
  - Click here for Dr. Smith's biographical statement
- **Dr. Julia Viscomi**
  - Click here for Dr. Viscomi's biographical statement
  - Click here or watch below for a message from Dr. Viscomi



You can also visit Dr. Viscomi's profile here

- **Dr. Adam Wade**
  - Click here for Dr. Wade's biographical statement

District 5: Central West

One CCO Council position is available. Click here to access all candidates' biographical statements.

- **Dr. Dennis Mizel**
  - Click here for Dr. Mizel's biographical statement
  - Click here or watch below for a message from Dr. Mizel

Re-elect Dr. Dennis Mizel: Integrity, ability to delegate, communication, self-awareness, gratitude, influence, empathy respect, courage

- **Dr. John Riva**
  - Click here for Dr. Riva's biographical statement
  - Click here or watch below for a message from Dr. Riva

Here is a link to a short reminder video regarding the elections in District 5. I encourage everyone to share this link with their networks!

District 7: Academic

One CCO Council position is available. Click here to access all candidates' biographical statements.

- **Dr. Chadwick Chung**
  - Click here for Dr. Chung's biographical statement
- **Dr. Jarrod Goldin**
  - Click here for Dr. Goldin's biographical statement

Click here for CCO Elections - March 2021

The OCA's mission is to serve our members and the public by advancing the understanding and use of chiropractic care. To achieve this mission, we deliver a range of programs, services and initiatives to help our members and partners deliver quality patient care and improve Ontario's health care system. Visit our website at https://chiropractic.on.ca/.

We're here for you:

Contact us via your Self-Serve Member Portal or

Tel: 416-860-0070 (local) | 1-877-327-2273 (toll-free)

Email: oca@chiropractic.on.ca

Our mailing address is:

Ontario Chiropractic Association

70 University Avenue, Suite 201

Toronto, ON M5J 2M4

Canada

Add us to your address book

Want to change how you receive these emails?

You can update your preferences or unsubscribe from this list.

From: Jo-Ann Willson
Sent: Thursday, March 25, 2021 8:30 PM
To: Rose Bustria
Subject: Fwd: CCGI Stakeholder Report
Attachments: image013.jpg; image014.png; image015.png; image016.png; image017.png; image018.png; Stakeholder Report_March 2021 _English.pdf

Council.

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

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Begin forwarded message:

> **From:** Leslie Verville <Leslie.Verville@ontariotechu.ca>
> **Date:** March 25, 2021 at 8:13:33 PM EDT
> **To:** Jo-Ann Willson <jpwillson@cco.on.ca>, "cco.info" <cco.info@cco.on.ca>
> **Cc:** Carolina Cancelliere <Carolina.Cancelliere@ontariotechu.ca>, ldp.rhcc@sasktel.net
> **Subject: CCGI Stakeholder Report**
>
> Dear Ms. Jo-Ann Wilson and Dr. Dennis Mizel,
>
> Please find attached our bi-annual stakeholder report for September 2020.
>
> Thank you very much for your past and future commitment to the CCGI. Please do not hesitate to contact me or Carol if you have any questions, or require further information.
>
> Yours sincerely,
>
> Dr. David Peeace, DC
> Chair, Guideline Steering Committee
> Canadian Chiropractic Guideline Initiative (CCGI)

Dr. Carol Cancelliere, DC, MPH, PhD
CCGI Project Lead
CCRF Research Chair in Knowledge Translation
Faculty of Health Sciences
Ontario Tech University
Centre for Disability Prevention and Rehabilitation at Ontario Tech University and CMCC

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Leslie Verville MHSc
Research Project Manager - Faculty of Health Sciences
Canadian Chiropractic Guideline Initiative (CCGI)
Centre for Disability Prevention and Rehabilitation
Ontario Tech University
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Ontario Tech University acknowledges the lands and people of the Mississaugas of Scugog Island First Nation. We are thankful to be welcomed on these lands in friendship. The lands we are situated on are covered under the Williams Treaties and the traditional territory of the Mississauga, a branch of the great Anishinaabeg Nation, including Algonquin, Ojibway, Odawa and Pottawatomi. These lands remain home to a number of Indigenous nations and people.

Canadian Chiropractic Guideline Initiative

ADVANCING EXCELLENCE IN CHIROPRACTIC CARE

March 2021

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Canadian Chiropractic Guideline Initiative Bi-Annual Stakeholder Report

Enhancing the health of Canadians by fostering excellence in chiropractic care

Stakeholder Report: March 2021

Canadian Chiropractic Guideline Initiative
ADVANCING EXCELLENCE IN CHIROPRACTIC CARE

A message from the Chair & Project Lead

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One year into the pandemic, if COVID-19 has taught us anything, it is the importance of evidence and evidence-based practice skills in our clinical decision-making. COVID-19 has emphasized the value of lifelong learning, of adjusting our ways and practices as new knowledge emerges. We have expected our leaders to keep abreast of the evidence and make evidence-based decisions on our behalf. With the vaccine rollout, we demanded evidence of safety and effectiveness from rigorously conducted trials. We have not been satisfied with anecdotes, small studies or biased research. Our patients expect no different from our profession - to provide them with safe and effective treatment and/or guide them to safe and effective options. They expect us to deliver knowledge of high-quality evidence. Even though they may present with specific beliefs about their health issues and expectations, we have a role to play in re-shaping those to bring them in line with current knowledge. Patients deserve the best care. It is the chiropractor's duty to provide it, and it is our mission to facilitate this.

Since our last report, we have continued with developing guidelines, the evidence base to inform them, and tools to help chiropractors and patients use best-practice recommendations. We hope you enjoy reading about some of the work we have highlighted in this report.

Thank you for continuing to support us during this most challenging year. Please do not hesitate to contact us for more information.

Yours Truly,

David Peeace, DC
Chair, Guidelines Steering Committee

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

CCGI Research Team

Hainan Yu MBBS, MSc
Research Project Manager – Guidelines

Leslie Verville MHSc
Research Project Manager – Knowledge Translation

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

Gaelan Connell BHK, DC, MRSc
Knowledge Broker

Heather Shearer DC, MSc, FCCS(C)
PhD (candidate)
Research Associate

Danielle Southerst DC, FCCS(C)
Research Associate

Anne Taylor-Vaisey MLS
Research Associate,
Health Sciences Librarian

Poonam Cardoso BHSc, PMP
Finance Officer

Stakeholder Report: March 2021

Canadian Chiropractic Guideline Initiative
ADVANCING EXCELLENCE IN CHIROPRACTIC CARE

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New Guidelines

Two new guidelines will be published soon regarding the management of shoulder pain and lumbar spinal stenosis. We will update our clinician summaries and patient handouts to reflect the updated evidence thereafter.

Post-surgical Rehabilitation for Low Back Pain

The rate of surgical procedures for treating low back and leg pain is increasing in Europe, North America, and Asia. These patients may require post-surgical rehabilitation; however, little is known about the effectiveness of these rehabilitative interventions. With joint funding by Eurospine, we have been working on a systematic review and meta-analysis to understand the effectiveness and safety of post-surgical rehabilitation interventions for adults with low back and leg pain treated surgically. We have also systematically reviewed qualitative studies to understand the experiences of patients, healthcare providers, caregivers or others involved with the rehabilitation. This review will guide researchers, clinicians, patients and other decision makers to improve outcomes in this population. We presented some results during a CCA webinar on March 4, 2021. Our full protocol can be accessed here.

Rehabilitative Management of Back Pain in Children

Back pain begins early in life with physical, mental and social consequences (school-related, sporting activities, general physical activity, and well-being) that extend into adulthood. We have been working on a systematic review and meta-analysis to synthesise the evidence regarding effective, cost-effective and safe rehabilitation interventions for children with back pain to improve their functioning and other health outcomes. Findings from this mixed studies review will facilitate our understanding of a wide range of rehabilitation interventions for children with back pain. Our full protocol can be accessed here.

Photo by Artem Kniaz on Unsplash

Exploring clinicians' experiences and perceptions about knowledge development

Involving clinicians in developing evidence-based tools for clinical practice may result in increased uptake and improved patient outcomes. We developed a care pathway for the management of shoulder pain with clinician input. We then conducted a qualitative study to explore their experiences and perceptions about knowledge development. This work will help us to improve our processes in co-developing practice tools with clinicians. We also submitted our work for publication to facilitate the science of integrated knowledge translation – a strategy for accelerating the uptake and impact of research.

Photo by freestocks.org from Pexels

Exercises for Pregnant Women with Low Back Pain

We are working with CMCC faculty and students to develop an evidence-based exercise module for pregnant women with low back pain. Our exercise videos and forms are widely accessed, and we are pleased to add modules.

Stakeholder Report: March 2021

Canadian Chiropractic Guideline Initiative
ADVANCING EXCELLENCE IN CHIROPRACTIC CARE

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Patient Handouts

We developed two new patient handouts regarding osteoporosis, and knee pain and mobility impairments. These are user-friendly resources that patients can refer to regarding a range of conditions relevant to the chiropractic scope of practice. They can also be used to support the dialogue between clinicians and patients. For more patient handouts visit the guidelines section of our website by clicking here.

Continuing Education for Clinicians

We are developing an up-to-date, evidence-based continuing education module on detecting pathology in people with back pain. Stay tuned...

Publications

To check our growing list of publications, please visit the publications page on our website: https://www.ccgi-research.com/publications.

Please visit our website to access all of our latest resources and projects

Our YouTube videos now have more than 450,000 views!

2,190+ YouTube subscribers

880+ Twitter followers

1100+ 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: Wednesday, February 24, 2021 10:30 AM
To: Rose Bustria
Subject: FW: CCPA Communiqué

Exec and Council.

Jo-Ann Willson, B.Sc., M.S.W., LL.B.
Registrar & General Counsel
*Note Address Change
College of Chiropractors of Ontario
59 Hayden St., Suite 800
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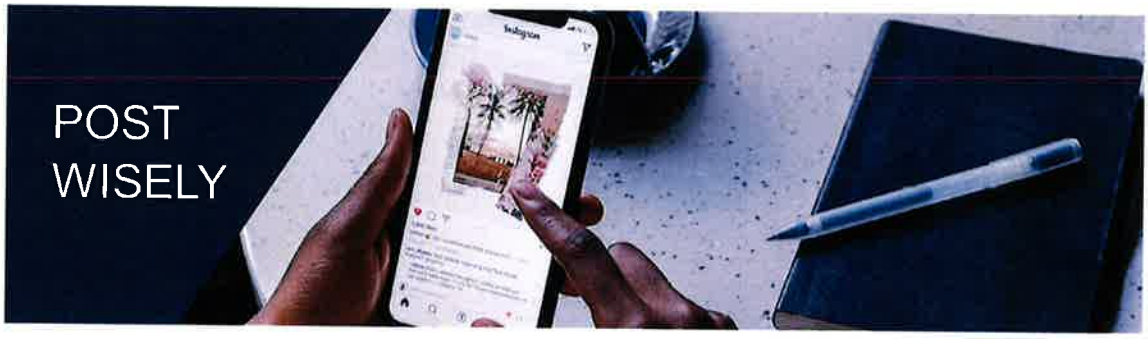
Begin forwarded message:

From: CCPA <admin@ccpaonline.ca>
Subject: CCPA Communiqué
Date: February 24, 2021 at 10:10:55 AM EST
To: bruce@n8power.ca
Reply-To: admin@ccpaonline.ca

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

CCPA Communiqué



Dr. Dean J. Wright

You have heard us talk about this before, however, it warrants further discussion. Be very – and I mean very – aware of what you post on social media. Social media allows us to stay connected with our friends, colleagues, and patients. This is a great thing, especially considering the times that we currently find ourselves in. What you share matters! It can have a dramatic impact on your life and your practice.

You must remember, you will always be evaluated on the basis that you are a regulated health professional, even if you think you are operating in your own "personal time". This is the blessing and the curse of being a regulated provider; your position and status comes with responsibility. Is it fair? Maybe not, however, it is the reality of the world in which we currently live.

Unless you are looking for conflict and a great deal of stress, do not post information that might put you at odds with your regulatory obligations.

Recently, some practitioners posted information on a group chat they thought was restricted and private. I think the practitioners felt the posts were innocuous and that the group was a "safe zone". For a few reasons that was not the case, and subsequently these practitioners found themselves in a conflict position with the provincial regulator. While the facts and circumstance could be disputed, what cannot be contested is that this caused a great deal of anguish and strain for these colleagues, who believed their actions contained no malfeasance or ill will.

I am not advising you to stop using social media. Rather, I am imploring you to adopt the strategy: think once, think twice and quite possibly think a third time before you post something on social media. Always operate under the assumption that anything posted digitally is visible to everyone. Do not imagine for a moment that the groups you have joined are completely restricted, private or safe.

OUCH File 02.2021: Sometimes, Less Really is More

In the latest installment of the OUCH Files, a DC finds out why it's crucial to take the time to re-evaluate a strange patient situation, dig deeper, and carefully consider each treatment. Click here to read more.

Your member portal has a new look!

We've made a few changes to the CCPA member portal, making it cleaner and more user friendly. We've tidied up our navigation menus and created a more

consistent layout so you can easily find all the continuing education resources, self-serve membership options and other helpful information that the member portal has to offer. Click here to check it out, or go to www.ccpaonline.ca, click "Sign in" on the top right corner, then enter your email and password.

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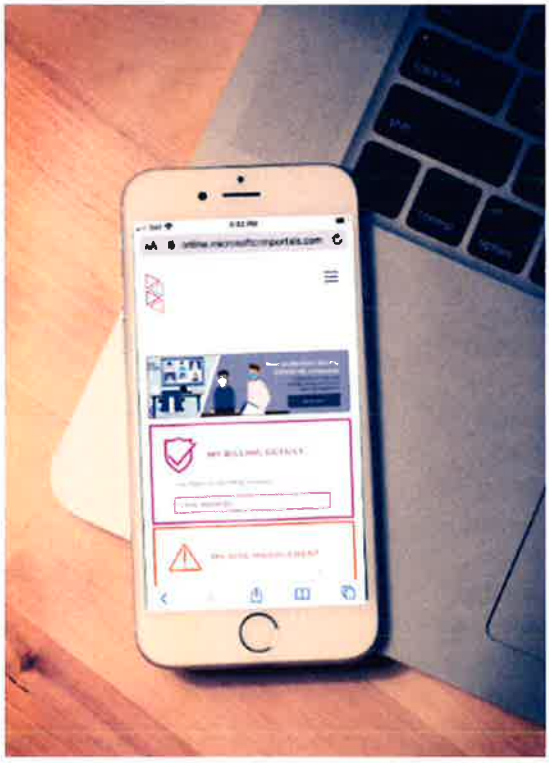

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Ministry of Health
Ministry of Long-Term Care

Health Workforce Regulatory Oversight Branch

438 University Avenue, 10th floor
Toronto ON M5G 2K8

Telephone: 437-219-4602

Ministère de la Santé
Ministère des Soins de longue durée

Direction de la surveillance réglementaire relative aux ressources humaines dans le domaine de la santé

438 avenue University, 10e étage
Toronto ON M5G 2K8

Téléphone: 437-219-4602

To: Health Regulatory College Registrars/Executive Directors

Subject: Consultation on Proposed Exemptions Under the *Police Record Checks Reform Act, 2015*

Date: March 1, 2021

I am writing to provide you with information about a review of the Exemptions regulation made under the *Police Record Checks Reform Act, 2015* (PRCRA), which was communicated to you in December 2020.

The PRCRA sets out standards to govern how police record checks are conducted and disclosed in Ontario. The Exemptions regulation (O. Reg. 347/18), grants temporary exemptions to requests for a police record check that are made for a variety of purposes, including for the purpose of screening individuals for positions in certain sectors. These temporary exemptions will expire on July 1, 2021.

A consultation document has been posted on the Ontario Regulatory Registry to seek input on the development of a framework for permanent exemptions to the PRCRA that would replace the temporary exemptions on July 1, 2021. Your valuable feedback on how the approach may affect your organization and sector is appreciated. The consultation will be open until Friday, March 12, 2021.

If you have any questions, please don't hesitate to contact Monica Shamsoun (monica.shamsoun@ontario.ca).

Thank you for your continued support.

A. Henry

Allison Henry
Director

E-mail

Your comments will be sent directly to the organization responsible for this posting.

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Tracking Number: 21-SOLGEN001

Ministry: Ministry of the Solicitor General

Instrument Type: Regulation - LGIC

Published: February 10, 2021

Comments Due: March 12, 2021

Subject: Police Record Checks Reform Act, Exemptions Proposal

Contact Information

You will only be contacted if the Ministry requires a clarification of your comment. Your contact information will not be used for any other purpose.
The handling of all personal information by Government of Ontario organizations is governed by the Freedom of Information and Protection of Privacy Act (FIPPA).

First Name Joel

Last Name Friedman

Organization College of Chiropractors of C

Address 59 Hayden Street, Suite 800

City Toronto

Province ON

Postal Code M4Y 0E7

Telephone 4164646066

E-mail jfriedman@cco.on.ca

Cc:

Comment:

Thank you for the opportunity to provide feedback on this consultation.

The College of Chiropractors of Ontario (CCO) is one of the 28 professional health regulators under the Regulated Health Professions Act, 1991 (RHPA), whose mandate is to regulate the profession in the public interest. This mandate includes registering applicants who have met the standards for entry to the profession. Once an applicant has been registered, they will be

Attached Document (PDF, Microsoft Word or text): Choose File No file chosen

Please Note: All comments and submissions received will become part of the public record. You will not receive a formal response to your comment,

however, relevant comments received as part of the public participation process for this proposal will be considered by the decision maker for this proposal.

Please do not put any personal information in the comment box as this will prevent your comment from being viewed by others.

Send

658

Thank you for the opportunity to provide feedback on this consultation.

The College of Chiropractors of Ontario (CCO) is one of the 28 professional health regulators under the Regulated Health Professions Act, 1991 (RHPA), whose mandate is to regulate the profession in the public interest. This mandate includes registering applicants who have met the standards for entry to the profession. Once an applicant has been registered, they will be authorized to work as a chiropractor in the province of Ontario. One of the requirements for registration is for an applicant to provide CCO with a Canadian Police Information (CPIC) Vulnerable Sector (VS) Check.

Chiropractors are primary care providers who are authorized to use the "Doctor" title and communicate a diagnosis within the scope of practice, and provide care in a multitude of settings, including: solo practices, multidisciplinary clinics, hospitals, rehabilitation centres, and mobile clinics. Chiropractors provide care to patients of all ages, from young children to the elderly, with a wide variety of health conditions, who often are in vulnerable and dependent positions.

As primary health care providers, chiropractors are in positions of authority and trust over their patients. CCO standards of practice require chiropractors to maintain that position of trust in all aspects of practice, including obtaining informed consent, performing consultations, examinations and treatments consistent with the standards, achieving and maintaining clinical competency in any diagnosis or therapeutic procedure, keeping accurate and current records, maintaining the privacy and confidentiality of personal health information of patients, and using accurate and verifiable information in advertising and representations to the public.

Because chiropractors are in positions of trust and authority, CCO is requesting that applicants for membership with CCO are able to obtain CPIC VS screenings from police throughout Ontario. Several other Ontario health regulatory colleges have adopted this practice, and CCO has received legal advice that the CPIC VS is the most comprehensive search available for screening applicants.

Thank you for your consideration of this feedback.

News

Amendments to the PCH: Routine and Repeat Imaging

February 8, 2021(https://www.chirobc.com/2021/02/08/) 1:30 pm News (https://www.chirobc.com/category/news/)

On February 4, 2021, the College Board approved amendments to the Professional Conduct Handbook (PCH) Part 2, Part 15 and Appendix L regarding diagnostic imaging. These amendments state that "*Routine or repeat X-rays used as a regular protocol during the evaluation and diagnosis of patients are not clinically justified.*"

View the amendments to the PCH Part 2, Part 15 and Appendix L: https://www.chirobc.com/amended-pages-from-ccbc-professional-conduct-handbook-february-2021/ (https://www.chirobc.com/amended-pages-from-ccbc-professional-conduct-handbook-february-2021/).

View the revised PCH in its entirety: https://www.chirobc.com/ccbc-professional-conduct-handbook-february-2021/. (https://www.chirobc.com/ccbc-professional-conduct-handbook-february-2021/)

The College recognizes the importance of X-ray as a tool of which chiropractors are competent to apply and interpret, and supports the use of radiography by chiropractors where appropriate. The application of radiography is not without risk and therefore, must be carefully considered. Note the following amendments to Part 15 Diagnostic Imaging:

15.1 A chiropractor may

(a) apply X-rays to a patient, or

(b) issue an authorization or instruction for another person to apply X-rays to a patient, including X-rays for the purpose of computerized axial tomography,

only if the application of X-rays is indicated by a patient history or physical examination that identifies serious pathology or clinical reasons to suspect serious pathology.

15.2 ***Routine or repeat X-rays used as a regular protocol during the evaluation and diagnosis of patients are not clinically justified****. This includes*

(a) X-rays to screen for spinal anomalies or serious pathology in the absence of any clinical indication,

(b) X-rays to diagnose or re-assess spinal conditions in the absence of any clinical indication, and

(c) X-rays to conduct biomechanical analysis or listings to identify spinal dysfunction, whether called subluxation, fixation or by any other term.

In developing these policy amendments, the Board considered the research review of the clinical utility of routine spinal radiographs from Ontario Tech University's rapid review (https://chiromt.biomedcentral.com/articles/10.1186/s12998-020-00323-8) that did not recommend the clinical routine use of radiographs for repeat evaluation of the structure and function of the spine, and the analysis of feedback from the September 2020 public consultation.

If you have any questions or concerns, please email registrar@chirobc.com (mailto:registrar@chirobc.com).

ITEM 6.2

The Chronicle of Chiropractic
The Source for News on Conservative, Traditional Chiropractic

695

BC Board Vote to Ban X-rays Not Unanimous - Laypersons Voted to Tip the Scales

Friday, February 26, 2021 - 16:25

NEWS STAFF

Registrar is Struggling to Present a United Front Among a Deeply Divided Board

The vote by the College of Chiropractors of British Columbia (CCBC) that recently **banned the use of radiographs for the evaluation and assessment of vertebral subluxation** was highly contentious according to reports from those present during the meeting.

In fact, if it were not for the **non-chiropractic lay people** on the board, the motion would **not have passed**. The following was the vote tally according to people who were present for the virtual meeting:

Voted for the Ban:

Ms. Susan Powell
Mr. Ken M. Kramer Q.C. Vice-Chair
Mr. Colin Bennett
Amarpaul (Paul) Dhaliwal DC
Stephen Mogatas DC
Jennifer Forbes DC
Johnny Suchdev Board Chair DC

Voted Against the Ban

Arvin Bahri DC
Travis Morgan DC
Shannon Patterson DC
Chris Anderson DC

Making the ridiculous decision to ban x-rays for vertebral subluxation analysis and management even more absurd is the fact that these three lay people did not have the common sense nor the ethical and moral wherewithal to admit that they know nothing about radiology nor that they know anything about the management of vertebral subluxation and **abstain from the vote.**

How did they not have the sense to do that?

To suggest with a straight face that an **attorney specializing in estates and trusts, a social worker and a retired accountant** should have any role in deciding the standard of care for a licensed clinical specialty that takes years to earn a degree in is absurd.

Yet that is just what these folks did.

Adding to the lay people who voted for the ban are the chiropractors:

Amarpaul (Paul) Dhaliwal DC
Stephen Mogatas DC

BLOGS

Historic, First Ever Conference on Chiropractic & Immunity Reveals Widespread Evidence for Role of the Profession

Historic Conference on Chiropractic & Immunity Scheduled

Is Jennifer Forbes - Western States Chiropractic College Board of Trustees Member - on War Path Against Subluxation Based Chiropractors?

BC Board Vote to Ban X-rays Not Unanimous - Laypersons Voted to Tip the Scales

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Jennifer Forbes DC
Johnny Suchdev Board Chair DC

Dhaliwal is a graduate of **Western States Chiropractic College** which is well known for supporting the move of chiropractic into the practice of medicine with the addition of drugs to the scope. Western States has also never embraced the concept of vertebral subluxation management.

Despite the CCBC position that its acting on evidence in its decisions, Dhaliwal's website is chock full of procedures and interventions that do not meet the standard the Board has set.

CLICK HERE to review his website

Stephen Mogatas has already been the subject of an investigation into his practices based on his website.

CLICK HERE for that review

Mogatas is a graduate of **Canadian Memorial Chiropractic College (CMCC)** and CMCC is well know as an institution that denigrates the practice of subluxation management.

CLICK HERE for more on that: President of Canadian Memorial Calls Subluxation Chiropractors the "Gangrenous Arm" of the Chiropractic Profession

Besides serving on the CCBC, **Jennifer Forbes DC** also serves as the **Vice Chair for the Board of Trustees at University of Western States Chiropractic College**. Her clinic's website is another treasure trove of violations of the very policies of CCBC Board.

CLICK HERE to review her website

Rounding out this group of "do as I say not as I do" board members is the **CCBC Board Chair himself: Johnny Suchdev DC**, who was the subject of an earlier investigation into practices that violated the Board rules.

CLICK HERE to review that investigation

Suchdev is also a Graduate of **Western States Chiropractic College**. We reached out to Suchdev to ask about his vote but he has not responded.

Is it a coincidence that all three members of the board who are **Western States graduates (including one who is Western's Vice Chair)** voted to ban x-ray for the analysis and management of vertebral subluxation?

The Chronicle reached out to the lay persons on the board and asked them why they did not abstain from voting on such a highly specialized and technical issue with such serious implications for public health.

Michelle Da Roza, the Board's Registrar, responded informing us that the board members are not allowed to speak publicly and must refer all questions to her.

"CCBC Board Members speak with one voice, the voice of the Board, regardless of how they vote on any particular matter."

Da Roza also stated:

"While public appointed individuals may not have a level of understanding of the profession such that a chiropractor would, their role is to reflect the public that they serve. Further, information is prepared for all Board Members who have an obligation to ask questions and request additional information if they feel they do not have enough to make an informed decision".

So the CCBC rationale for allowing lay persons to cast the deciding votes on such a technical issue is that they were given "further information" and were able to "ask questions".

We can do away with all National Board exams then since the only knowledge required for clinical expertise is to be given some information and ask some questions.

That Da Roza put this nonsense in writing without giving it a second thought is further evidence of how screwed up this Board is in terms of its judgement.

Since the news of the ban became public the chiropractic profession has erupted in outrage. Nearly **4000 individuals have signed a petition** expressing that outrage and there is a fundraising effort underway for legal action which includes filing for an injunction against the board.

CLICK HERE for the petition

The CCBC is no stranger to controversy having adopted **APPENDIX N** just a few years ago.

CLICK HERE for that story

And then in 2019 the CCBC **went after the care of pregnant women** by adding more nonsense to their **APPENDIX N efficacy claims policy falsely claiming:**

Due to the absence of acceptable evidence supporting such claims, registrants must NOT represent to patients or the public that chiropractic:

(c) has any beneficial effect on fetal development or position such as: breech/breech turning or position and intrauterine/in utero constraint.
(d) 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.
(e) has any beneficial effect on hormone function or postpartum depression.

CLICK HERE for that story

Ultimately what is battling out in Canada is a microcosm of the larger issues being fought within the profession. The controlling faction of the profession, which has **complete control over the educational, licensing and regulatory functions** of the entire profession has been working hard to limit chiropractic to the **treatment of a narrow range of musculoskeletal disorders through joint cavitation.**

One of their tactics relative to regulatory boards is to fill the lay positions with people who they are friendly with and then feed them information to get them to vote their way thereby controlling the boards.

That tactic is working well for them in British Columbia.

The Chronicle of Chiropractic
The Source for News on Conservative, Traditional Chiropractic
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X-Ray Debacle in Canada Heats Up - Injunction Lawsuit Filed Against College of Chiropractors of British Columbia

Saturday, March 20, 2021 - 13:46

NEWS STAFF

Regulatory Board Controlled by Deniers Purposely Ignored Large Body of Research & Expert Opinions That Would Have Contradicted its Decision

In a historic move, chiropractors from across the province of British Columbia Canada **filed for an injunction in the British Columbia Supreme Court** on Wednesday March 10, 2021 to reverse a recent decision by the BC regulatory body that **banned x-rays for use in the management of vertebral subluxation.**

The regulatory board (College of Chiropractors of British Columbia CCBC) falsely claims that X-ray findings don't influence patient diagnosis and care, but rather, unnecessarily expose patients to radiation.

The filing of the injunction is being **supported by nearly 4500 people** who have signed a petition in support of patients rights to have their doctor make health care recommendations without the intrusion of the government.

CLICK HERE for more on that

The Canadian National Alliance for Chiropractic (CNAC) has established a legal fund to support the lawsuit

CLICK HERE for more on that

The CCBC vote to ban x-rays is mired in scandal and is just the latest controversy that the Board has created for itself as Canadian chiropractors attempt to wrest themselves out from under the grip of Subluxation Deniers that control the profession throughout the country.

The CCBC and its cadre of supporters who deny the clinical meaningfulness of subluxation management recently pulled off a coup for control of the Board. The urgency of pulling off this coup was expressed by **Jennifer Forbes DC, Vice Chair of the Western States Chiropractic College Board of Trustees and Board Member of the College of Chiropractors of BC** in a video she circulated claiming the vote was essentially between good and evil.

CLICK HERE for more on that story

Once the majority was established, the Subluxation Deniers on the CCBC set their sites on **banning the use of x-rays for subluxation analysis.** And according to sources, **they did so by contriving a scenario that there were complaints against chiropractors coming into the board for issues related to x ray that the board simply had to deal with and put a stop to.**

One of the CCBC's tactics was to **use government funding** to pay for a so called "Rapid Review" of the literature on: The clinical utility of routine spinal radiographs by chiropractors.

And the CCBC got a bunch of well known Subluxation Deniers to write it and then get it published in the main journal controlled by the Subluxation Deniers.

Melissa Corso, Carol Cancelliere, Silvano Mior, Varsha Kumar, Ali Smith & Pierre Côté, the hired gun "researchers" who conducted the "Rapid Review", came to this conclusion:

BLOGS

Historic, First Ever Conference on Chiropracti Immunity Reveals Widespread Evidence for F of the Profession

Historic Conference on Chiropractic & Immun Scheduled

X-Ray Debacle in Canada Heats Up - Injuncti Lawsuit Filed Against College of Chiropractor British Columbia

British Columbia Vote to Ban X-Rays Mired in Scandal - Legal Action is in the Works

BC Board Vote to Ban X-rays Not Unanimous Laypersons Voted to Tip the Scales

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PAYMENT LAUNCH

"We found no evidence that the use of routine or repeat radiographs to assess the function or structure of the spine, in the absence of red flags, improves clinical outcomes and benefits patients. Given the inherent risks of ionizing radiation, we recommend that chiropractors do not use radiographs for the routine and repeat evaluation of the structure and function of the spine."

Of course they ignored any and all literature, practice guidelines and standards of care in support of the evaluation of the biomechanical integrity of the spine related to vertebral subluxation - because it would negate the narrative and muddy the water.

Given that there are **three lay people on the CCBC Board** they needed to obfuscate the issues so these lay people would vote along with them and put a stop to x-rays.

CLICK HERE for a breakdown of the vote

The money trail in this debacle will prove to be interesting and appears as though a real scandal has developed between the **CCBC Board, Ontario Tech University, the Canada Research Chairs Program, the Canadian Chiropractic Research Foundation, the World Federation of Chiropractic and the Canadian Memorial Chiropractic College (CMCC).**

The funding for the sham study was provided by the **College of Chiropractors of British Columbia to Ontario Tech. Additional funding came from the Canada Research Chairs program and the Canadian Chiropractic Research Foundation.**

CLICK HERE for more on the money trail and the key players

The entire x-ray issue related to subluxation was originally fabricated by the **American Chiropractic Association (ACA) through its adoption of the "Choosing Wisely"** document which the ACA mandates must be followed by all members of the ACA. Those mandates were **resoundingly rejected by the chiropractic profession** at the time.

CLICK HERE for those stories

The use of X-rays are a favorite target of the Subluxation Deniers who control the Chiropractic Cartel because generally speaking the chiropractors who use x-rays utilize an evidence informed framework to manage vertebral subluxation. The strategy by the Deniers is to take out the most scientific methods to determine the presence and character of subluxation such as x-rays and neurological assessments such as SEMG, thermal scanning, and HRV among others. This will accomplish their goal to establish chiropractic as the use of spinal manipulation to unstick stuck joints for a narrow range of neck and back symptoms and rid itself of what was described by David Wickes, the President of Canadian Memorial Chiropractic College, as the "gangrenous arm of the chiropractic profession" - those who practice chiropractic in a subluxation, vitalistic and salutogenic model.

CLICK HERE for that story

If you cannot measure the most significant components of vertebral subluxation - biomechanical and neurological - then you cannot show that it exists and you cannot show that care directed at reducing those manifestations leads to improved health outcomes.

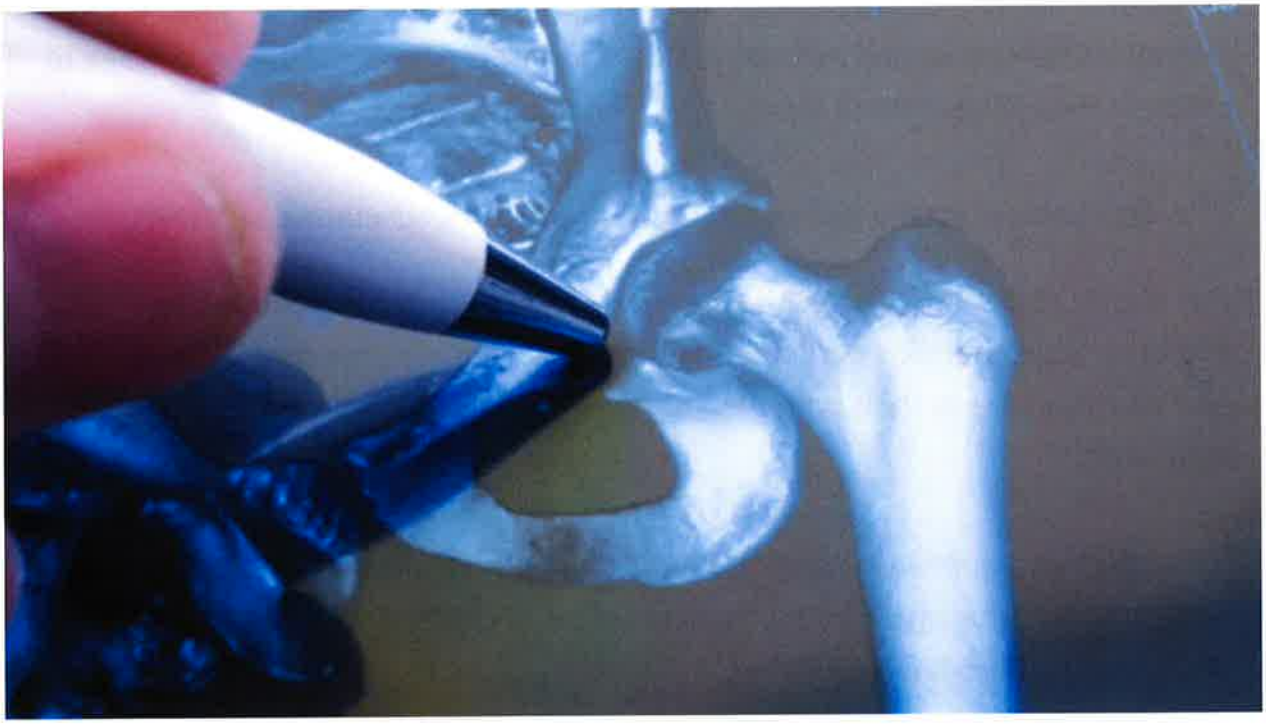
CLICK HERE for all stories on the CCBC

British Columbia

Battle over chiropractors' ability to do routine X-rays headed for B.C. court

College says repeat radiography shows no benefit to patients and increases radiation risk

Bethany Lindsay · CBC News · Posted: Mar 22, 2021 4:00 AM PT | Last Updated: March 22



Policy amendments from the College of Chiropractors of B.C. state that X-rays can only be used for diagnosis when there are signs something is seriously wrong. (Shidlovski/Getty Images)

An internal struggle that's been building for years in the chiropractic profession has broken out into legal battle as a group of B.C. chiropractors heads to court, accusing their professional regulator of unfairly limiting their ability to do business.

701

At the heart of the fight is a policy change from the College of Chiropractors of B.C., which says chiropractors are no longer allowed to perform routine and repeat X-rays because of a lack of evidence supporting any benefit to patients.

The amendments, approved in February, state that radiography is only acceptable when a physical exam or patient history raises red flags that something is seriously wrong.

This change has prompted international outrage from some chiropractic groups, who argue that regular use of X-rays is safe and fundamental to their work. They've also warned that B.C.'s move marks the beginning of a worldwide effort to root out certain segments of the profession.

Earlier this month, Langley chiropractor Melody Jesson filed a petition in B.C. Supreme Court on behalf of at least a dozen chiropractors, calling for a judge to overrule the college and reject the policy change.

- **B.C. chiropractors warned about 'inappropriate' claims on COVID-19**

The March 10 petition alleges that as a result of the college's actions, Jesson and other chiropractors "are potentially prevented from providing safe, ethical, and effective care to their patients." It argues their "trade is unfairly and unduly restrained."

Jesson has also applied for an injunction barring the college from enacting its new rule while the case is being heard in court and preventing it from taking disciplinary action against her.

The college has yet to file a response to the petition, and registrar Michelle da Roza said she was unable to comment while the matter is before the courts.

Ongoing conflict over what chiropractic can treat

The court action is just the latest symptom of a larger conflict within the chiropractic profession across Canada.

On one side are chiropractors who advocate for what they describe as evidence-based practice targeting the musculoskeletal system.

On the other are the "vitalists," who argue that slight vertebral misalignments or subluxations are the root cause of an endless range of diseases, and that chiropractic treatment can help with everything from immunity to brain function.

- **B.C. chiropractor under investigation for letter to the editor spreading false claim about masks**

In recent years, the B.C. college has enacted a number of rules that favour the evidence-based side of the argument, cracking down on chiropractors who make misleading claims and commissioning reviews of scientific research.

The college's decision to restrict the use of X-rays comes after a rapid review of the scientific literature on the topic. The team that conducted that research included Pierre Côté, Canada Research Chair in Disability Prevention and Rehabilitation at Ontario Tech University.

Some chiropractors argue that routine and repeat X-rays are a crucial part of their work. (LightField Studios/Shutterstock)

703

Côté said that some chiropractors may use X-rays once when they begin treatment of a new patient and then again when the treatment is complete. Others do it more often — and research suggests that chiropractors in the U.S. are increasing their use of the technology.

"What we found is there have actually never been studies that we are aware of that documented that patients benefit from these practices or techniques," Côté told CBC.

He said there are some risks as well associated with repeated exposure to radiation.

"The risks are believed to be small, but ... the best way to minimize risk is not to be exposed to radiation," he said.

'Patients should be concerned'

There has been national and international opposition to those findings and the actions of the B.C. college.

Not long after the changes were announced, the New York-based International Federation of Chiropractors and Organizations, which advocates for "vitalists," began circulating a petition against the college. In a post on Facebook, IFCO president Grant Dennis said the federation was reaching out to like-minded chiropractors in B.C. to help fight the amendments.

"We believe that this is being used as a 'template' or 'proof of concept' to be initiated in other areas of Canada, and that it will eventually [make] its way into other parts of the world," Dennis wrote.

Jesson's petition has also attracted funding from the Canadian National Alliance for Chiropractic, a 17-month-old group that argues chiropractic care "enhances

for chiropractic, a 17-month-old group that argues chiropractic care "enhances the body's ability to adapt and heal" and improves immunity. The organization says its board has donated "several thousand dollars" toward the legal effort.

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- **No 'significant risk' to children from chiropractic therapy, B.C. college says**

In a press release announcing Jesson's court action, Burnaby chiropractor Cameron Allan argued chiropractors use X-rays because they are necessary for diagnosis.

"Patients should be concerned that their chiropractor may not have a full understanding of their spine, which in turn could possibly compromise their safety during treatment, as well as reduce timely and appropriate referral to medical colleagues for appropriate medical management," Allan said.

- **Ministry considered options for handling 'dysfunctional' chiropractors college after CBC report, FOI shows**

He and the other chiropractors involved in the legal effort argue that X-rays have been an essential tool of the trade for more than a century, and that the risks are minimal.

They've also described Côté's research as flawed, a criticism Côté rejected.

"I would invite those critics to actually provide evidence that would go against our conclusions, because we have not been able to find it," he said.

4 UPDATED 705

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ITEM 6.4

707

CANADIAN Lawyer

Practice areas · Medical malpractice

Battle over chiropractors' ability to do routine X-rays headed for B.C. court

Chiropractor college says no benefits for repeat radiography to patients and increases risks

By Zena Olijnyk

30 Mar 2021

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708

A group of chiropractors in British Columbia is headed to court to obtain an injunction against a new rule that does not allow chiropractors to perform routine and repeat X-rays unless a physical exam or patient history indicates something is seriously wrong.

The chiropractors fighting the rules argue that the College of Chiropractors of B.C. is failing in its duties to "serve and protect" the public, as the changes "do not account for patients who have found tremendous benefits in chiropractic modalities that rely on X-rays."

The rule changes adopted by the college in February will "prevent chiropractors from providing safe, ethical, and effective care to their patients."

The group says in court documents that using radiographic imaging in their practice "to identify spinal dysfunction and subluxation" is taught in all accredited chiropractic colleges and is a "fundamental aspect" of a chiropractor's practice.

Those asking for the injunction say that the college does not have the authority under B.C laws to make amendments restricting the use of X-rays. They claim the Health Professions Act (HPA) and its relevant regulations allow chiropractors to use X-rays and other radiographic tools for diagnostic or imaging purposes.

The college does not have the authority under the HPA to make amendments that "run contrary to the express permission granted to chiropractor," the court documents say.

Claire Immega, partner and co-chair of the commercial litigation practice group at Singleton Urquhart Reynolds Vogel LLP, says her firm is in discussions with opposing counsel about the timing for the injunction application. She expects it to be heard in early April.

She says her clients are asking the court to return chiropractors' practice rights to the status quo before the Feb. 4 college vote that passed the amendment, pending resolution of the request for an injunction. That means asking the court to prevent the college from enforcing an amendment to the college's "Professional Conduct Handbook," which would "allow chiropractors to continue to order and take x-rays in accordance with . . . their professional training and judgment, as they have done for years."

"This failure to address the rights of patients to select the health care options of their choice runs contrary to the college's own stated policies and the laws of British Columbia," the petitioners say. "Rather than relying on the expertise and clinical discretion of chiropractors, the amendments limit the use of X-ray imaging "to circumstances where serious pathology or clinical reasons to suspect serious pathology are identified."

As well, the amendments do not recognize the rights of patients "to give consent or refuse to a particular form of available health care on any grounds."

"Many chiropractic patients have found significant benefit from their access to chiropractic medicine techniques that use radiographic imaging," the court documents state. "Many of these patients rely on this treatment to maintain their mobility, limit their pain, and maintain their health and wellness. As a result of the amendments, these patients . . . are potentially prevented from accessing their chosen treatment."

Earlier this month, Langley chiropractor Melody Jesson filed a petition in B.C. Supreme Court on behalf of at least a dozen chiropractors, calling for a judge to overrule the college and reject the policy change.

The Mar. 10 petition alleges that the college's actions "unfairly and unduly" restrain Jesson and other chiropractors' right to practice their trade.

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"The restraint of trade is against public policy in that it contravenes the principle of freedom to conduct business. The restraint of trade in this instance cannot be justified as reasonable in the interests of the parties nor of the public."

The college has yet to file a response to the petition, and registrar Michelle da Roza said she was unable to comment while the matter is before the courts.

However, the B.C. college has enacted over the last few years several rules that favour the idea of "evidence-based" treatment as it tries to crack down on chiropractors who make misleading claims.

In the case of using X-rays, a review of scientific literature commissioned by the college suggests that there is no hard evidence that patients benefit from repeated radiographic imaging and that there are risks associated with repeated exposure to radiation.

Immega says the February vote to pass the amendments was based on "a single literature review commissioned by the college for the purpose of the change, which many chiropractors view as deeply scientifically flawed and biased." She adds that chiropractors who rely on x-rays for their practice now face disciplinary action or are unable to continue to practice.

There have been national and international opposition to those findings and the actions of the B.C. college. The New York-based International Federation of Chiropractors and Organizations, for example, has circulated a petition against the college. In a Facebook post, the president of this organization Grant Dennis wrote that his group believes "this is being used as a 'template' or 'proof of concept' to be initiated in other areas of Canada, and that it will eventually [make] its way into other parts of the world."

The college's reliance on the one review also "demonstrated a lack of fairness in its decision-making process." The group opposed to the new amendments say that during the Feb. 4 board meeting at which the amendments passed, there was "demonstrated bias and lack of fairness," including disabling the comment function on the video conferencing platform and board members "repeatedly pushing for an early vote."

Immega says modern x-rays cause very low amounts of radiation exposure. There have been zero reported cases of harm arising from chiropractic x-rays in British Columbia, and no complaints to the college regarding over-use of x-rays in chiropractic care.

"Many medical processes require x-rays," she says. "Many dentists take annual x-rays without any specific clinical indication for the same. Patients are able to choose cosmetic and other medical treatments that require x-rays. It is our client's position that chiropractic patients should have the same rights."

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ITEM 6.5

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No. Court File No. VLC-S-S-212175
Vancouver Registry

IN THE SUPREME COURT OF BRITISH COLUMBIA

Between

DR. MELODY JESSON

Petitioner

And

THE COLLEGE OF CHIROPRACTORS OF BRITISH COLUMBIA

Respondent

NOTICE OF APPLICATION

Name(s) of applicant(s): Dr. Melody Jesson (the "Applicant")

To: The College of Chiropractors of British Columbia
200 Granville St #900
Vancouver, BC V6C 1S4
Attention: Registrar

And to: The Attorney General of the Province of British Columbia
Ministry of Attorney General
Parliament Buildings
Victoria, BC

TAKE NOTICE that an Application will be made by the Applicant to the Presiding Judge at the Courthouse at 800 Smithe Street, in the City of Vancouver, in the Province of British Columbia, on March 22, 2021 at 9:45 a.m., for the Order(s) set out in Part 1 below.

Part 1: ORDERS SOUGHT

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1. An interim injunction and/or prohibition pursuant to section 2(2) of the *Judicial Review Procedure Act*, R.S.B.C. 1996, c. 241 (the "***JRPA***"):

   a) enjoining the Respondent from giving effect to the decision of the College of Chiropractors of British Columbia (the "**College**") made on February 4, 2021 (the "**Decision**") to amend the Professional Conduct Handbook ("**PCH**") by the addition of Part 15 thereof; and

   b) enjoining the Respondent from taking any potential professional disciplinary action against the Applicant in relation to or arising out of the Decision.

2. A permanent injunction and/or prohibition pursuant to section 2(2) of the *JRPA*:

   a) enjoining the Respondent from giving effect to the Decision of the College to amend the PCH by the addition of Part 15; and

   b) enjoining the Respondent from taking any potential professional disciplinary action against the Applicant in relation to or arising out of the Decision.

   In the alterative

3. An interim injunction pursuant to Rule 10-4 of the *Supreme Court Civil Rules*:

   a) enjoining the Respondent from giving effect to the Decision of the College to amend the PCH by the addition of Part 15; and

   b) enjoining the Respondent from taking any potential professional disciplinary action against the Applicant in relation to or arising out of the Decision.

4. A permanent injunction pursuant to Rule 10-4 of the *Supreme Court Civil Rules*:

   a) enjoining the Respondent from giving effect to the Decision of the College to amend the PCH by the addition of Part 15; and

   b) enjoining the Respondent from taking any potential professional disciplinary action against the Applicant in relation to or arising out of the Decision.

5. Costs; and

6. Such further and other relief as this Honourable Court deems just.

Part 2: FACTUAL BASIS

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A. NATURE OF RELIEF SOUGHT

1. The Applicant Dr. Melody Jesson seeks an injunction against the Respondent to preserve the status quo pending the hearing of the Petition under the *JRPA* in which the Applicant is seeking the following relief:

   a) A Declaration pursuant to section 2(2) of the *JRPA* that the Decision is of no force and effect;

   In addition or in the alternative,

   b) an Order under sections 2(2) and 7 of the *JRPA* in the nature of certiorari quashing and setting aside the Decision; and

   c) A Declaration that the Decision be set aside as its scope and effect exceeds the statutory authority of the Respondent and is, therefore, *ultra vires*.

B. BACKGROUND

2. The Applicant is a Chiropractor and Registrant of the College. The Petition is a representative proceeding pursuant to Rule 20-3 of the *Supreme Court Civil Rules*. The Applicant represents the interests of all Registrants of the College.

3. The Respondent, the College, is a body continued pursuant to section 15.1(1) of the *Health Professions Act*, R.S.B.C. 1996, c. 183 (the "***HPA***"), with an address of 200 Granville St #900, Vancouver, BC V6C 1S4.

4. On August 11, 2020, the College announced a public consultation process on the use of radiography proposed amendments to the PCH.

5. On July 15, 2020, prior to the commencement of the public consultation, the College stated that it anticipated amendments to the PCH on the basis of:

   The clinical utility of routine spinal radiographs by chiropractors: a rapid review of the literature, published on July 9, 2020 by Corso et al.

   (the "**Review**").

6. At that time, the College anticipated significantly restricting the ability of Registrants to apply or requisition X-rays in their practices.

7. On September 8, 2020, the Applicant as part of the public consultation process, provided submissions to the College objecting to the proposed restriction on the use of radiography (the "**Submissions**"). In the Submissions, the Applicant specifically objected to the restriction in the proposed amendments on the use of radiography for diagnostic and treatment purposes, absent a contra-indication or so-called "red flag".

8. The Submissions set out the shortcomings of the Review, demonstrating that the Review is inconclusive, and where it purported to be conclusive, it was flawed.

9. The College ignored the Submissions, as well as the submissions of other Registrants and provided no response to the public consultation process.

10. On February 4, 2021, the Board of the College approved the amendments to Part 2 and Appendix "L" of the PCH. This Petition does not address any of these changes.

C. THE AMENDMENTS TO THE PCH

11. On February 4, 2021, in addition to the foregoing, the College made the addition of the new Part 15 to the PCH (the "**Amendments**"). The College cited the Review as its justification for the Amendments. The Amendments are the subject of the Applicant's Petition for the Judicial Review.

12. The Amendments, being the addition of Part 15 to the PCH, significantly restricts the ability of chiropractors to use and interpret radiographic imaging.

13. Part 15 of the PCH reads as follows:

> ***Part 15 Diagnostic Imaging***
>
> *15.1 A chiropractor may*
>
> *a) apply X-rays to a patient, or*
>
> *b) issue an authorization or instruction for another person to apply X-rays to a patient, including X-rays for the purpose of computerized axialtomography,*
>
> ***only if the application of X-rays is indicated by a patient history or physical examination that identifies serious pathology or clinical reasons to suspect serious pathology.***
>
> *15.2* ***Routine or repeat X-rays used as a regular protocol during the evaluation and diagnosis of patients are not clinically justified.*** *This includes*
>
> *a) X-rays to screen for spinal anomalies or serious pathology in the absence of any clinical indication,*

b) X-rays to diagnose or re-assess spinal conditions in the absence of any clinical indication, and

c) X-rays to conduct biomechanical analysis or listings to identify spinal dysfunction, whether called subluxation, fixation or by any other term.

[Emphasis added]

D. RADIOGRAPHIC IMAGING AND CHIROPRACTIC CARE

14. Radiographic imaging is fundamental to the Applicant's practice, and the practice of many other Registrants of the College in British Columbia.

15. Radiographic imaging to conduct biomechanical analysis and to identify spinal dysfunction and subluxation is taught in all accredited chiropractic Colleges, and is a fundamental aspect of the practices of the many of the Registrants.

16. As a result of the Amendments, the Applicant is potentially prevented from providing safe, ethical, and effective care to their patients.

17. As a result of the Amendments, the Applicant's trade is unfairly and unduly restrained.

18. Many chiropractic patients have found significant benefit from their access to chiropractic medicine techniques that use radiographic imaging. Many of these patients rely on this treatment to maintain their mobility, limit their pain, and maintain their health and wellness.

19. As a result of the Amendments, these patients of the Applicant are potentially prevented from accessing their chosen treatment.

20. As a result of these Amendments, the nature and viability of the Applicant's professional practice are at risk. The Application will suffer irreparable harm if the Amendments are allowed to stand.

E. STATUTORY FRAMEWORK

(i) Statutory Authority, Duties, and Objects of the College

21. The College, and its power to implement and amend standards for its registrants, are governed by the *HPA*.

22. The College is permitted to make bylaws to establish practice standards as set out in section 19 of the *HPA*. The following subsection is relevant to the herein proceedings:

19 (1) A board may make bylaws, consistent with the duties and objects of a college under section 16, that it considers necessary or advisable, including bylaws to do the following:

(k) establish standards, limits or conditions for the practice of the designated health profession by registrants; ...

23. The College's statutory duties and objects are set out in section 16 of the *HPA*. The College has the following duties set out in subsection 16(1):

> *16 (1) It is the duty of a college at all times*
> *(a) to serve and protect the public, and*
> *(b) to exercise its powers and discharge its responsibilities under all enactments in the public interest.*

24. The College has the following objects set out in subsection 16(2) of the *HPA* which are relevant to the herein proceedings:

> *(2) A college has the following objects:*
>
> *(b) to govern its registrants according to this Act, the regulations and the bylaws of the college;*
>
> *...*
>
> *(d) to establish, monitor and enforce standards of practice to enhance the quality of practice and reduce incompetent, impaired or unethical practice amongst registrants; ...*

(ii) Jurisdiction to Review

25. This Honourable Court has jurisdiction to review the decision of the College Board at issue in the Petition filed in this proceeding.

26. The *HPA* provides the following powers and duties of the Health Professions Review Board under subsection 50.53(1):

> *50.53 (1) The review board has the following powers and duties:*
>
> *(a) on application under section 50.54 (2), to review a registration decision;*
>
> *(b) on application by a registrant or complainant under section 50.57 (1), to review the failure, by the inquiry committee, to dispose of a complaint made under section 32 (1) or an investigation under section 33 (4) within the time required under section 50.55;*
>
> *(c) on application by a complainant under section 50.6, to review a disposition of a complaint made by the inquiry committee under section 32 (3), 33 (6) (a) to (c) or 37.1;*
>
> *(d) to develop and publish guidelines and recommendations for the purpose of assisting colleges to establish and employ registration, inquiry and discipline procedures that are transparent, objective, impartial and fair.*

27. The College's decision to approve the Amendments does not fall within the scope of the powers and duties provided to the Health Professions Review Board under the *HPA*. As such, the Health Professions Review Board does not have jurisdiction to review the decision of the College Board at issue in this petition.

28. Subsection 2(2) of the *JRPA* provides:

> *2 (2) On an application for judicial review, the court may grant any relief that the applicant would be entitled to in any one or more of the proceedings for:*
>
> *(a) relief in the nature of mandamus, prohibition or certiorari;*
>
> *(b) a declaration or injunction, or both, in relation to the exercise, refusal to exercise, or proposed or purported exercise, of a statutory power.*

29. The College purported to exercise its statutory powers under sections 16 and 19 in its decision to approve the Amendments, which were amendments to the standards of practice applicable to Registrants of the College.

30. Section 2(2) of the *JRPA* authorizes this Honourable Court to grant relief in relation to the College's exercise of statutory power in this instance.

F. THE AMENDMENTS ARE ULTRA VIRES THE AUTHORITY OF THE COLLEGE

31. It is the position of the Applicant that the College does not have authority under the laws of British Columbia to make the Amendments restricting the use of X-rays, and as such, its decision to approve the Amendments is *ultra vires*.

32. The authority of the College to govern its affairs is subject to the *HPA* and the *Health Professions General Regulation*, B.C. Reg. 275/2008 (the "***Regulation***"). Section 16(2)(b) of the *HPA* states that regulatory colleges have the duty to govern their Registrants according to the *HPA,* the *Regulation,* and the bylaws of the College. The *Regulation* states that:

> *4 (1) A registrant in the course of practising chiropractic may do any of the following:*
>
> *[...]*
>
> *(e) apply X-rays for diagnostic or imaging purposes, excluding X-rays for the purpose of computerized axial tomography;*

33. This section of the *Regulation* is clear. Chiropractors can apply X-rays for diagnostic or imaging purposes. The *Regulation* does not stipulate any further restrictions aside from X-rays for the purpose of CAT scans. The College does not have authority under the *HPA* to make the Amendments to the PCH as those amendments run contrary to the express permission granted to chiropractors in the *Regulation.*

34. None of the other activities that chiropractors are permitted to carry out under section 4 of the *Regulation* have been restricted by the PCH.

35. It should be within a chiropractor's clinical judgment to determine whether to recommend X-rays to their patients, and the frequency of their application in any particular patient's care.

36. The powers of the College arise from the statutory grant of power set out in the *HPA*. It is not open to the College to specifically override the Legislature and the *Regulation* by withdrawing the unqualified authority of the chiropractors to apply X-rays for diagnostic or imaging purposes.

37. The College's decision to approve the Amendments therefore contravenes the College's object under subsection 16(2) of the *HPA* to govern its registrants in accordance with the *HPA* and the *Regulation*.

G. FAILURE IN DUTY TO THE PUBLIC

38. By approving the Amendments, the College failed in its duties to serve and protect the public and exercise its powers in the public interest, in accordance with subsection 16(1) of the *HPA*.

39. The Amendments do not account for patients who have found tremendous benefits in chiropractic modalities that rely on X-rays. This failure to address the rights of patients to select the health care options of their choice runs contrary to the College's own stated policies and the laws of British Columbia, including the duties set out in subsection 16(1) of the *HPA* to serve and protect the public and exercise its powers in the public interest.

40. Rather than relying on the expertise and clinical discretion of chiropractors, the Amendments arbitrarily limit the use of X-ray imaging exclusively to circumstances where serious pathology, or clinical reasons to suspect serious pathology, are identified.

41. The Amendments arbitrarily state that routine or repeat X-rays used as a regular protocol during the evaluation and diagnosis of patients are not clinically justified. As a result, the Amendments significantly limit the ability of chiropractors to make use of radiography in patient care.

42. The PCH (at page 2) states that:

> *"registrants are reminded of their obligation to know and abide by the Health Profession Act, the Bylaws and other legislation that governs the practice of chiropractic in British Columbia, including: ... the Health Care (Consent) and Care Facility (Admission) Act."*
>
> (the "**HCCFA**").

43. The *HCCFA* defines health care to mean anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other purpose related to health. Section 4 of the *HCCFA* states that:

> *4 Every adult who is capable of giving or refusing consent to health care has:*

> *(a)* ***the right to give consent*** *or to refuse consent on any grounds, including moral or religious grounds, even if the refusal will result in death,*
> *(b)* ***the right to select a particular form of available health care on any grounds****, including moral or religious grounds,*
> *(d)* ***the right to expect that a decision to give, refuse or revoke consent will be respected****, and*
> *(e)* ***the right to be involved to the greatest degree possible in all case planning and decision making****.*
>
> [emphasis added]

44. The Amendments propose to take away this statutorily-given right from the patients who have found significant benefit from chiropractic treatment involving X-rays.

45. Given that the College and its Registrants are bound by the *HCCFA*, the Amendments put many chiropractors in the position of having to act contrary to their patients' rights under the *HCCFA* or face professional repercussions under the PCH and the College's bylaws.

46. Accordingly, by approving the Amendments, the College failed in its duties to the public as required under the *HPA*.

H. RESTRAINT OF TRADE

47. As stated above, X-rays are a necessary and fundamental part of the Applicant's practices, and the practices of many of the Registrants. As a result of the Amendments, the Applicant is not able to continue to practice effectively amounting to a restraint of trade.

48. The restraint of trade is against public policy in that it contravenes the principle of freedom to conduct business. The restraint of trade in this instance cannot be justified as reasonable in the interests of the parties nor of the public. The decision of the College to approve the Amendments that resulted in the restraint of trade affecting the Applicant was made through an inappropriate and unauthorized exercise of the College's statutory authority, and should be set aside.

I. LACK OF FAIRNESS AND BIAS

49. The College displayed a lack of fairness and bias in its decision-making process relating to the Amendments.

50. The Review was created at the behest of the College to provide a basis for the Amendments. However, the Review is inconclusive, and where it is potentially conclusive, its methodology is flawed.

51. The Applicant made the College aware of the significant flaws in the Review by providing the College with the Submissions. The Submissions set out the following issues and concerns, among others:

a. The Review is inconclusive in relation to its objective;

b. The Review's methodological limitations call its conclusions into question;

c. The College should prefer the findings from the available more reliable sources over the findings of the Review; and

d. The Review lacks substantive data to justify its conclusions on radiation in chiropractic practice.

52. Further, the College stated that it "anticipate[d] amendments" to the PCH on the basis of the Review alone, before the public consultation process had even begun. This indication of the College's intended course of action prior to the findings of the purported consultation was inappropriate and demonstrated the College's bias in its decision-making relating to the Amendments.

53. Events during the meeting of the College Board on February 4, 2021, at which the Amendments were authorized, also demonstrate bias and lack of fairness, including:

a) disabling the comment function on the video conferencing platform hosting the Board meeting, effectively disallowing Registrants from participating in the meeting and asking questions of the Board;

b) members of the Board repeatedly pushing for an early vote; and

c) questions and concerns of Board members relating to the proposed amendments to the PCH going unanswered.

54. The College's reliance on the Review in arriving at its decision to approve the Amendments, despite its myriad flaws, demonstrated a lack of fairness in its decision-making process.

55. Further, the decision-making process was tainted by the actual or perceived bias of the College arising from its reliance on the Review despite conducting a public consultation.

56. As a result, the College failed to act as an impartial decision-maker in relation to the Amendments, and its decision should be set aside.

J. TIMING OF THE AMENDMENTS

57. The College is facing amalgamation with other professional relating businesses.

58. The end of the consultation period for the Amendments arrived only twelve days after the Minister of Health Adrian Dix announced, namely on August 27, 2020, that the College will

be amalgamated into a multi-profession regulatory body tentatively referred to as the Regulatory College of Complementary and Alternative Health and Care Professions ("**RCCAHCP**"). There is no date yet set for the formal amalgamation to take place.

59. It is not appropriate for the College to make the Amendments when the College is facing amalgamation. In light of the shortcomings of the Review, the Amendments' disregard for patients' rights, and the lack of authority for the College to make the Amendments, the College should not make a decision that will necessarily have to be reconsidered by the RCCAHCP when it drafts new guidelines.

60. There is no justification for the College's unauthorized and unjustified exercise of its statutory authority in approving the Amendments when its Decision will ultimately be nothing but a short holdover until a new PCH is considered.

61. It will be up to the RCCAHCP to consider the future of its registrants. Further, the *HPA* and the *Regulation* will be redrafted and the Legislature will have the opportunity consider the appropriate scope of chiropractic practice, including radiography.

Part 3: LEGAL BASIS

62. At the hearing of the Petition, the Applicant intends to rely on the following Rules and Enactments:

a) Rules 2-1, 10-4, 14-1, 16-1, 20-3, and 21-3 of the Supreme Court Civil Rules;

b) *Judicial Review Procedure Act*, R.S.B.C. 1996, c. 241;

c) *Health Professions Act*, R.S.B.C. 1996, c. 183; and

d) *Health Professions General Regulation*, B.C. Reg. 275/2008.

A. Injunctive Relief: Common Law Basis

The test for the granting of an interlocutory injunction

63. The test for granting interim injunctive relief is set out in *British Columbia (Attorney General) v. Wale*. The Court may grant an injunction if:

a) there is a fair question to be tried as to the existence of the right which is alleged and the breach thereof, actual or reasonably apprehended; and

b) the balance of convenience favours granting the injunction.

British Columbia (Attorney General) v. Wale, [1986] B.C.J. No. 1395 (C.A.) at 45, aff'd at [1991] 1 S.C.R. 62 *("Wale");*
Onkea Interactive Ltd. v. Smith, 2006 BCCA 521 at ¶ 9 *("Onkea")*

64. While the Supreme Court of Canada in RJR-MacDonald Inc. v. Canada (Attorney General), [1994] 1 S.C.R. 311 (S.C.C.) has also approved a three-pronged test for granting interim injunctive relief, in which the question of irreparable harm is a separate inquiry, the two pronged test set out in Wale is commonly applied by the British Columbia courts. The Wale test considers the issue of irreparable harm at the balance of convenience stage of the analysis. The fundamental question of the analysis is whether the granting of an injunction is just and equitable in all the circumstances of the case.

Onkea at ill 10, citing *Roxum (West) Inc. v. 445162 B.C. Ltd.,* 2001 BCCA 362; *Expert Travel Financial Security (E.F.T.S.) Inc. v. BMS Harris & Dixon Insurance Brokers Ltd.,* 2005 BCCA 5 at 11 54-55

65. With regard to the first prong of the test for interim injunctive relief, the applicant's burden is low; the applicant need only demonstrate that its claim is not frivolous or vexatious.

Onkea at 1116 citing *RJR-McDonald Inc. v. Canada (Attorney General),* [1994] 1 S.C.R. 311

66. The question of whether an interlocutory injunction should be granted requires a weighing of the relative risks of harm to the applicant if the injunction is refused and to the respondent if the injunction is granted.

Onkea, supra, at 28

67. The general principles governing the granting of interlocutory injunctive relief in British Columbia was stated as follows by Mr. Justice Smith in Expert Travel Financial Security (E.F.T.S.) Inc. v. BMS Harris & Dixon Insurance Brokers Ltd., 2005 BCCA 5:

> **54** The test for the granting of an interlocutory injunction has been expressed as both a three-part test (see *RJR-MacDonald Inc. v. Canada (Attorney-General)*, [1994] 1 S.C.R. 311 at [paragraph] 77) and a two-part test (see *A.G. British Columbia v. Wale* (1986), 9 B.C.L.R. (2d) 333 (C.A.) at 345, aff'd [1991] 1 S.C.R. 62). As Madam Justice Saunders said in *Coburn v. Nagra* (2001), 96 B.C.L.R. (3d) 327, 159 B.C.A.C. 299, 2001 BCCA 607:
>
> > [7] Whether the criteria for an injunction is two part or three may be a topic of debate for scholars. In British Columbia the common test for injunctions has been two-pronged since British Columbia *(Attorney General) v. Wale* (1986), 9 B.C.L.R. (2d) 333 (B.C.C.A.), with the issue of irreparable harm being subsumed into the discussion of balance of convenience (or inconvenience). As Madam Justice McLachlin (now C.J.C.) noted in *Wale*,

> the distinction is likely without practical effect. The question in most cases is the relative weight of the convenience and inconvenience of the order sought, always considering the paramount measure, the interests of justice.
>
> **55** The test set out in *A.G. British Columbia v. Wale, supra*, was described in *Canadian Broadcasting Corp. (CBC) v. CKPG Television Ltd.* (1992), 64 B.C.L.R. (2d) 96 (C.A.) at p. 101:
>
> > The two-pronged test is this: "First, the applicant must satisfy the court that there is a fair question to be tried as to the existence of the right which he alleges and a breach thereof, actual or reasonably apprehended. Second, he must establish that the balance of convenience favours the granting of an injunction."
>
> **56** The burden on the applicant to show a fair question to be tried is a low one; generally, unless the case can be said to be frivolous or vexatious, this part of the test will be satisfied: see *RJR-MacDonald Inc. v. Canada (Attorney-General), supra*, at [paragraph] 49, 50, 78.

68. In *Doubleview Capital Corp. v. Day, 2016 BCSC 231* at para.75, the Court confirmed the test in RJR and elaborated that the Applicant must show that there is a serious case that would entitle it to the injunction it seeks.

Serious question to be tried

69. In this case, on the evidence before this Honourable Court, the Applicant submits that there is clearly a serious question to be tried.

Irreparable Harm

70. Irreparable harm is caused when a party will suffer harm that is not capable of being adequately compensated in monetary terms.

71. As set out in the Affidavits filed in support hereof, the Applicant will suffer irreparable harm if the Amendments are allowed to stand.

Balance of convenience

72. The test is not to be applied as a rigid formula. As stated by the Court of Appeal in *Coburn v. Nagra*:

> *"The question in most cases is the relative weight of the convenience and inconvenience of the order sought, always considering the paramount measure, the interests of justice."*

73. In assessing the balance of convenience, the Court of Appeal said that the Judge should consider these points:

(a) the adequacy of damages as a remedy for the applicant if the injunction is not granted and for the respondent if an injunction is granted;

(b) the likelihood that if damages are finally awarded they will be paid;

(c) the preservation of contested property;

(d) other factors affecting whether harm from the granting or refusal of the injunction would be irreparable;

(e) which of the parties has acted to alter the balance of the relationship and so affect the status quo;

(f) the strength of the applicant's case;

(g) any factors affecting the public interest;

(h) any other factors affecting the balance of justice and convenience.

74. The balance of convenience (perhaps better called the balance of inconvenience) is a determination of the question of which of the opposing parties will suffer the greater harm from the granting or refusal of an interlocutory injunction.

Metropolitan Stores (MTS) Ltd. v. Manitoba Food and Commercial Workers, Local 832 [1987] 1 SCR

75. These factors are not to be analysed and weighed separately, but rather, all of the relevant factors must be assessed together to reach an overall conclusion about where the balance of convenience rests.

Rand v. Anglican Synod of the Diocese of British Columbia, [2008] B.C.J. No. 1302, 2008 BCCA 294

76. In reaching its conclusion, the Court held as follows:

> *"[9] There is a fair question to be tried as to the plaintiff's claim that its right to use the road for public access to its property has been breached by the blockades and would be breached by continuation of them."*
>
> *"[11] The balance of convenience clearly favours the granting of the injunction sought and it will go in the terms set out in the notice of motion."*

77. The balance of convenience also includes consideration of the public interest. The granting of an injunction to prevent the irreparable harm set out above all weighs heavily in favour of the public interest.

Yahey v. British Columbia, 2015 BCSC 1302

78. In the case at bar, the balance of convenience requires the granting of the injunctive relief requested by the Applicant.

79. The Respondents' conduct, if not enjoined, has and will continue to have the effect of preventing the Applicant from pursuing her professional practice as she has done to date.

80. The granting of the Injunction will not cause any prejudice or harm to the Defendants.

81. In the decision of *Cambie Surgeries Corporation v. British Columbia (Attorney General)*, the Plaintiffs were two corporations (Cambie Surgeries Corporation and Specialist Referral Clinic) and 4 individuals. The Plaintiffs successfully brought an application for an interlocutory injunction restraining the BC government from enforcing legislation that prohibited private-pay medically necessary health services. The larger action was a constitutional challenge of the legislation and the impact on wait times for medical services.

Cambie Surgeries Corporation v. British Columbia (Attorney General), 2018 BCSC 2084

82. The Plaintiffs argued that irreparable harm would be suffered by BC residents in two ways:

(1) the prohibition would impact those patients seeking private surgical services; and

(2) it would burden the public system because those who would have used private surgical services must now be integrated into the public health care system (at para. 164).

83. The evidence the Court relied on in finding irreparable harm is set out at para 167.

84. The Court emphasized the "balance of convenience" branch of the RJR MacDonald test in its analysis, saying *"It is here where the interests of the public must be considered and it is here where a case such as this one is typically decided"* (at para 129).

85. The Court was satisfied that the Plaintiffs established a sufficient nexus between the prohibition and wait times for medical services, which resulted in increased risk of suffering physical and psychological harm by having to wait for public health care service. This tipped the balance of convenience in favour of the Plaintiffs (at para 185). The Court was also satisfied that the Plaintiffs would be impacted in a far greater manner than the government of BC were the injunctive relief not granted.

86. In the case of *Perimeter Transportation Ltd. v. Vancouver International Airport Authority*, the Plaintiff bus service company successfully applied for an interlocutory injunction compelling the Defendant to provide the Plaintiff with road, parking and pedestrian access to the Vancouver International Airport. The purpose of the application was to preserve the viability of the Plaintiff's Whistler Express bus service, which amounted to fifty percent of the Plaintiff's revenues.

Perimeter Transportation Ltd. v. Vancouver International Airport Authority, 2006 BCSC 684

87. The Court was satisfied that there was a likely prospect of irreparable harm if an interlocutory injunction was not granted in the circumstances (at paras. 26-27).

88. The Court considered public interest factors in the "balance of convenience" analysis, noting that the Plaintiff's passengers would be inconvenienced if the Plaintiff's access to the Airport were not continued (at para. 34). Additionally, granting the injunction did not create unmanageable conditions for the Defendant.

89. In the case of *Summerside Seafood Supreme Inc. v. Prince Edward Island (Minister of Fisheries, Aquaculture & Environment)*, the Minister of Fisheries sought to overturn the decision of the Motions Judge granting an injunction prohibiting the Minister from withholding a fish processing licence to the Plaintiff fish processing plant.

Summerside Seafood Supreme Inc. v. Prince Edward Island (Minister of Fisheries, Aquaculture & Environment), 2006 PESCAD 11 (Prince Edward Island Supreme Court Appeal Division)

90. The Plaintiff argued that its business would be severely impacted, if not put out of business, without the licence at issue. At the least, the Plaintiff argued it would lose goodwill from being unable to meet its customers' demands while fighting this matter in Court.

91. The Minister cited no irreparable harm on its part, and the Court noted that there did not appear to be any difficulty on the Minister's part in maintaining its past practices (at para. 90).

92. Similarly, there was no inconvenience cited by the Minister. The inconvenience to the Plaintiff was that without its license it could not process fish, hire workers, or meet the requirements of its suppliers, and may have gone out of business (at para 91).

93. There was therefore overwhelming reason to support continuing of the status quo between the parties. The Appeal Court varied the wording of the injunction to state that the minister was enjoined from refusing to issue a fish processing license to the Plaintiff on the basis that it was indebted to the Province.

Part 4: MATERIAL TO BE RELIED ON

729

1. Affidavit #1 of Dr. Melody Jesson, made March 10, 2021;
2. Affidavit #1 of Dr. Brian Bittle, made March 10, 2021;
3. Affidavit #1 of David Nicol, made February 23, 2021;
4. Affidavit #1 of Dr. Shawn Thomas, made February 23, 2021;
5. Affidavit #2 of Dr. Shawn Thomas, made March 10, 2021;
6. Affidavit #1 of Dr. Joshua Korten, made February 24, 2021;
7. Affidavit #1 of Dr. David Beaudoin, made February 24, 2021;
8. Affidavit #1 of Dr. David MacKenzie, made February 23, 2021;
9. Affidavit #1 of Dr. Surdeep Dhaliwal, made February 23, 2021;
10. Affidavit #1 of Jaye Kim Jarvis, made February 23, 2021;
11. Affidavit #1 of Kevin Kirechuk, made February 24, 2021;
12. Affidavit #1 of Jen Temple, made February 25, 2021;
13. Affidavit #1 of Ellen Stolting, made February 23, 2021;
14. Affidavit #1 of Dr. Michael Foran, made February 23, 2021;
15. Affidavit #1 of Dr. Michael Foullong, made March 5, 2021; and
16. Affidavit #1 of Makaela Peters, made March 10, 2021.

The applicant(s) estimate(s) that the Application will take 1.5 hours.

☒ This matter is not within the jurisdiction of a master.

TO THE PERSONS RECEIVING THIS NOTICE OF APPLICATION: If you wish to respond to this notice of application, you must, within 5 business days after service of this notice of application or, if this application is brought under Rule 9.7, within 8 business days after service of this notice of application.

730

(a) file an application response in Form 33,

(b) file the original of every affidavit, and of every other document, that

(i) you intend to refer to at the hearing of this application, and

(ii) has not already been filed in the proceeding, and

(c) serve on the applicant 2 copies of the following, and on every other party of record one copy of the following:

(i) a copy of the filed application response;

(ii) a copy of each of the filed affidavits and other documents that you intend to refer to at the hearing of this application and that has not already been served on that person;

(iii) if this application is brought under Rule 9.7, any notice that you are required to give under Rule 9.7 (9)

Date: March 10, 2021

Name and address of lawyer for the applicant:

Signature of **Claire Immega**
Lawyer for the applicant

Singleton Urquhart Reynolds Vogel LLP
1200 – 925 West Georgia Street
Vancouver, BC V6C 3L2
Tel: 604-682-7474
Fax: 604-682-1283
Email: cimmega@singleton.com
Attention: Claire Immega

To be completed by the court only:

Order made

[ ] in the terms requested in paragraphs _____ of Part 1 of this notice of application

[ ] with the following variations and additional terms:

_____

_____

_____

Date [*day/month/year*]

_____

Signature of [ ] Judge [ ] Master

APPENDIX

[*The following information is provided for data collection purposes only and is of no legal effect.*]

THIS APPLICATION INVOLVES THE FOLLOWING:

- ☐ discovery: comply with demand for documents
- ☐ discovery: production of additional documents
- ☐ other matters concerning document discovery
- ☐ extend oral discovery
- ☐ other matter concerning oral discovery
- ☐ amend pleadings
- ☐ add/change parties
- ☐ summary judgment
- ☐ summary trial
- ☐ service
- ☐ mediation
- ☐ adjournments
- ☐ proceedings at trial
- ☐ case plan orders: amend
- ☐ case plan orders: other
- ☐ experts.

INFORMATION
(HTTPS://DIALOGUE.CPSO.ON.CA/CATEGORY/FEATURE/INFORMATION/)

New Eligibility Criteria for Council Election

December 11, 2020 (https://dialogue.cpso.on.ca/2020/12/)

Reading time: 2 minutes

Recent Posts

Pembroke FP becomes College President (https://dialogue.cpso.on.ca/2C fp-becomes-college-president/)

Implicit Bias in Health Care (https://dialogue.cpso.on.ca/2C bias-in-health-care/)

Advertising Policy Approved (https://dialogue.cpso.on.ca/2C policy-approved/)

Making Patients Partners in their Care (https://dialogue.cpso.on.ca/2C patients-partners-in-their-care/)

Treating Root Causes, Not Symptoms (https://dialogue.cpso.on.ca/2C root-causes-not-symptoms/)

Categories

Select Category

(https://dialogue.cpso.on.ca/2020/12/new-eligibility-criteria-for-council-election/?print=print)

Council approved the following amendments to the eligibility criteria for district elections in the CPSO General By-laws (https://www.cpso.on.ca/admin/CPSO/media/Documents/about us/legislation-bylaws/general-bylaw.pdf):

- Provide for a cooling-off period before physicians who have held certain positions with other organizations may be eligible to run for CPSO Council;
- Require prospective Council election nominees to complete an orientation or educational session regarding the roles, responsibilities and obligations of CPSO Council and committee members prior to submitting their nomination material; and
- Clarify the eligibility criterion relating to disqualification and amend the time limit for its application.

The changes are part of CPSO's efforts to modernize the governance structure and processes of the CPSO and align with new government expectations for health regulatory colleges.

Cooling-Off Period

The Ministry of Health has identified the use of cooling-off periods as a governance best practice and will be asking health regulatory colleges to report on this, among other leading practices, beginning in March 2021. A member will not be eligible to stand for Council election: if the member holds, or has held within one year before the date of the election, a position which would cause the member, if elected as a councillor, to have a conflict of interest by virtue of having competing fiduciary obligations to both the College and another organization. While this applies to any organization where there may be competing fiduciary obligations, members specifically cannot be a director or officer of the Ontario Medical Association, the Canadian Medical Protective Association, the Canadian Medical Association, the Coalition of Family Physicians, the Specialists of Ontario or the Ontario Specialists Association within one year before the date of election; or if the member is, or has been within five years before the date of the election, an employee of the College.

Mandatory Orientation

It is important that Council members are well-informed and aware of their expectations and the time commitment required as a Council member. The intent behind the orientation is to inform candidates about what being a Council member and CPSO committee member entails, and what will be expected of them in advance of standing for elections.

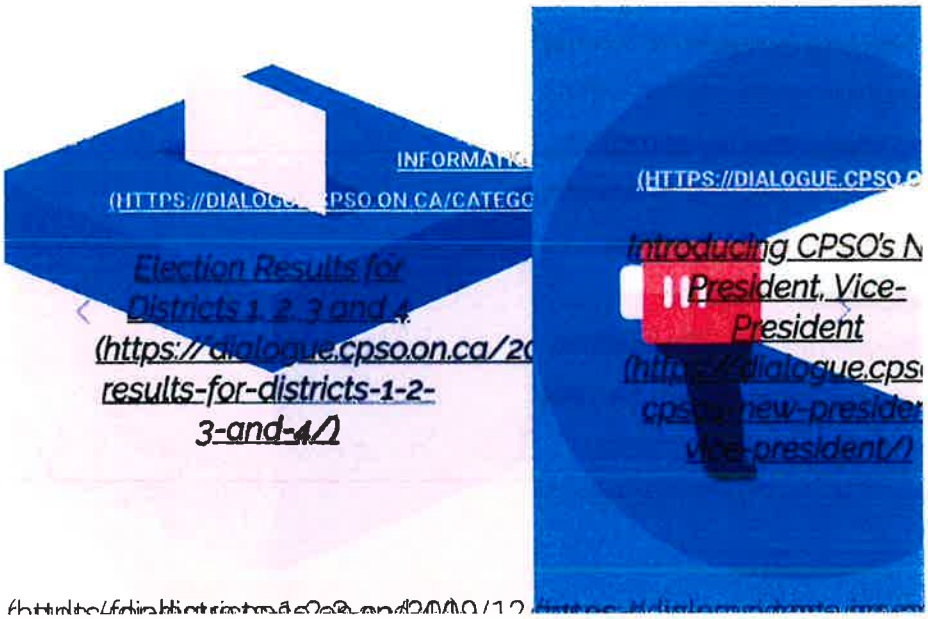
Disqualification

The by-laws currently provide that a member is not eligible for election to Council if Council has disqualified the member during the three years before the election date.

The amendment clarifies that it applies to both disqualification from Council and from a CPSO committee. The amendments also address members who may have resigned from Council or from a committee in face of a disqualification.

Council supported the extension of the three-year time period to five years.

You Might Also Like



ITEM 6.7

738

College of Respiratory Therapists of Ontario

Ordre des thérapeutes respiratoires de l'Ontario

Don't Take a Selfie

Posted on March 8, 2021 by Kelly Arndt

With healthcare workers now becoming vaccinated against Covid-19, we see many of these m posted on social media, through "vaccine selfies". Pictures of band aids, masked smiles and reflect celebration and relief, after the culmination of an incredibly long and difficult year. If platforms, it is important to be aware of the dangers that exist due to the information sha distributed. Your full name, birthdate, and partial health card number, along with the location th vaccine, is visible on the vaccine card. If this not blacked out or blocked from view, it can be use to gain access to other private, personal information and may put you at risk for further scams.

In the UK, who began their vaccination program prior to Canada, there are instances of scam vaccination cards using this type of information found on the internet.

Do not allow something that has been created to protect you from one enemy, be the reason another. Pause before you post.

The CRTO will be circulating its new document on The Use of Social Media by Respiratory The shortly. We are interested in your thoughts and feedback!

This entry was posted in Members, Practice Blog, Students. Bookmark the permalink.

LEAVE A REPLY

Your email address will not be published.

Subject: FW: Blog | SML-LAW

From: Jo-Ann Willson <jpwillson@cco.on.ca>
Sent: Wednesday, April 7, 2021 9:58 AM
To: Rose Bustria <RBustria@cco.on.ca>
Subject: FW: Blog | SML-LAW

Council.

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

From: Dennis Mizel <drmizel@stcatharineschiropractic.com>
Sent: Wednesday, April 7, 2021 9:55 AM
To: Jo-Ann Willson <jpwillson@cco.on.ca>
Cc: Rob MacKay <Mackayrob@tbaytel.net>
Subject: Blog | SML-LAW

FYI
https://www.sml-law.com/blog-regulation-pro/

Wed Apr 7

Tweet

Richard Steinecke
@steineckerich

I am sure that this case will be cited to the hearing panel in almost every joint sumbmission at discipline hearings in Ontario for the foreseeable future.

> **SML Law** @SMLLawToronto · 22h
>
> "Joint Submission Was not "Unhinged"" by @nsdanson is the latest Regulation Pro blog entry: sml-law.com/blog-regulatio... #professionalregulation

12:13 PM · 2021-04-06 · Twitter Web App

Sent from my iPad

CITATION: Timothy Edward Bradley v. Ontario College of Teachers, 2021 ONSC 2303
DIVISIONAL COURT FILE NO.: 504/19
DATE: 20210326

ONTARIO

SUPERIOR COURT OF JUSTICE

740

DIVISIONAL COURT

D.L. Corbett, Doyle and Favreau JJ.

BETWEEN:	)	
Timothy Edward Bradley	)	Jerry Raso, for the Appellant
Appellant	)	
– and –	)	
Ontario College of Teachers	)	Christine Wadsworth, for the Respondent
Respondent	)	
	)	**HEARD by videoconference:** July 9, 2020

[1] On July 9, 2020, the panel granted an order on consent allowing the appeal with reasons to follow. These are the reasons.

Background

[2] At the relevant time, the appellant, Timothy Edward Bradley, was a teacher with the London District School Board.

[3] The appellant was the subject of disciplinary proceedings before the Discipline Committee of the Ontario College of Teachers. The allegations against the appellant were that he made harassing comments and engaged in harassing behaviour toward a female teaching candidate who was assigned to work with the appellant as part of her practicum.

[4] The hearing before the Discipline Committee was held on June 24, 2019. At the hearing, the parties presented an agreed statement of fact and a joint penalty submission. The joint penalty submission included various terms, including a proposed two-month suspension of the appellant's Certificate of Qualification and Registration. The suspension was to commence immediately after

the hearing which, given the date of the hearing, meant that the suspension would take place over the summer months.

[5] At the hearing, the panel expressed concern over the proposal that the suspension take place over the summer months and asked counsel for the parties to make additional submissions on the issue. Counsel made submissions justifying the proposal that the two-month suspension take place over the summer, including the following arguments:

a. Suspensions are often served in the summer, including in a similar case: *Ontario College of Teachers v. Bergin*, 2018 ONCT 29;

b. Regardless of the timing, the suspension will be made public and become part of the appellant's permanent record, thereby still having a deterrent effect;

c. The Panel can accept the joint penalty submission while still expressing strong views about the inappropriateness of the appellant's conduct;

d. The appellant had been teaching for a number of years since the events giving rise to discipline without further incidents, which is a mitigating factor;

e. A suspension during the school year would be disruptive to the appellant's students; and

f. The appellant has shown remorse, fully cooperated with the investigation and voluntarily taken a course on professional boundaries.

[6] In a decision released on August 13, 2019, the Panel rejected the parties' submission that the suspension should take place over the summer and instead directed that the appellant was to start serving his suspension on September 3, 2019. In its reasons, the Panel stated that accepting the joint submission on penalty "would bring the administration of the discipline process into disrepute or be otherwise contrary to the public interest". The Discipline Committee gave two reasons for rejecting the joint submission:

> (1) Accepting the joint submission would cause the public to lose confidence in the College's disciplinary process; and (2) the penalty objectives of specific deterrence, general deterrence, rehabilitation, and protection of the public interest would not be sufficiently met if the Member were allowed to serve his suspension during the summer.

Standard of review

[7] Section 35(4) of the *Ontario College of Teacher's Act, 1996*, S.O. 1996, c.12, gives a party to a hearing before the Disciplinary Committee a right of appeal to the Divisional Court on a question of law or fact or both. Accordingly, given the statutory right of appeal, the appellate standards of review apply. Errors of law are reviewed on a standard of correctness and errors of fact or mixed fact and law are reviewed on a standard of palpable and overriding error.

Analysis

[8] The only issue on the appeal is whether the Discipline Committee erred in rejecting the parties' joint submission on penalty. We agree with the parties that the Discipline Committee made an error in its application of the principles to be applied when a disciplinary body decides to reject a joint submission on penalty.

[9] The governing authority on this issue is the Supreme Court of Canada's decision in *R. Anthony-Cook*, 2016 SCC 43. While decided in the criminal law context, *Anthony-Cook* has been applied by disciplinary bodies in Ontario, including by the Discipline Committee of the College of Teachers: *Ontario College of Teachers v. Sadaka*, 2019 ONOCT 60. See also: *Law Society of Upper Canada v. Archambault*, 2017 ONLSTH 86, para. 14; *Ontario (College Pharmacists) v. Mikhael*, 2017 ONCPDC 25, para. 28; *Ontario (College of Physicians and Surgeons of Ontario) v. Cameron*, 2018 ONCPSD 25; *Ontario (College of Massage Therapists of Ontario) v. Tang*, 2018 ONCMTO 26; and *College of Nurses of Ontario v. Lopes*, 2017 CanLII 50755 (ON CNO).

[10] In *Anthony-Cook*, at para. 25, the Court emphasized the importance of joint submissions on sentence:

> It is an accepted and entirely desirable practice for Crown and defence counsel to agree to a joint submission on sentence in exchange for a plea of guilty. Agreements of this nature are commonplace and vitally important to the well-being of our criminal justice system, as well as our justice system at large. Generally, such agreements are unexceptional and they are readily approved by trial judges without any difficulty. Occasionally, however, a joint submission may appear to be unduly lenient, or perhaps unduly harsh, and trial judges are not obliged to go along with them…

[11] The Supreme Court went on to adopt a "public interest" test for rejecting a joint submission. Joint submissions on sentence are to be accepted "unless the proposed sentence would bring the administration of justice into disrepute or is otherwise contrary to the public interest" (para. 32). At para. 34, the Court emphasized that this is a very stringent test:

> [A] joint submission should not be rejected lightly, a conclusion with which I agree. Rejection denotes a submission **so unhinged from the circumstances of the offence and the offender** that its acceptance would lead reasonable and informed persons, aware of all the relevant circumstances, including the importance of promoting certainty in resolution discussions, to believe that the proper functioning of the justice system had broken down. This is an undeniably high threshold… [emphasis added]

[12] The Court went on to explain the benefits and necessity of a stringent test: paras. 35-45. Guilty pleas in exchange for a joint sentence submission are a necessary part of the criminal justice system. They benefit the accused, victims, witnesses, lawyers and the administration of justice. However, in order for these benefits to be meaningful, the accused must have a "high degree of certainty" that the joint submission will be accepted:

> Hence, the importance of trial judges exhibiting restraint, rejecting joint submissions only where the proposed sentence would be viewed by reasonable and informed persons as a breakdown in the proper functioning of the justice system. A lower threshold than this would cast the efficacy of resolution agreements into too great a degree of uncertainty. The public interest test ensures that these resolution agreements are afforded a high degree of certainty. (para. 42).

[13] In this case, the Discipline Committee referred to the *Anthony-Cook* decision as the guiding authority on the issue of whether it could reject the joint submission on penalty, but it misunderstood the stringent nature of the public interest test and thereby misapplied it. In particular, the Discipline Committee did not find that or articulate any basis for finding that serving the two month penalty in the summer was so "unhinged from the circumstances of the offence and the offender that its acceptance would lead reasonable and informed persons, aware of all the relevant circumstances, including the importance of promoting certainty in resolution discussions, to believe that the proper functioning of the justice system had broken down". This is evident in a number of respects, including the following:

a. The Discipline Committee ignored other decisions in which two-month suspensions were to be served over the summer, and failed to distinguish those decisions. In particular, the Discipline Committee did not address the decision in *OCT v. Bergin*, 2018 ONOCT 29, involving similar facts that led to a two-month suspension over the summer, which was brought to its attention at the hearing. The parties' joint submission could hardly be viewed as "unhinged" if the Discipline Committee imposed a similar penalty in similar cases.

b. The Discipline Committee impermissibly focused on the "fitness" of the sentence, and in particular whether a two-month suspension over the summer months would sufficiently serve the purposes of specific and general deterrence. In *Anthony-Cook*, the Supreme Court explicitly rejected a fitness test or even a "demonstrably unfit" test in favour of the public interest test: paras. 46-48.

c. Having found that a two-month suspension was an appropriate length, the Discipline Committee engaged in impermissible "tinkering" by moving the suspension from the summer to the early fall: *Anthony-Cook,* para. 63.

d. The Discipline Committee found that a suspension in the summer was largely "symbolic", without having regard to the submissions made by the parties that the penalty would remain on the appellant's record and would be publicly available.

e. The Discipline Committee erroneously suggested that the parties should have shared more information about the circumstances that led to the joint submission. In *Anthony-Cook*, the Supreme Court recognized that the Crown and defence are best placed to understand the circumstances of the case as a rationale for a stringent test, but there was no suggestion that the parties are required to share that information with the court in order to justify the joint submission.

f. The Discipline Committee had no regard to the benefits and importance of joint submissions on penalty, and no regard to the impact of its decision on those benefits.

[14] The public interest test in *Anthony-Cook* applies to disciplinary bodies. Any disciplinary body that rejects a joint submission on penalty must apply the pubic interest test and must show why the proposed penalty is so "unhinged" from the circumstances of the case that it must be rejected. In this case, the Discipline Committee clearly misunderstood the stringent public interest test, and impermissibly replaced the proposed penalty with its own view of a more fit penalty. This was an error and we agree with the parties that the appeal should be allowed.

Conclusion

[15] For the reasons above, the appeal is granted in accordance with the terms of the order signed on July 9, 2020, which includes a term that the appellant's Certificate of Qualification and Registration was to be suspended for two months starting from the date of the order.

[16] No costs were ordered.

D.L. Corbett J.

Doyle J.

Favreau J.

Released: March 26, 2021

CITATION: Timothy Edward Bradley v. Ontario College of Teachers, 2021 ONSC 2303
DIVISIONAL COURT FILE NO.: 504/19
DATE: 20210326

ONTARIO

SUPERIOR COURT OF JUSTICE

DIVISIONAL COURT

D.L. Corbett, Doyle and Favreau JJ.

BETWEEN:

Timothy Edward Bradley

Appellant

– and –

Ontario College of Teachers

Respondent

REASONS FOR JUDGMENT

Released: March 26, 2021

Toronto

Registered nurse could face discipline after refusing COVID-19 testing, quarantine at Toronto airport

Registered Nurses' Association of Ontario calls behaviour offensive, unprofessional

Sabrina Jonas · CBC News · Posted: Mar 06, 2021 4:00 AM ET | Last Updated: March 6

Toronto registered nurse Jessica Faraone appeared maskless at Toronto's Pearson airport after coming back from an international trip. She refused to take a COVID-19 test and\ to quarantine in a hotel — actions the Public Health Agency of Canada says could lead to a fine of up to $750,000 or six months in jail. (Evan Mitsui/CBC)

comments 747

A registered nurse who openly refused to comply with quarantine rules and other mandated COVID-19 safety requirements after returning from an international trip at a Toronto airport could face disciplinary action by the body that regulates nurses in Ontario.

In a series of videos posted to her social media account from Pearson International Airport on Thursday, Toronto registered nurse Jessica Faraone appears maskless and says she refused to take a COVID-19 test as well as to quarantine in a hotel.

Both of these regulations were made mandatory for air travellers returning to Canada from outside the country on Feb.1 and Feb. 21, respectively.

In one of the videos, an airport official can be heard telling Faraone that while she's entitled to her opinion, she must respect others by complying with the public health guidelines, to which Faraone replies she's a registered nurse.

"I'm a front-line worker," she can be heard saying. "Actually, I'm considered a hero."

Jessica Faraone is pictured here second from the left in Arusha, Tanzania. She says she

worked at a public hospital there for five weeks and arrived back at Toronto's Pearson airport on Thursday. (GoFundMe)

748

In an emailed statement to CBC News, Faraone said she had gone to Arusha, Tanzania to volunteer as a nurse at a hospital for five weeks.

When she returned on Thursday, she said she refused to comply with the public health guidelines because they are "100 per cent against our Charter of Rights and Freedoms."

She also said when the pandemic began, she decided to work in long-term care homes that were hard hit by the virus. It is not clear whether she will be returning to long-term care homes by her own volition or if she'll even be allowed to.

Anti-masking statements grounds for discipline: CNO

The province's nursing regulatory body, the College of Nurses of Ontario, says it is aware of the videos posted online and according to the conditions outlined on their website, Faraone could face disciplinary action.

When nurses communicate with the public and identify themselves as nurses, they are accountable to the CNO and the public it protects, the regulatory body says. And that applies to public health measures aimed at slowing the spread of COVID-19.

- **Regulator investigating 2 Ont. nurses who travelled to D.C. rally promoting 'COVID fraud' conspiracy**

"Nurses have a professional responsibility to not publicly communicate anti-vaccination, anti-masking and anti-distancing statements that contradict the available scientific evidence. Doing so may result in an investigation by CNO, and disciplinary proceedings when warranted."

On multiple videos in her series, Faraone tagged the Instagram account of Chris Saccoccia, also known as "Chris Sky," an anti-masker who has consistently rallied

Succeeda, also known as "Chris Sky," an anti-masker who has consistently railed against health measures meant to keep people safe during the pandemic. His social media posts are rife with conspiracy theories and misinformation.

749

"I got the courage to stand up for myself by watching Chris Sky stand up for his own rights at the airport. This made me dive deeper into actually learning and studying the Charter of Rights," Faraone said.

RNAO calls behaviour offensive, unprofessional

Doris Grinspun, CEO of the Registered Nurses' Association of Ontario, say Faraone displayed "offensive behaviours that are unprofessional and that contravene public health measures."

"To have this video surfacing on social media at the same time thousands and thousands of RNs, RPNs, NPs and other health professionals are working 24 hours a day, seven days a week protecting Ontarians and trying to save lives is unfathomable," Grinspun said in an emailed statement to CBC News.

Grinspun added that if Faraone is a practising nurse in Ontario, the CNO should deal with this matter "as they are obligated to do."

Having any health professional acting in this way compromises the collective effort to mitigate the damage caused by COVID-19, she said, and she urges the public to continue following public health measures advised by the province.

Violators of Quarantine Act could face $750K fine: PHAC

In a statement, the Public Health Agency of Canada (PHAC) told CBC News it is aware of Faraone's conduct and it is looking into the incident.

Although the PHAC couldn't provide additional details of the case citing privacy concerns, it said travellers are legally obligated to follow the instructions of a

screening officer or quarantine officer on testing and mandatory hotel quarantining

quarantining.

"Violating any instructions provided to you when you entered Canada is an offence under the *Quarantine Act* and could lead to up to six months in prison and/or $750,000 in fines," the agency said.

750

- **Anti-masker broke quarantine to speak at Toronto anti-lockdown protest after travelling to Europe**

"It's a very difficult situation when that happens but I think we have the right people and the right professionals to manage through it accordingly," said Dwayne Macintosh, the director of safety and security for the Greater Toronto Airports Authority, referring to the conduct of Faraone and passengers like her.

"There are rules that we all have to follow and we are following the guidance that is provided to us by the Public Health Agency of Canada."

569 reading now

751

Rose Bustria **752**

Subject: FW: Social Media Posts

From: Jo-Ann Willson <jpwillson@cco.on.ca>
Sent: Friday, March 5, 2021 8:59 PM
To: Rose Bustria <RBustria@cco.on.ca>
Subject: Fwd: Social Media Posts

Exec and Council.

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

College of Chiropractors of Ontario
59 Hayden St., Suite 800
Toronto, ON M4Y 0E7
Tel: (416) 922-6355 ext. 111
Fax: (416) 925-9610
E-mail: jpwillson@cco.on.ca
Web Site: www.cco.on.ca

Begin forwarded message:

> **From:** "Dr.Mizel" <drmizel@stcatharineschiropractic.com>
> **Date:** March 5, 2021 at 7:53:22 PM EST
> **To:** Jo-Ann Willson <jpwillson@cco.on.ca>
> **Cc:** Rob MacKay <mackayrob@tbaytel.net>
> **Subject: Social Media Posts**

FYI

7:44

753

Richard Steinecke · 1st
Counsel at Steinecke Maciura LeBlanc
3h ·

Careful wording of decision reflects the legal and competing public interest complexities of these types of cases.

Steinecke Maciura LeBlanc
85 followers
8h ·

Practitioner cautioned "with respect to a lack of professionalism and failure to exercise caution in her posts on social media, which is irresponsible behaviour ... and presents a possible risk to public health." https://lnkd.in/dxD4MXT #professionalregulation

754

https://www.cbc.ca/news/health/college-cautions-doctor-tweets-1.5936538

Sent from my iPhone

From: Jo-Ann Willson
Sent: Monday, March 8, 2021 11:05 AM
To: Rose Bustria
Subject: FW: Discussion on the value of case reports as clinical evidence
Attachments: 247-Article Text-505-1-10-20200929.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
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

From: Elizabeth Anderson-Peacock <drliz@bellnet.ca>
Sent: Monday, March 8, 2021 11:04 AM
To: Jo-Ann Willson <jpwillson@cco.on.ca>
Subject: Discussion on the value of case reports as clinical evidence

Thought there was interesting perspectives within perhaps for council. Link is to the Chiropractic Journal of Australia.

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THE VALUE OF CASE REPORTS AS CLINICAL EVIDENCE

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ABSTRACT

Objective: To demonstrate that under certain conditions case reports may be considered by chiropractors as high-level clinical evidence.
Methods: To present a narrative of contemporary views of the hierarchical biomedical evidence pyramid and then apply from Western philosophical thinking the qualitative principles of 'aboutness' and 'consilience' to the preparation of a chiropractic case report and demonstrate the manner in which these tools increase the report's evidential value.
Discussion: The common biomedical evidence pyramid is reported by some to be flawed with little application in chiropractic practice; indeed, some health disciplines are forming new evidential hierarchies presenting a need in chiropractic to reconsider the evidential value of case reports. Palmer case reports have been a consistent feature of chiropractic and should now be written in accord with the CARE Guidelines. When written in this manner and interpreted through the philosophical lenses of aboutness and consilience, the significance to clinicians has the potential of being elevated without compromising evidence-based care.
Conclusion: Case reports represent high evidential value for chiropractors. Appropriately utilised, case reports have the potential to improve the methodological design of clinical trials, thereby improving patient care.

Keywords: Case Reports; Evidence-Based; CARE Guidelines; Philosophy; Evidence Pyramid.

INTRODUCTION

The standard pyramid of evidence is hierarchical and ranks case reports and case series as having low if not least evidential value. This paper will show that the evidence pyramid has been reconsidered by other clinical disciplines seeking a greater relevance of evidence to the patient and will propose that within chiropractic the well-written case report can have high evidential value with targeted patient relevance when interpreted through a specific philosophical lens.

We offer two means to achieve this outcome; the first is to ensure that the writing of a case report is strengthened by following the CARE Guidelines, (1) and the second is that the application of the case report at the clinical level is strengthened through the lens of two principles from Western philosophy: aboutness and consilience.

First we give a brief orientation to the status of the hierarchical evidence pyramid in clinical disciplines and show how others have come to modify it to better inform their practice.

The Hierarchical Pyramid of Evidence

Some consider that the hierarchical pyramid is dead (2) for clinical practitioners. It is reported to have unravelled in complicated clinical disciplines such as orthodontics, (3) and its limitations and inapplicability in chiropractic are recognised. (4)

Epidemiologists Walach and Loef (5) found the hierarchical pyramid to be flawed in that '*the implicit assumptions of the hierarchical model are wrong, if generalized to the concept of evidence in total.*' La Caze (6) agrees to a point, responding: '*Therapeutic decisions require a judgment of both efficacy and effectiveness and as such an assessment of evidence in terms of both internal and external validity.*' The arguments resolve as indicating the need for a paradigm shift, where '*the theoretical foundation of "evidence-based" decision making*' is replaced '*with something considerably more complex.*'

The clinician's need

The need for clinicians is to readily access *'guidelines to effective clinical care,'* and the Mayo Clinic has proposed to modify the evidence pyramid (7) by depicting the boundaries between levels of evidence as 'wavy' and using a new lens to view the resultant. On the other hand, nursing (8) has proposed a 'new pyramid' that builds from patient interaction, and osteopaths Figg-Latham and Rajendran (9) have argued that the '*Levels of Evidence Pyramid*' needs a lens they term '*Precedence of Osteopathy*' which does nothing but create an upside-down pyramid where '*expert opinion*' is the highest level of evidence. This position lacks intellectual rigour, as it is a view based upon a small study of English osteopaths who believed that their opinion was the most important evidence.

The discipline of Occupational Therapy has presented what we consider the most credible and comprehensive new pyramid to date, calling it *'A new Evidence-Based Practice Model for Occupational Therapy.*' (10) While addressing the perceived needs of that profession, it is complex and difficult to apply to other clinical disciplines, however it is important to discuss.

The problem

The hierarchical pyramid derives from classical physics and has '*become a habit of thinking to conceptualize everything, all matter, all people, all animals, all molecules, in analogy to billiard balls moving or planets traveling an orbital sphere.*' (11) Clearly, the chiropractic patient is more than an inanimate billiard ball, (12,13) and Rosner (14) acknowledges this complexity by stating that '*clinical judgment and patient values and expectations*' form a tripartite and realistic '*guideline to effective clinical care*'.

The underlying problem with hierarchies lies in their number of interpretations (15) and the differing interpretations (16) that are needed in order to try to make sense for chiropractic of a dated construct developed for hospital-based medicine that has been hijacked (17) for pharmaceutical trials. When all is said and done, pyramids are guides, not rules. (18) Evidence-based medicine (EBM) may best be considered as a movement that emerged in the mid-90s and will continue to evolve to better guide those disciplines that adopt the movement, no matter the way they reconsider their hierarchical pyramids.

THE EVIDENCE LEVEL OF CASE REPORTS

This paper is not the first to question the low assigned-evidential value of chiropractic case reports. With regard to their ranking level, Bolton (19) stated '*we might take issue with* [low ranking] *in that not only are case reports informative, but they are particularly relevant to clinical practice from whence they came.*' (19)

The main argument for this ranking is that case reports lack 'scientific rigour'. We see three reasons why case reports may be classified by some in the field of biomedicine as low ranking:

- *N of 1*: it is accepted that a case report represents a single patient or, when a case series, several. The argument that its outcomes are not applicable fails when it is appreciated that just one case with a negative outcome, such as a vertebrobasilar accident, carries significant weight. It is duplicitous to claim that one report has value when it highlights a negative outcome, and refuse to accept it when one reports a positive outcome.

Further, increasing use is being made of 'N of 1 studies' (19) to uncover subtle results that could be lost in a cohort study, particularly for individualised health issues such as pain, nutrition, and psychology. These are all factors in Waddell's biopsychosocial model of low back pain. (20) The fathers of EBM, Guyatt and Sackett, (21) speak in favour of the power of randomised trials in individualised patients (a sophisticated N of 1 study) to determine optimal therapy;

- *Not controlled*: this view fails for multiple reasons, the most obvious being that clinical care is personalised-care not recipe-care, more so in nursing (22) and chiropractic (23) and increasingly so in medicine (24) where N of 1 reports are valued. Guyatt et al (22) have developed a control protocol for N of 1 reports;

- *Unfiltered*: this argument fails completely due to the rigour of the publication process. The report must first be written which necessitates gathering and reflecting on clinical material and the relevant literature and then submitted to a journal where the editor will initially filter to accept, reject, or modify. The next stage is peer-review, typically a very critical filtering by at least two experienced practitioners with knowledge of the subject matter, followed by a final review by the author and considered-acceptance by the editor.

This paper dismisses these claimed weaknesses and proposes two methods to improve the evidential level of case reports.

ADDRESSING THE PROBLEM

The argument of this paper is that, by broadening the scientific lens to read a case report with philosophical principles, one is able to add rigour and improve the relevance of a published case report to a new clinical situation.

The first method, addressed elsewhere in detail (25,26) by one of us (PE) is to produce a case report in accord with the CARE guidelines. (1) The second is to consume a case report with regard to the Western philosophical principles of 'aboutness' and 'consilience'. We will, through the lens of the Philosophy for Medicine, (27) offer an understanding of the case report as a powerful clinical tool.

1. The CARE Guidelines

The CARE Guidelines now provide the appropriate inclusions for a case report to be acceptable for consideration to publish. These were first published in 2013 (28) as guidelines with the acronym taken from *CAse REport Statement and checklist*. This and related documents are held online for open access. (29) These guidelines are recommended for all chiropractic journals as the preferred format for the submission of case reports for consideration to publish. However, to date the '*reporting quality of case reports in the nursing field apparently has not improved*' since the publication of these guidelines. (30) However, establishing pragmatic evidence-based guidelines that are sensitive to chiropractic populations and settings is important.

The guidelines were elaborated in 2017 (1) and are specifically intended to inform medical education. One of the lead developers of the CARE guidelines, medical researcher and editor Riley, (31) described case reports as '*records written by medical professionals that outline the diagnosis, treatment, and outcomes of the medical problems of patients. They are written in a narrative style and are extremely useful in providing early signals of effectiveness, adverse events, and cost.*'

We offer a final comment that the value of any case report is enhanced with what McAulay calls '*competent referencing*'. (32) His paper is a valuable refresher with important guidance on the use of the literature when preparing a case report, as every report requires a literature review.

2. Philosophical Principles

NOMA has been applied by theologian Chaberek (33) to demonstrate that science and faith can each be held by an individual at the same time as two world-views that sit side-by-side without overlapping to the detriment of either. Whilst primarily a tool to aid an understanding of the science of evolution concurrent with acceptance of the Biblical account of creation, its use in chiropractic is to demonstrate that a conventional chiropractor is perfectly able to practice in an evidence-based manner while including Palmer's concepts of subluxation (34) and, for example, Stephenson's Principles. (35)

The term 'magisteria' primarily applies to the body of teachings of the Catholic church and has the sense that these represent an authority. Chaberek argues that these can be held at the same time as an understanding of the world-view of evolutionary science. Our application to chiropractic holds that our 'magisteria' is the body of authoritative teachings of DD Palmer which we see as conventional chiropractic, and we argue that conventional chiropractors can hold these at the same time as they apply evidence-based practice.

The literature reports surveys of practitioners (36,37) and notably students (38) but less so of some academics (39) as consistently showing acceptance of both conventional chiropractic ideas and the value of evidence in clinical practice.

Noetics

From the Gr *nous*, [mind, intellect] and considered as common sense. It embodies the idea of what is known 'to work' in the real world of clinical practice beyond the strictures of academia. Noetics sits hand-in-hand with phrónēsis (below) to represent what would be most likely done by a peer in any given circumstance.

Noetics excludes the esoteric and the experimental and represents best practice in conventional chiropractic. It also excludes the extreme of 'evidence-only' practice as evident in the Danish thread of chiropractic thought, (40) the so-called evidence-based practice of the extreme left (41,42) of Wardwell's Gaussian representation (43) of chiropractic thought. Excluding this minority allows for a blended practice by the greater majority of conventional chiropractors to include spinal adjusting in accord with established principles of specialised techniques, and adjunctive approaches including exercise and nutrition, informed as needed by evidence.

Phrónēsis

Phrónēsis is a type of wisdom or intelligence best considered as 'practice wisdom'. It derives from heuristics, the act of problem-solving in clinical decision-making. Phrónēsis is informed by

induction (44) as much as deduction and as such has a practical character related to prudence. In terms of practice wisdom, phrónēsis embodies good clinical judgment or 'practice virtue'.

Aboutness

Aboutness is the quality derived from non-exactness and arises from Sober's ideas. (45) Basically if the statement is made '*I will meet you at 3:00 PM*' and that person arrives at 3:01 PM, in quantitative terms they are wrong. However when the given time of 3:00 PM is taken as 'about 3 PM' there is a degree of correctness. In terms of a case report, the practitioner may have a male patient who is 7 years old with otitis media (OM) and reads a report about another practitioner's male patient who is 6 years old. Aboutness lets the practitioner look at these two cases and make a decision whether or not the patient in the case report is 'about' the same as the presenting patient. It may be that the actual age of the reported patient is 6 years 5 months and 30 days, and the practitioner's patient is 6 years 6 months and 1 day; temporarily much closer than the reported, rounded ages may suggest.

The principle of aboutness therefore allows evidence to be drawn from case reports of a patient who is 'about' the same as a particular patient in terms of age, gender, race and other features that may be thought clinically relevant.

Consilience

Consilience is a '*drawing together of things that are about the same*'. (46,47) This requires more than one case report for it to be used as a tool, but using the case above, it allows case reports by different authors of 'about' patients with OM, maybe a different gender, race and certainly age, to be gathered with the intent to find the common thread of clinical intervention that may produce a similar and desired outcome. A 2018 study actually found '*no significant demographic differences in the incidence of children with OM … with respect to sex, race, ethnicity, or insurance status*' (48) and while not reported, the incidence itself did not seem significantly different between genders.

THE APPLICATION OF PHILOSOPHICAL TOOLS

The use of these tools avoids the need for extrapolation from the general to the specific and allows the more clinically relevant application of discovery and implementation of clinical intervention in circumstances similar to those reported and thus most likely to deliver the outcome sought. This is defensible clinical decision-making with a high level of clinical application.

The Confidence Interval in qualitative terms

The confidence interval (CI) is a mainstay in reports of quantitative clinical research. Intimately related to the *p-value* (49) the CI represents a range in which an outcome is expected to fall. The

problem is that the *p-value* is known to be '*an unobjective and inadequate measure of evidence when statistically testing hypotheses.*' (50) The idea is that these numbers given as the CI actually estimate range in which there is a 90 or 95% chance the expected outcome will fall. This means there is a 5 to 10% chance it won't and therefore will be of no use in a particular situation. There is no way to predict where the result of any intervention will fall, which in turn diminishes the applicability of group results to individual patients.

Whereas quantitative research allows for Confidence Intervals to add meaning and relevance to data, qualitative research in the form of case reports applies the two simple tools of 'aboutness' and 'consilience'. These function with noetics and phrónēsis as dependable measures to assess the relevance or otherwise of a particular report or case series.

Case Reports Are Valuable

As clinical evidence

The case report documents a specific sequence of clinical interactions with a single patient that can be extrapolated to a similar case within a general clinical population. This is a significant difference from studies with large cohorts which draw findings from the general with the expectation they are equally applicable to any one patient.

Large cohorts generate data by amalgamating gender, age, race, and sociodemographic factors from which average, mean or median values are statistically derived and a CI created, the quantitative counterpart of qualitative's aboutness and consilience.

While it is true to state that no one case report is directly applicable to one other specific patient, an informed application of philosophical principles allows greater clinical value for extraction of specific clinical guidance from one or more case reports of similar patients.

To inform research

Case reports are defined as '*the scientific documentation of a single clinical observation and have a time-honored and rich tradition in medicine and scientific publication.*' (51) Well-constructed case reports inform formal research inquiry (52) and are in themselves a research method '*that focuses on the contextual analysis of a number of events or conditions and their relationships.*' (53) As such, they are strengthened by being evidence-based. (54)

Apart from identifying new topics to be examined with rigour, case reports provide value by informing what some chiropractic academics crudely call the 'dose/response' relationship. (55,56) When the case report literature is ignored, poor decisions are made with the design of studies. An example is infantile colic where a naive research question would seek to determine whether

chiropractic intervention is better than placebo. A knowledge of the case report literature allows the mature research question to be '*what is the optimal titration of care (patient visit number) for an infant with colic*'?

A research protocol to answer this question must be informed by the literature which reports outcomes for similar conditions most likely published as case reports. Doing so prevents design errors, an example of which is found in a recent proposal (57) for a single-blind randomised controlled trial of care for infantile colic, where the protocol allows for only four visits over two weeks. This protocol is inexplicably weak and fatally flaws the study before it begins. This critical judgment is made on the basis of previously published case reports on the resolution of colic reporting '*6 chiropractic visits over a three week period*', (58) '*8 visits over 4 weeks*', (59) and '*9 visits in a period of 11 months*'. (60) A further case report (61) details the subluxations in one such patient as C1 and Sacrum with a total of 18 visits required to achieve resolution. That report also includes the nature of the intervention as '*infant toggle Headpiece and Logan Basic Protocol*', an example of the specificity of language needed to increase the validity of a chiropractic case report.

Singular case reports thus indicate a range of 6 to 18 visits over a time period ranging from 3 or 4 weeks to 11 months. An argument may arise that natural resolution would be expected within 11 months, therefore the application of 'aboutness' and 'consilience' could suggest an appropriate protocol for investigating infantile colic which allows a period of 3 to 4 weeks with up to 9 interventions. Further, it is known that some cases are secondary to allergies (62), which makes an intake protocol critical to screen out subjects for whom chiropractic manual intervention may not be indicated. A more sophisticated protocol would include all potential subjects and report those entered to the manual care arm, and those managed by non-manual means.

A protocol without screened subjects and specifying 4 interventions over 2 weeks therefore lacks design credibility. Had the information reported above been available in 2000, it could have prevented another (63) flawed (64) study in 2001 of infantile colic.

THE LITERATURE REVIEW

A case report must be anchored in the literature; however, the extent is at the discretion of the author. Some attempt an exhaustive review of the literature and generally fail. Others seem to miss obvious reports previously published, while still others specifically avoid some literature, which is the point made by McAulay about not cherry-picking.

To be considered for publication, a case report today needs a pertinent review of literature, not one that pretends to be exhaustive. There is value in a key-point review of the literature of the presenting condition and of standard approaches with their outcomes and effectiveness or otherwise. It is unlikely for there to be a systematic review or meta-analysis of any specific chiropractic case, but should there be, then it is essential to cite.

Particular value lies in citing other case reports on the same or very similar presentation. After all, the point of publishing is to add to the evidence base that allows consilience through the gathering of 'about' cases. The trick is for the author to tease a particular thread showing a different approach that may have improved patient outcomes.

To this point this paper has presumed a case report is about a patient's clinical presentation, and given the political challenges to the chiropractic profession, there is specific value and merit in documenting the breadth of chiropractic practice, particularly for potentially sensitive areas of practice such as care of the ageing and care of children and infants--even for simple presentations. (65) The point is to put on record the diversity of care provided to the Australian public by conventional chiropractors practicing in a safe and responsible manner.

However, there are other matters relevant to conventional chiropractic practice that are worthy of reporting. These include anatomical discoveries (66) and new clinical tools (67) or protocols, (68) as well as reports that include cross-discipline care, (69) and interesting cases such as those with surprises like transient syncope (70) and a Chance fracture. (71) When clinical outcomes are other than expected, a 'case review' is worthy of consideration. (72)

Given the importance of X-ray to guide safe and effective patient care (73) and the dangers of not imaging a patient where indicated, (74) diagnostic images provide a rich field to report. (75) Australian chiropractors have ready access to a chiropractor who specialises in image reporting (76), and expert comment should be included in the practitioner's report. Where significant, the radiologist may become second author and provide an expanded expert interpretation of the images.

CONCLUSION

Some chiropractic journals no longer consider case reports for publication, perhaps in the belief they are 'low level evidence'. On the other hand, the prestigious medical journal *The Lancet* (77) publishes '*a single interesting case, which should not be a rarity but one that a general physician might encounter, in which there was some difficulty in reaching a diagnosis, and that provides a teaching point.*' Coles at al (78) suggest that the value of a case report lies in a practitioner sharing '*their unravelling of a neurological case*'. Given the intimacy of chiropractic with neurology, there are strong reasons for chiropractors to share their interesting cases using the case report method. And not just rarities, as interesting as rarities may be.

There are peer-reviewed journals designed to significantly advance the case report/series literature as high-value clinical evidence. These include the *International Journal for Practising Chiropractors,* (78) and the *World Journal of Clinical Cases.* (79)

The objective of this paper has been to demonstrate that case reports represent evidential value for chiropractors. Through '*aboutness*' and '*consilience*' they allow a highly relevant care protocol to be developed, considered, and applied for any one patient. Case reports also inform scholarly inquiry and must be used more appropriately by researchers when developing research protocols.

DECLARATIONS

Competing Interests

The authors declare that they have no competing interests.

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REFERENCES

1. Riley DS, Barber MS, Kienle GS, AronsonJK, von Schoen-Angerer T, et al. CARE guidelines for case reports: explanation and elaboration document. J Clin Epidemiol 2017 May 18 pii: S0895-4356(17)30037-9. DOI 10.1016/j.jclinepi.2017.04.026.

2. Tugwell P. Is the 'Evidence-Pyramid' now dead? [Editorial]. J Clin Epi 2015;68(11):1247-50 DOI https://doi.org/10.1016/j.jclinepi.2015.10.001

3. Mulimani PS. Evidence-based practice and the evidence pyramid: A 21st century orthodontic odyssey. Am J Orthod Dentofacial Orthop 2017 Jul;152(1):1-8 DOI 10.1016/ j.ajodo.2017.03.020

4. Amorin-Woods LG. Sophisticated research design in chiropractic and manipulative therapy; what you learn depends on how you ask. Part C: Mixed Methods: "Why can't science and chiropractic just be friends?" [Part 3 of 3]. Chiropr J Aust 2016;44(2):http://www.cjaonline.com.au/ index.php/cja/article/view/70

5. Walach H, Loef M. Using a matrix-analytical approach to synthesizing evidence solved incompatibility problem in the hierarchy of evidence. J Clin Epi 2015;68:1251-60 http://dx.doi.org/ 10.1016/j.jclinepi.2015.03.027

6. La Caze A. The hierarchy of evidence and quantum theory [Variance and Dissent]. J Clin Epi 2016;72:4-6 http://dx.doi.org/10.1016/j.jclinepi.2015.06.014

7. Murad MH, Asi N, Alsawas M, Alahdab F. New evidence pyramid. BMJ Evid Based Med 21(4):125-7 DOI 10.1136/ebmed-2016-110401

8. Thompson CJ. 6SPyramid-7levels Categories, Nursing Education Expert blog May 9 (2017) adapted from (C) DiCenso, Bayley, & Haynes, 2009, accessed 7 Apr 2018 at https:// nursingeducationexpert.com/pre-appraised-evidence/6spyramid-7levelscategories/

9. Figg-Latham J, van Rajendran D. Quiet dissent: The attitudes, beliefs and behaviours of UK osteopaths who reject low back pain guidance. A qualitative study. Musculo Sci Prac 2017;27:95-105 https://doi.org/10.1016/j.math.2016.10.006

10. Tomlin G, Borgetto B. Research Pyramid: A new evidence-based practice model for occupational therapy. Am J Occ Ther 2011;65:189-96 at https://ajot.aota.org/Article.aspx? articleid=1853025

11. Walach H. Old habits die hard - a reply to Adam La Caze. J Clin Epi 2016;72:7-9 http:// dx.doi.org/10.1016/j.jclinepi.2016.01.024

12. McDowall D, Emmanuel E, Grace S. Chsaseling M. Tone as a healthy concept. Complement Ther Clin Pract 2017;29:27-34 https://doi.org/10.1016/j.ctcp.2017.08.001

13. Richards D, Emmanuel E, Grace S. Duelling ontologies: Might vitalism offer balance and value? [Reflection]. Explore 2017;13(2):133-7 http://dx.doi.org/10.1016/j.explore.2016.12.004

14. Rosner AL. Evidence-based medicine: Revisiting the pyramid of priorities. J Bodywork Movement Therapies 2012; 16(1):42-49. doi:10.1016/j.jbmt.2011.05.003

15. Burns PB, Rohrich RJ, Chung KC. The Levels of Evidence and their role in Evidence-Based Medicine. Plast Reconstr Surg 2011;128(1):305-10 DOI 10.1097/PRS.0b013e318219c171

16. Alper BS, Haynes RB. EBHC pyramid 5.0 for accessing preappraised evidence and guidance. BMJ Evid Based Med 2016;21(4) DOI http://dx.doi.org/10.1136/ebmed-2016-110447

17. Bolton J. Evidence-based case reports [Commentary]. J Can Chiropr Assoc 2014;548(1):6-7https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3924510/pdf/jcca_58_1_006.pdf

18. Shaneyfelt T. Pyramids are guides not rules: the evolution of the evidence pyramid [Editorial]. BMJ Evid Based Med 2016;21(4) DOI http://dx.doi.org/10.1136/ebmed-2016-110498

19. Schork NJ, Goetz LH. Single-subject studies in translational nutrition research. Annual Rev Nut 2017;37:395-422 https://www.annualreviews.org/doi/pdf/10.1146/annurev-nutr-071816-064717

20. Waddell G. The biopsychosocial model, In The back pain revolution 2e. Edinburgh: Churchill Livingstone 2004:265-81

21. Guyatt G, Sackett D, Taylor DW, Chong J, Roberts R, at al. Determining optimal therapy--randomized trials in individual patients. N Engl J Med 1986;314(14):889-92 DOI 10.1056/NEJM198604033141406

22. Al-Kaiyat M. Precision Coordination: The growing role of the nurse coordinator in the era of personalized medicine. Clin J Onc Nurs 2018;22(1):113-5 http://dx.doi.org.ezproxy.scu.edu.au/10.1188/18.CJON.113-115

23. Myburgh C, Brandborg-Olsen D, Albert H, Hestbaek L. The Nordic maintenance care program: What is maintenance care? Interview based survey of Danish chiropractors. Chiropr Manual Ther 2013;21:27. http://www.chiromt.com/content/21/1/27

24. Chalmers I, Smeeth L, Goldacre B. Personalised medicine using N-of-1 Trials: Overcoming barriers to delivery [Discussion]. Healthcare 2019;7(4),134 DOI 10.3390/healthcare7040134

25. Ebrall PS, Murakami Y. How to write a well constructed, credible Case Report for Integrative Medicine. Jap J Int Med 2018;11(3):285-91

26. Ebrall PS, Murakami Y. Rigorous case reports in chiropractic: Towards credible evidence. J Jap Soc Chiropr Sci 2019; *in press*

27. Weatherall DJ. Philosophy for medicine [Book Review]. J R Soc Med 2004;97(8):403-5 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1079566/pdf/0970403.pdf

28. Gagnier JJ, Kienle G, Altman DG, Moher D, Sox H, Riley D, CARE Group. The CARE Guidelines: Consensus-based clinical case reporting guideline development. Glob Adv Health Med. 2013;2(5):38-43. DOI 10.7453/gahmj.2013.008. PMID: 2441669

29. CARE Case Report guidelines. About, https://www.care-statement.org/about

30. Yasng KL, Lu CC, Sun Y, Wang B, Shang Y, et al. How about the reporting quality of case reports in nursing field? World J Clin Cases 2019;7(21):3505-3516 DOI 10.12998/wjcc.v7.i21.3505

31. Integrative Therapeutics. Personal insights: Q&A with Dr David Riley, Case reports. Accessed 8 Sep 2018 https://www.integrativepro.com/Resources/Integrative-Blog/2016/Personal-Insights-David-Riley-Case-Reports

32. McAulay BJ. Rigor in the philosophy of chiropractic: Beyond the Dismissivism/Authoritarian polemic. J Chiropr Humit 2005;12:16-32

33. Chaberek M. Aquinas and Evolution. Trinity, BC: Chartwell Press 2017:13

34. Senzon, S.A. The chiropractic vertebral subluxation Part 1: Introduction. J Chiropr Humanit 2018; 25C:10-21 DOI: 10.1016/j.echu.2018.10.002

35. Senzon, S.A. The Chiropractic Vertebral Subluxation Part 4: New perspectives and theorists from 1916 to 1927. J Chiropr Humanit 2018; 25C:52-66 https://doi.org/10.1016/j.echu.2018.05.001

36. Schneider MJ, Evans R, Haas M, Leach M, Hawk C, et al. US chiropractors' attitudes, skills and use of evidence-based practice: A cross-sectional national survey. Chiropr Man Ther 2015;23:16. http://www.chiromt.com/content/23/1/16

7. Bussières AE, Terehost L, Leach M, Stuber K, Evans R, et al. Self-reported attitudes, skills and use of evidence-based practice among Canadian doctors of chiropractic: A national survey. J Can Chiropr Assoc 2015;59(4):332-348.http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4711333/

38. de Luca KE, Gliedt JA, Fernandez M, Kawchuk G, Swain MS.The identity, role, setting , and future of chiropractic practice: A survey of Australian and New Zealand chiropractic students. J Chiropr Educ 2018;32(2):115-25 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6192485/

39. Parkinson J, Lau J, Kalirah S, Gleberzon BJ. Attitudes of clinicians at the Canadian Memorial Chiropractic College towards the chiropractic management of non-musculoskeletal conditions. J Can Chiropr Assoc 2011;55(2):107-19 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3095585/

40. Ebrall P. Murakami Y. A Critical analysis of the Reality Distortion of chiropractic among scientists with constructive criticism of the current debate. J. Phil Princ Prac Chirop 2019;July 11 https://www.vertebralsubluxationresearch.com/2019/07/10/a-critical-analysis-of-the-reality-distortion-of-chiropractic-among-scientists-with-constructive-criticism-of-the-current-debate/

41. Edwards J. What Is the CCE Trying to Pull? [News]. Dynamic Chiropractic October 21 2010;28(22): http://www.dynamicchiropractic.com/mpacms/dc/article.php?id=54917

42. Kent C. A New Direction for the CCE? Dynamic Chiropractic [News]. November 18 2010;28(24): https://www.dynamicchiropractic.com/mpacms/dc/article.php?id=55021

43. Wardwell W. Continuing Problems and Dilemmas, In Chiropractic. History and Evolution of a New Profession. St Louis: Mosby Year Book 1992:257

44. Milton JR. Induction before Hume. Br J Phil Sci 1987;38:49-74 https://academic.oup.com/bjps/article-abstract/38/1/49/1557159?redirectedFrom=fulltext

45. Sober E. Constructive empiricism and the problem of aboutness. Br J Phil Sci 1985:36(1):11-8 http://www.jstor.org/stable/687153

46. Robertson D. The consilience of autonomic neuroscience: can we all work together? Auton Neurosci 2001;17;92(1-2):100 DOI 10.1016/S1566-0702(01)00307-1

47. Peterson A. Consilience, clinical validation, and global disorders of consciousness [Opinion]. Neurosci Consciousness 2016;1-9 DOI 10.1093/nc/niw011

48. Chang JE, Shapiro NL, Battacgaryya N. Do demographic disparities exist in the diagnosis and surgical management of otitis media? Laryngoscope 2018 Dec;128(12):2898-2901 DOI 10.1002/lary.27396

49. Altman DG. How to obtain the P value from a confidence interval. BMJ 2011;343:d2304 DOI https://doi.org/10.1136/bmj.d2304

50. Hubbard R, Lindsay RM. Why p-values are not a useful measure of evidence in statistical

significance testing. Theory Psychology 2008,18.69. DOI 10.1177/0959354307086923 http.// tap.sagepub.com/content/18/1/69

51. Gopikrishna V. A report on case reports. J Conservative Dent 2010;13(4):265-71 DOI 10.4103/0972-0707.73375

52. Nissan T, Wynn R. The clinical case report: a review of its merits and limitations. Research Notes 2014, 7:264 http://www.biomedcentral.com/1756-0500/7/264

53. Sayre JW, Tokelau HZ, Ye F, Mazza J, Yale S. Case reports, case series – From clinical practice to evidence-based medicine in graduate medical education. Cureus 2017;9⊗8):e1546 DOI https://dx.doi.org/10.7759%2Fcureus.1546

54. Guimarães CA. Evidence based case report. Rev Col Bras Cir 2015;42(5):280 DOI 10.1590/0100-69912015005001

55. Passmore SR, Gelley GM, Malone Q, MacNeil BJ. Tactile perception of pressure and volitional thrust intensity modulate spinal manipulation dose characteristics. J Manipulative Physiol Ther 2019;42(5):335-42 https://www.ncbi.nlm.nih.gov/pubmed/31272711

56. Pasquier M, Daneau C, Marchand A-A, Lardon A, Descarreaux M. Spinal manipulation frequency and dosage effects on clinical and physiological outcomes: A scoping review. Chiropr Man Ther 2019;27:23. https://chiromt.biomedcentral.com/articles/10.1186/s12998-019-0244-0

57. Holm LV, Jarbøl DE, Chgristenson HW, Søndergaard J, Hestbæk L. The effect of chiropractic treatment on infantile colic: study protocol for a single-blind randomized controlled trial. Chiropr Man Ther 2018;26:17 DOI 10.1186/s12998-018-0188-9

58. Rollette D. Improvement of infant colic and reflux following chiropractic care: A case report & selective review of the literature. J Paed Mat Fam Health Chiropr 2012;2:143-8 https:// www.vertebralsubluxationresearch.com/2017/09/10/improvement-of-infant-colic-and-reflux-following-chiropractic-care-a-case-report-selective-review-of-the-literature/

59. Castellucci RR. Resolution of colic in an eight week old infant undergoing chiropractic care: A case study. J Paed Mat Fam Health Chiropr 2012;4:109-112 https:// www.vertebralsubluxationresearch.com/2017/09/10/resolution-of-colic-in-an-eight-week-old-infant-undergoing-chiropractic-care-a-case-study/

60. Colman LA, Merced J. Resolution of infantile colic in a three-month-old infant undergoing chiropractic care to reduce subluxation: A case report and selective review of literature. J Paed Mat Fam Health Chiropr 2016;1:22-27 https://www.vertebralsubluxationresearch.com/ 2017/09/10/resolution-of-infantile-colic-in-a-three-month-old-infant-undergoing-chiropractic-care-to-reduce-subluxation-a-case-report-and-selective-review-of-literature/

61. Guliani K, Rubin D. Improvements in developmental delay, colic and GERD in a child undergoing chiropractic care: A case report and review of literature. J Paed Mat Fam Health Chiropr 2012;1:1-4 https://www.vertebralsubluxationresearch.com/2017/09/10/improvements-in-developmental-delay-colic-and-gerd-in-a-child-undergoing-chiropractic-care-a-case-report-and-review-of-literature/

62. Miller J. Evidence-Based Chiropractic Care for Infants: Rationale, Therapies, and Outcomes. Amarillo Tx: Praeclarus Press LLC 2019 https://www.amazon.com/Evidence-Based-Chiropractic-Care-Infants-Rationale/dp/1946665363

63. Olafsdottir E, Forshei S, Fluge G, Markestad T. Randomised controlled trial of infantile colic treated with chiropractic spinal manipulation. Arch Dis Child 2001 Feb;84(2):138-41 DOI 10.1136/ adc.84.2.138 PMCID: PMC1718650

64. Grunnet-Nilsson. Infantile world Federation of Chiropractic. Colic - the evidence base for spinal manipulation. Proceedings, WFC's and FCER's International Conference on Chiropractic Research.Toronto: WFC 2005

65. Ellis WB, Ebrall PS. The resolution of chronic inversion and plantar flexion of the foot: A

pediatric case study. J Chiropr Technique 1991;3:55-9

66. Smoll N, Ebrall P. The piriformis muscle and its relationship to the autonomics of the pelvis: A single bilateral case. Chiropr J Aust 2010;40:86-7

67. De Souza R, Ebrall PS, Kimpton A. Preliminary report: Practice-based measures of wellbeing in a typical Australian chiropractic practice. Chiropr J Aust 2007;37:126-34

68. Ebrall PS, Bales G, Frost B. An improved clinical protocol for ankle cryotherapy. J Manual Med 1992;6:161-5

69. Gimblett PA, Saville J, Ebrall P. A conservative management protocol for calcific tendinitis of the shoulder. J Manipulative Physiol Ther 1999;22:622-7

70. Ebrall PS, Ellis WB. Transient syncope in chiropractic practice: A case series. Chiropr J Aust 2000;30:82-91

71. Plaugher G, Alcantara J, Hart CJ. Management of the patient with a Chance fracture of the lumbar spine and concomitant subluxation [case report]. J Manipulative Physiol Ther 1996;19(8):539-51 https://www.ncbi.nlm.nih.gov/pubmed/8902666

72. Ebrall PS. Residual disability from delayed manipulative treatment for mechanical low-back pain: A case review. Chiropr J Aust 1993;23:54-8

73. Kent C. An Evidence-Informed approach to spinal radiography in vertebral subluxation centered chiropractic practice. A Vert Subluxation Res 2017:142-6

74. Carpani J. Chiropractors should carry out X-rays before treating clients to prevent future deaths [News Report]. The Telegraph 18 November 2019 5:24 PM retrieved from https://www.telegraph.co.uk/news/2019/11/18/chiropractors-should-carry-x-rays-treating-clients-prevent-future/

75. Ebrall PS, Molyneux TP. Rotary subluxation of the atlas: An exploration of the diagnostic potential of the CT scan. Chiropr J Aust 1993;23:42-7

76. Dr Martin D. Timchur. Professional Radiology Outcomes. About, retrieved 20 November 2019 https://proxraymanagement.com/pro_team/dr-martin-d-timchur

77. Coles A, Mukherjee M, Compston A. Case reports in The Lancet [Correspondence]. The Lancet 2003;361(9364):P1230 DOI https://doi.org/10.1016/S0140-6736(03)12946-7

78. International Journal for Practising Chiropractors. Home at 02 December 2019 https://www.ijpconline.org

79. World Journal of Clinical Cases. Home at 02 December 2019 http://www.wjgnet.com/2307-8960/current.htm

Grey Areas ITEM 6.11

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A COMMENTARY ON LEGAL ISSUES AFFECTING PROFESSIONAL REGULATION

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Is Irremediable Becoming the New Ungovernable?

by Natasha Danson
March 2021 - No. 254

A practitioner's past history can have a significant impact on subsequent disciplinary sanctions. Previously, a practitioner with a significant past history was labelled "ungovernable". It appears that term is being replaced with the less loaded term of "irremediable".

In *Hanson v. College of Physicians and Surgeons of Ontario*, 2021 ONSC 513 (CanLII), https://canlii.ca/t/jct84 the practitioner admitted engaging in three types of professional misconduct:

1. Being found guilty of an offence for billing for services unsupported by records;
2. Failing to meet the standards of practice with respect to patient assessment and treatment as well as record keeping, and demonstrating a lack of knowledge and judgment; and
3. Permitting a vaccine to be administered by a staff person and then engaging in a lengthy cover up to mislead the regulator, including by preparing a false record and encouraging a staff person to take responsibility for it.

The discipline panel revoked the practitioner's registration. The Court upheld that outcome despite the fact that the practitioner had, since the alleged conduct, successfully completed a course of clinical remediation and mentorship resulting in a report that the practitioner "was a skilled physician, his charting consistently met the standard of care, he did not expose his patients to danger and did not lack judgment or knowledge." If these were the only facts, a sanction of revocation would be difficult to justify.

However, the practitioner had an extensive prior history going back almost twenty years. The Court summarized the prior history as follows:

> … [the] disciplinary history encompassed two prior Discipline Committee hearings and 11 decisions of the ICRC or Complaints Committee which resulted in the Appellant:
>
> 1. Being suspended from practice in 2001 for six months, reduced by three months upon completion of an ethics course;
> 2. Receiving two reprimands;
> 3. Being cautioned five times;
> 4. Being counseled once;
> 5. Being referred to the Quality Assurance Committee to address clinical issues and poor records;
> 6. Being required to take numerous educational courses concerning clinical issues, record keeping and ethics;
> 7. Undergoing clinical supervision and/or re-assessment of his practice on three separate occasions; and
> 8. Entering into three separate undertakings with the College concerning his practice and health.

The concerns involved numerous examples of unethical conduct, including misleading other health care practitioners and the regulator, clinical concerns, and record keeping lapses.

In addressing the standard of review, the Court applied the case of *Mitelman v. College of Veterinarians of Ontario*, 2020 ONSC 3039 (CanLII),

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https://canlii.ca/t/j883c to conclude that the test was whether the sanction was clearly unfit or contained errors in principle.

The Court held that in finding that the practitioner was irremediable, it was appropriate for the discipline panel to consider his entire disciplinary history. The Court said "when considering penalty, the Committee was entitled to consider the whole of the Appellant's disciplinary record, including conduct which occurred after the conduct that led to the misconduct in issue". The Court said:

> The Committee's decision that the Appellant was irremediable was based on its consideration of the Appellant's lengthy disciplinary record, that he already had several opportunities at rehabilitation, without success and that his improvements were not sustained over time. In reaching that conclusion the Committee considered both the 2018-2019 clinical assessment and the subsequent reassessment. The Committee made no error in principle.

The Court also found that the practitioner's history of mental illness and substance abuse did not establish a basis for a sanction less than revocation:

> While there was evidence before the Committee of the Appellant's diagnosis of substance use and bipolar disorders and that he had been subject to health monitoring since 2019, there was no evidence or submissions made to the Committee that the Appellant's mental health or the treatment of his disorders in any way contributed to the misconduct in issue.
>
> In the absence of such evidence or submissions, the Committee did not err in not considering those issues as mitigating factors. There must be some connection in the evidence between the health issue and the misconduct in question before the matter can be considered in respect of penalty.

In addition, the Court noted that the practitioner's compliance with three previous undertakings did not detract from the finding that he was irremediable. The Court accepted the panel's observation, borrowed from another case, that while the practitioner had "responded to the direction of the College in the sense that he completed the educational courses required of him, attended cautions, and worked under supervision, the Committee finds that they have had little or no impact and that he had made few of the fundamental changes necessary."

The Court concluded that the revocation was proportional both in the sense that it was appropriate for the finding made and in that it was consistent with prior similar cases:

> Given the evidence before the Committee together with its findings, I do not consider the penalty imposed on the Appellant of revocation was disproportionate. The misconduct in question involved clinical matters, record keeping, as well as integrity and dishonesty issues. In light of the serious, repetitive nature of the Appellant's misconduct, the lengthy history of disciplinary matters and the fact that the Appellant had not benefitted from repeated efforts at rehabilitation, the Committee's conclusion that rehabilitation was not a factor supports a penalty of revocation having regard to the principles in play, protection of the public,

> general deterrence and public confidence in the regulation of the profession.
>
> The penalty proposed by the Appellant of a 12-month suspension followed by supervision and reassessment does not meet those principles.
>
> Finally, while no two cases are alike, the penalty of revocation is consistent with the misconduct in the cases of revocation the Committee considered, [*citations omitted*]. Revocation is not limited to matters of incompetence or breach of an undertaking.

This case shows that a finding that a practitioner is irremediable, similar to the more traditional finding that a practitioner is ungovernable, justifies a sanction of revocation.

Council Member Terms as at April 14, 2021 [1]

Name	District	Date First Elected/Appointed	Date Re-elected/ Reappointed	Date of Expiry of Current Term
Elected Members				
Dr. Kyle Grice	4 (Central)	April 2021	NA	April 2022
Dr. Jarrod Goldin	7 (Academic)	April 2021	NA	April 2023
Dr. Colin Goudreau	6 (Western)	April 2020	NA	April 2023 [2]
Dr. Sarah Green	5 (Central West)	April 2020	NA	April 2023
Dr. Paul Groulx	2 (Eastern)	April 2019	NA	April 2022
Dr. Steven Lester	3 (Central East)	April 2019	NA	April 2022
Dr. Dennis Mizel	5 (Central West)	April 2018	April 2021	April 2024
Dr. Angelo Santin	1 (Northern)	April 2021	NA	April 2024
Dr. Julia Viscomi	4 (Central)	April 2021	NA	April 2024
Appointed Members [3]				
Mr. Gagandeep Dhanda	Mississauga	April 9, 2020	April 9, 2021	April 9, 2024
Ms Robyn Gravelle	Burlington	May 16, 2019	May 16, 2020	May 16, 2023
Mr. Rob MacKay	Thunder Bay	November 28, 2018	NA	November 27, 2021
Mr. John Papadakis	Scarborough	June 30, 2019	NA	June 30 2022
Mr. Shawn Southern	Union	October 8, 2020	NA	October 8, 2021
Ms Anuli Ausbeth-Ajagu	Richmond Hill	December 10, 2020	NA	December 9, 2021
Mr. Markus de Domenico	Toronto	December 10, 2020	NA	December 9, 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.