COLLEGE OF CHIROPRACTORS OF ONTARIO

ELECTRONIC PUBLIC INFORMATION PACKAGE FOR COUNCIL MEETING

WEDNESDAY, JUNE 16, 2021 – 8:30 A.M.

MAIN

RHPA

Duties and Objects of Colleges

Duty of College

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

Objects of College

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

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

Duty

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

Version date: October 12, 2017

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

MISSION

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

VISION

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

VALUES

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

STRATEGIC OBJECTIVES

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

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

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

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

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

Developed at the strategic planning session: September 2017

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

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

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

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

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

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

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

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

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

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

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

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

[1] There is a general assumption of real or perceived conflict unless confirmation of no conflict by the Executive Committee and/or Council, which will be addressed promptly.
[2] This section does not preclude the use of professional biographies for professional involvement.

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

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

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

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

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

Potential Breaches of the Code of Conduct

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

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

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

Signature: _____ Witness: _____

Date: _____

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

Rules of Order of the Council of the College of Chiropractors of Ontario

Approved by Council: September 20, 2014
Amended: June 17, 2020

1. In this Schedule, "Council Member" means a Member of the Council of the CCO.

2. Each agenda topic may be introduced briefly by the person or committee representative raising it. Council Members may ask questions for clarification. However, a Council Member shall make a motion and another Council Member shall second the motion before it can be debated.

3. When any Council Member wishes to speak, they shall so indicate by raising their hand. When speaking the Council Member shall address the presiding officer and confine themselves to the matter under discussion.

4. Staff persons and consultants with expertise in a matter may be permitted by the presiding officer to provide information or answer specific questions about the matter.

5. Observers at a Council meeting shall not speak to a matter that is under debate.

6. A Council Member shall not speak again on the debate of a matter until every other Council Member of Council who wishes to speak to it has been given an opportunity to do so. An exception is that the person introducing the matter or a staff person or consultant may answer questions about the matter. Council Members shall not speak to a matter more than twice without the permission of the presiding officer.

7. No Council Member may speak longer than five minutes upon any motion except with the permission of the Council.

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

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

10. When it appears to the presiding officer that the debate on a matter has concluded, that Council has passed a motion to vote on the motion or that the time allocated to the debate of the matter has concluded, the presiding officer shall put the motion to a vote.

11. When a matter is being voted on, no Council Member shall enter or leave the Council room, and no further debate is permitted.

12. No Council Member shall be present in the room, participate in a debate or vote upon any motion in which they have a conflict of interest, and the vote of any Council Member so interested shall be disallowed.

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

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

15. The presiding officer shall preserve order and decorum, and shall decide questions of order, subject to an appeal to the Council without debate.

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

17. Council Members shall not discuss a matter with observers while it is being debated.

18. Council Members shall turn off their electronic devices during Council meetings and, except during a break in the meeting, shall not use their electronic devices. Computers shall only be used during Council meetings to review materials related to the matter under debate (e.g., electronic copies of background documents) and to make personal notes of the debate. The presiding officer may make reasonable exceptions (e.g., if a Council Member is awaiting an important message on an urgent matter).

19. Council Members shall be silent while others are speaking.

20. In all cases not provided for in these rules or the by-laws, the current edition of Robert's Rules of Order shall be followed so far as they may be applicable and consistent with these rules.

List of Commonly Used Acronyms at CCO

as at June 10, 2021

Acronym	Full Name
ACE	Accessing Centre for Expertise, Institute of Health Policy, Management and Evaluation, Dalla Lana School of Public Health, University of Toronto
ADR	Alternative Dispute Resolution
AFC	Alliance For Chiropractic (formerly CAC)
CCBC	College of Chiropractors of British Columbia
BDC	Board of Directors of Chiropractic
CCA	Canadian Chiropractic Association
CCEB	Canadian Chiropractic Examining Board
CCEC	Council on Chiropractic Education (Canada)
SCERP	Specified Continuing Education or Remediation Program
CCGI	Canadian Chiropractic Guideline Initiative
CCO	College of Chiropractors of Ontario
CCPA	Canadian Chiropractic Protective Association
CCRF	Canadian Chiropractic Research Foundation
Chiropractic Act	*Chiropractic Act, 1991*
CMCC	Canadian Memorial Chiropractic College
CNO	College of Nurses of Ontario
Code	*Health Professions Procedural Code, Schedule 2 to the RHPA*
CONO	College of Naturopaths of Ontario
CPGs	Clinical Practice Guidelines
CPMF	College Performance Measurement Framework
CPSO	College of Physicians and Surgeons of Ontario
CRC	Chiropractic Review Committee
D'Youville	D'Youville College – Chiropractic Program
DAC	Designated Assessment Centre
FCC	Federation of Canadian Chiropractic
FCCOS(C)	Fellow of the College of Chiropractic Orthopaedic Specialists (Canada)
FCCR(C)	Fellow of the Chiropractic College of Radiologists (Canada)
FCCPOR(C)	Fellow of the Canadian Chiropractic College of Physical and Occupational Rehabilitation (Canada)
FCCS(C)	Fellow of the College of Chiropractic Sciences (Canada)
FRCCSS(C)	Fellow of the Royal College of Chiropractic Sports Sciences (Canada)
FCLB	Federation of Chiropractic Licensing Boards
HARP	*Healing Arts Radiation Protection Act*
HIA	*Health Insurance Act*
HPARB	Health Professions Appeal and Review Board
HPRAC	Health Professions Regulatory Advisory Council
HPRO	Health Profession Regulators of Ontario
ICRC	Inquiries, Complaints and Reports Committee
LSO	Law Society of Ontario
MESPO	Model for the Evaluation of Scopes of Practice in Ontario
MOHLTC	Ministry of Health and Long-Term Care
MTCU	Ministry of Training, Colleges and Universities
NBCE	National Board of Chiropractic Examiners
NHSU	National University of Health Sciences – Chiropractic Program
NYCC	New York Chiropractic College
OCA	Ontario Chiropractic Association
OCRWG	Ontario Chiropractic Reform Working Group
ODP	Office Development Project
OFC	Office of the Fairness Commissioner
OHIP	Ontario Health Insurance Plan
OHPR	Ontario Health Professions Regulators

Acronym	Full Name
OHR	OntarioHealthRegulators.ca (HPRO's public-focused website)
OHRC	Ontario Human Rights Commission
PHIPA	*Personal Health Information Protection Act*
PPA	*Protecting Patients Act, 2017*
PIPEDA	*Personal Information and Protection of Electronic Documents Act*
PSA	Professional Standards Authority for Health and Social Care (U.K.)
RFP	Request for Proposal
RHPA	*Regulated Health Professions Act, 1991*
SCERP	Specified Continuing Education or Remediation Program
SOAR	Society of Ontario Adjudicators and Regulators
SPPA	*Statutory Powers Procedural Act*
SWOT	Strengths, Weaknesses, Opportunities, Threats
TCL	Terms, Conditions and Limitations
UOIT	University of Ontario Institute of Technology
UQTR	Université du Québec à Trois-Rivières
WHO	World Health Organization
WSIB	Workplace Safety and Insurance Board

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

COUNCIL MEETING

Wednesday, June 16, 2021 ***(8:30 a.m. – 1:00 p.m.)*** [1]

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

Invited Guests

Beaconsfield

Attendees

Council members

Ms Jo-Ann Willson, Registrar and General Counsel
Mr. Joel Friedman, Director of Policy and Research
Ms Beth Ann Kenny, Recording Secretary

AGENDA (Public) [2][3]

Page No.	ITEM	Action Required	Action By	Priority Level [4]
	CALL TO ORDER AND WELCOME [5]		MacKay	***High***
	1. Consent Agenda	Approve	Council	***High***
10	1.1 Discipline Committee Report [6]			
11	1.1.1 *CCO v Dr. Gregory Nesterenko* (June 3, 2021)			
26	1.1.2 *CCO v Dr. Shawn Rossi* (June 3, 2021)			

[1] Subject to Council's direction.
[2] The main agenda includes only those matters requiring action by Council including high priority matters relating directly to CCO's public interest role and mandate. Background information for review and information is included in the Compendium Volume.
[3] If you would require the complete background documentation relating to any item on the agenda for CCO council or committee work, please speak to Mr. MacKay, President and Ms Willson (information may be subject to confidentiality provisions).
[4] Subject to Council's direction.
[5] All council members to be familiar with and comply with rules of order. If required, Mr. MacKay will be parliamentarian.
[6] Decisions received since last Council meeting are included in the council information package.

Page No.	ITEM	Action Required	Action By	Priority Level [4]
43	1.2 Fitness to Practise Committee Report			
44	1.3 Inquiries, Complaints, and Reports Committee (ICRC) Report			
45	1.3.1 HPARB decision - *Ryan Armstrong and Eve Choe* (May 12, 2021)			
58	1.4 Patient Relations Committee Report			
59	1.5 Quality Assurance Committee Report			
60	1.6 Registration Committee Report			
62	1.6.1 Extract from OFC newsletter May 2021 with CCO identified best practice			
68	1.6.2 Memo dated May 26, 2021 from OFC re: New Compliance analyst and Change of Portfolio Assignments			
72	1.6.3 Bulletins from CCEB re: Component C examinations [7]			
80	1.7 Advertising Committee Report			
	2. Main Agenda	Adopt	Council	***High***
	2.1 Conflict of Interest	Review/ Declare any real or perceived conflicts of interest as agenda item reached [8]	Council	***High***
	3. Adoption of Minutes [9]	Approve	Council	***High***

[7] CCO continues to process provisional certificates of registration in accordance with P-058: Provisional Certificates.
[8] Standing conflicts of interest do not need to be declared at every meeting.
[9] Only members present at the meeting should approve the minutes.

Page No.	ITEM	Action Required	Action By	Priority Level [4]
	4. Committee Reports			
103	4.1 Executive Committee Report	Report/ Approve Recom-menda-tions	MacKay/ Council	***High***
	Move in Camera [10]	Review Document s	Council	***High***
	Move Out of Camera and Ratify Decisions			
	Ministry of Health			
	College Performance Measurement Framework (CPMF) [11]	Verbal Report/ Review	Willson/ Friedman/ Council	***High***
298	4.1.13 Correspondence to Ms Henry from Ms Willson dated March 31, 2021	FYI		
301	4.1.14 Draft CPMF Action Plan dated May 3, 2021[12]	Provide feedback	Council	***High***
	Existing Documents to Facilitate CPMF Action Plan	Review existing document s and process and revise if required to impleme nt CPMF	Council	***High***
	Re: Knowledge/Skills/ Competencies			
	Candidacy for Election to Council			

[10] In accordance with Ss. 7(2) of the Code, Council *may* go in camera to discuss items identified in Ss. 7 (2) of the *Code*, traditionally financial matters, property acquisitions, lawsuits, government relations, and advice from lawyers.

[11] CCO's CPMF Report was submitted on March 31, 2021, and is available on CCO's website at https://cco.on.ca/wp-content/uploads/2021/03/CPMF-Reporting-Tool_March312021.pdf

[12] Approved by the Executive Committee May 14, 2021.

Page No.	ITEM	Action Required	Action By	Priority Level [4]
310	4.1.15 Undertaking/nomination documents			
	Other Ministry Matters [13]			
424	4.1.25 Communication dated May 20, 2021 from Sean Court re: Healing Arts Radiation Protection Act	Verbal Report (time permitting)	Friedman	Low
427	4.1.26 Correspondence dated June 8, 2021 to Robert Francis			
429	4.1.27 Correspondence dated June 8, 2021 re: governance reform			
430	4.1.28 Reappointment of Mr. Gagandeep Dhanda	Welcome back!		
	Chiropractic and Immunity (public interest lens) – Institute of Health Policy, Management and Evaluation, University of Toronto, Accessing Centre for Expertise (ACE)	Verbal Report	MacKay/ Papadakis/ Willson	Medium
	Information re: ACE included in Public Information Packages			
432	4.1.29 November 26, 2020 Council Meeting (Proposal dated October 2020)			
444	4.1.30 February 26, 2021 Council Meeting (Evaluation of Evidence Methods memo)			
451	4.1.31 April 14, 2021 Council Meeting (communication to stakeholders)			
516	4.1.35 Information re: ACE			
528	4.1.36 Academic CV for Dr. Mark Dobrow			
	Other Chiropractic/Health Related Stakeholders- Environmental Scan	Verbal Report/ Primarily FYI	MacKay	
	Federation of Canadian Chiropractic (FCC)			
557	4.1.39 Announcement from Manitoba			

[13] CCO is posting information on the website as it is received from government including Public Health Units.

Page No.	ITEM	Action Required	Action By	Priority Level [4]
	Chiropractors Association dated April 28, 2021 re: Resignation of President			
558	4.1.40 Information re: British Columbia general meeting re: Xray policy [14]			
	Four Directions Chiropractic College			
565	4.1.41 Correspondence dated May 5, 2021, to Mr. MacKay from Dr. Amlinger			
	Canadian Chiropractic Association			
594	4.1.43 News dated May 12, 2021 "CCA researching member attitudes about diversity, equity and inclusion			
	Canadian Chiropractic Research Foundation			
597	4.1.44 Information re: AGM June 10, 2021			
	Federation of Chiropractic Licensing Boards (FCLB)			
603	4.1.45 Information re: Meetings May 1, 2021			
618	4.1.46 *Texas Board of Chiropractic Examiners et al v Texas Medical Association, September 16, 2020* (Supreme Court of Texas)			
	5. New Business	TBD		
	DATE AND TIME OF MEETINGS [15]			
	ADJOURNMENT			

[14] Information to be reviewed by Quality Assurance Committee as part of its annual review of standards, policies, and guidelines.

[15] Please mark your calendar and advise Rose Bustria ASAP if you are unable to attend any meetings.

All Executive Committee and Council meetings are virtual and are scheduled from ***8:30 a.m. – 1:00 p.m.*** unless otherwise noted (no in person meetings until it is safe to do so).

Executive Committee Meeting Dates to December 2021

Year	Date	Time	Event	Location
2021	Friday, August 13	8:30 a.m. – 1:00 p.m.	Meeting	Virtual
	Friday, October 22	8:30 a.m. – 1:00 p.m.	Meeting	TBD

Council Meeting Dates to December 2021

Year	Date	Time	Event	Location
2021	Friday, September 10	12:00 noon – 4:30 p.m.	Council Meeting	Virtual
	Saturday, September 11	8:30 a.m. – 4:30 p.m.	Strategic Planning/Topic Specific Meeting	TBD (tentative)
	Sunday, September 12	8:30 a.m. – 12:00 noon	Strategic Planning/Topic Specific Meeting	TBD (tentative)
	Thursday, November 25	8:30 a.m. – 4:30 p.m.	Council Meeting (budget)	TBD
	Friday, November 26	8:30 a.m. – 12:00 noon	Council Training	TBD (tentative)
	Friday, November 26	6:00 p.m. – 9:00 p.m.	Holiday Party	TBD (tentative)

College of Chiropractors of Ontario
Discipline Committee Report to Council
June 16, 2021

10

Committee Members:	Mr. Robert MacKay, *Chair* Dr. Steven Lester Dr. Dennis Mizel Mr. John Southern Dr. Daniela Arciero, *non-Council member* Dr. Murray Townsend, *non-Council member* Dr. Matt Tribe, *non-Council member*
Staff Support:	Ms Jo-Ann Willson, *Registrar and General Counsel*

Committee Mandate

- To adjudicate specified allegations of professional misconduct or incompetence referred to the committee by the Inquiries, Complaints and Reports Committee.
- To review applications for reinstatement following a discipline hearing.

Report

Since the last report to Council, there have been no meetings of the committee. However there have been two hearings as follows:

- Dr. Gregory Nesterenko – May 27, 2021
- Dr. Shawn Rossi – May 27, 2021

Decisions of these matters are attached.

There are three hearings that are scheduled.

- Dr. John Clark – June 24, 2021 – 9:30 a.m.
- Dr. William McLeod – July 7, 2021 – 9:30 a.m.
- Dr. Joshua Binstock – July 7, 2021 – 1 p.m.

The Health Profession Regulators of Ontario (HPRO) is holding its next Discipline Orientation on October 1, 2021 (Basic) and October 7, 2021 (Advanced). Just a reminder that according to our bylaws, every member of Council is a member of the Discipline Committee and as such may be called upon to serve on an upcoming panel. Therefore, if any Council members are interested in the above training in order to enhance the skills which would better enable them to serve, please contact Ms Rose Bustria. The training is offered three times per year.

The Chair would like to thank the members of the discipline committee for their time and commitment. Also, thanks and much appreciation goes to all the members of Council who have given their time and expertise to serve on a panel or panels.

ITEM 1.1.1

Received by E-mail - Jun 3, 2021

11

DISCIPLINE COMMITTEE OF THE COLLEGE OF CHIROPRACTORS OF ONTARIO

PANEL:	Mr. Robert MacKay (Chair)	Public Member
	Ms. Robyn Gravelle	Public Member
	Dr. Steven Lester	Professional Member
	Dr. Murray Townsend	Professional Member
	Ms. Matthew Tribe	Professional Member

BETWEEN:	)	Appearances:[1]
COLLEGE OF CHIROPRACTORS OF ONTARIO	)	Mr. Chris Paliare and Ms. Karen Jones for the College of Chiropractors of Ontario
- and -	)	
DR. GREGORY NESTERENKO (Registration #4138)	)	Ms. Valerie Wise for Dr. Nesterenko
	)	Heard: May 27, 2021

DECISION AND REASONS

[1] Also in attendance at the hearing were: Mr. Colin Stevenson, Independent Legal Counsel to the Panel; Ms. Jo-Ann Willson, Registrar and General Counsel CCO; and Ms. Sheila Finlay, Court Reporter.

DECISION AND REASONS

Introduction

This was a hearing before a panel of the Discipline Committee (the "Panel") of the College of Chiropractors of Ontario (the "College") held on May 27, 2021 (the "Hearing"). The College has a mandate to regulate the practice of the chiropractic profession and to govern its members and, in so doing, serve and protect the public interest.

The Hearing was held virtually using video conferencing with the consent of the parties to comply with Provincial physical distancing recommendations.

The Allegations

The allegations against Dr. Gregory Nesterenko (the "Member") were set out in the Notice of Hearing, dated July 15, 2020. The Notice of Hearing was entered as Exhibit 1 at the Hearing and the allegations contained in the Notice of Hearing are attached as Appendix "A" of the Decision and Reasons of the Panel.

Mr. Paliare on behalf of the College stated that discussions with the Member had resulted in a Resolution Agreement. The College and the Member would therefore be jointly presenting an Agreed Statement of Facts and, if that were accepted by the Panel, a Joint Submission as to Penalty and Costs would then be made.

Agreed Statement of Facts

The Agreed Statement of Facts[2] which had been signed by the parties was entered as Exhibit 2. During the course of the submissions that followed, Mr. Paliare reviewed the Agreed Statement of Facts in its entirety. The Agreed Statement of Facts, Exhibit 2, provided as follows:

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[2] The evening before the Hearing, Exhibits 2 and 3 were delivered to the Panel members in the interests of hearing economy and on consent of the parties.

Background

1. Dr. Gregory Nesterenko ("Member") became a member of the College of Chiropractors of Ontario ("CCO") in 2001. He has no prior discipline history with the CCO.

2. At the relevant time, the Member practiced chiropractic in North Bay, Ontario.

Patient A.

3. Had the Member testified, he would have said that, during the period April – October 2010, he provided chiropractic treatment to a patient known as "Patient A." He also would have said that he did not treat Patient A. after October 2010, and that he began having a sexual relationship with Patient A. in the summer of 2011.

4. The Member has maintained a financial record for the treatments he provided to Patient A. and they reflect treatment during the period April – October 2010. By the time the CCO began to investigate the matter in 2019, the Member no longer had the patient record for Patient A.

Legislation and CCO Standards

5. Sexual abuse of a patient, which is prohibited by Health Professions Procedural Code ("Code") was defined in subsection 1.(3) of the Code during the relevant time as follows:

> 1.(3) In this Code, "sexual abuse" of a patient by a member means:
>
> a) sexual intercourse or other forms of physical sexual relations between the member and the patient;

b) touching, of a sexual nature, of the patient by the member; or

c) behaviour or remarks of a sexual nature by the member towards the patient.

6. At the relevant time, CCO Standard of Practice S-014 Prohibition of a Sexual Relationship with a Patient prohibited a member from having sexual relations with a patient. There was a minimum recommended waiting period of one year following the termination of the professional relationship with a patient before beginning a sexual relationship. If a chiropractor wanted to have a sexual relationship with a patient, the chiropractor was required to terminate the care of the patient, provide a referral to another chiropractor, and document these actions on the patient's health record. Chiropractors were required to advise patients of the legal restrictions and prohibitions against having a concurrent professional and sexual relationship with a patient.

7. Although it does not have retroactive application to this case, in 2013, the Code was amended to define "patient" for the purposes of the definition of sexual abuse:

1.(6) For the purpose of subsections (3) and (5) of the Code,

"patient", without restricting the ordinary meaning of the term, includes,

a) an individual who was a member's patient within one year or such longer period of time as may be prescribed from the date on which the individual ceased to be the member's patient; and

b) an individual who is determined to be a patient in accordance with the criteria in any regulations made under clause 43(1)(o) of the *Regulated Health Professions Act, 1991*.

8. Although it does not have retroactive application to this case, the CCO's Standard of Practice S-014 Prohibition of a Sexual Relationship was subsequently revised, and currently states that a concurrent sexual and doctor/patient relationship is strictly against the law regardless of which relationship was established first, that the definition of patient includes an individual who was a member's patient within one year, and that the prohibition includes providing patient care to a spouse, partner or anyone with whom the member has a sexual relationship.

Admissions

9. Had the Member testified, he would have admitted that he did not terminate the care of Patient A. after October 2010, refer her to another chiropractor, or document such actions in her health record. He also did not advise Patient A. of the legal restrictions and prohibitions about having a sexual relationship with a patient.

10. Further, had the Member testified, he would have admitted that he did not wait a year after he treated Patient A. before beginning his sexual relationship with her.

11. The Member acknowledges that, pursuant to the Code and CCO Standard of Practice S-014, chiropractors are prohibited from having concurrent professional and sexual relationships with patients.

12. The Member admits that he committed acts of professional misconduct, and in particular he:

    a. contravened a standard of practice of the profession or failed to maintain the standard of practice of the profession with respect to his treatment and documentation regarding Patient A. as described in allegation 2 of the Notice of Hearing; and

    b. engaged in conduct or performed an act or acts, that, having regard to all the circumstances, would reasonably be regarded by members as unprofessional with respect to his treatment and documentation regarding Patient A. as described in allegation 3 of the Notice of Hearing.

Other

13. The CCO withdraws allegation 1. It also withdraws the particulars in allegations 2 and 3 related to the Member's assessment and conduct towards Patient A.

14. The CCO agrees, with respect to allegation 3, that the Member's conduct was unprofessional.

15. The Member acknowledges that he received advice from his counsel, Valerie Wise prior to entering into this Resolution Agreement. The Member agrees that he is entering into this Resolution Agreement and signing the Agreed Statement of Facts freely and voluntarily.

Member's Plea

The Member admitted the remaining Allegations, as amended, contained in the Notice of Hearing (Exhibit 1) namely allegations 2 and 3. A plea inquiry was conducted by the

Panel Chair. At the conclusion of that process, the Panel was satisfied that the admissions of professional misconduct by the Member were voluntary, informed, and unequivocal.

Decision

The Panel heard submissions by Mr. Paliare on behalf of the College, and Ms. Wise on behalf of the Member with respect to the Agreed Statement of Facts. During the course of those submissions the parties highlighted the admitted facts and invited the Panel to make findings against the Member. In addition, the Panel sought and obtained advice from its independent legal counsel, who reminded the Panel that only the Agreed Statement of Facts could form the basis for their findings at this hearing.

After deliberation, the Panel was satisfied that the admissions of professional misconduct made by the Member were supported by the agreed-upon facts contained in the Agreed Statement of Facts.

Consequently, we made findings of professional misconduct against Dr. Gregory Nesterenko in relation to the admitted allegations set out in the Notice of Hearing (Exhibit 1). In particular, the Panel found that the Member has:

i. contravened a standard of practice of the profession or failed to maintain the standard of practice of the profession with respect to his treatment and documentation regarding Patient A. during the period December 2010-2014; and

ii. engaged in conduct or performed an act or acts, that, having regard to all the circumstances, would reasonably be regarded by members as unprofessional with respect to his treatment and documentation regarding Patient A. during the period December 2010-2014.

In reaching its decision the Panel reminded itself of s. 49 of the *Health Professions Procedural Code* and therefore relied exclusively on the evidence presented at the hearing as contained in the Agreed Statement of Facts (Exhibit 2). The Panel found the facts contained in it provided a sufficient foundation for the findings of professional misconduct.

Penalty and Costs

Counsel for the College advised the Panel that a Joint Submission as to Penalty and Costs had been agreed upon. The Joint Submission was entered as Exhibit 3. Mr. Paliare and Ms. Wise made submissions in support of the Joint Submission. In addition, the Panel sought and obtained advice from its independent legal counsel concerning the approach that discipline panels should take when joint submissions are placed before them.

The Joint Submission invited the Panel to make an order regarding penalty:

1. Requiring the Member to appear before the panel to be reprimanded.

2. Directing the Registrar and General Counsel ("Registrar") to suspend the Member's certificate of registration for a period of three months ("Suspension"), with the Suspension to take effect on June 14, 2021.

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

    a. By August 14, 2021, the Member must:

        i. review, and undertake in writing to comply with, all CCO regulations, standards of practice, policies and guidelines, including but not limited to CCO Standard of Practice S-014 Prohibition of a Sexual Relationship with

a Patient and CCO Standard of Practice S-002: Record Keeping;

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

iii. successfully complete, at his own expense, a course or courses in professional boundaries approved in advance by the Registrar.

b. Requiring the Member to be peer assessed at his own expense within six months of returning to practice after the lifting of the Suspension.

4. Directing the Registrar to suspend one month of the Suspension if the Member satisfactorily completes the Conditions set out in Paragraph 3a. by August 14, 2021.

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

The College and the Member also requested that the Panel make the following order regarding costs:

1. Requiring the Member to pay $15,000.00 to the CCO to partially pay for its costs of the investigation, and the costs and expenses of the hearing and of legal counsel, as follows:
   a. $7,500.00 to be paid by June 10, 2021; and
   b. $7,500.00 to be paid by December 31, 2021, with the Member to

provide post-dated cheques for the amount by June 10, 2021.

The Joint Submission as to Penalty, which was signed by Dr. Nesterenko, also contained the following:

> Dr. Nesterenko acknowledges that he received advice from his counsel, Valerie Wise, prior to entering into this Resolution Agreement, and affirms that he is signing the Joint Submission on Penalty and on Costs freely and voluntarily.

Penalty Decision and Reasons

The Panel was of the view that the parties had come to a fair and equitable resolution, having carefully balanced the issues of protection of the public interest and remediation of the Member and his practice. Mr. Paliare stated that by agreeing to the facts the Member has accepted responsibility for his actions. Dr. Nesterenko has thereby reduced the delay and expense that would have been incurred in resolving the allegations at a contested hearing.

The Panel therefore made an order:

1. Requiring the Member to appear before the panel to be reprimanded.

2. Directing the Registrar and General Counsel ("Registrar") to suspend the Member's certificate of registration for a period of three months ("Suspension"), with the Suspension to take effect on June 14, 2021.

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

    a. By August 14, 2021, the Member must:

i. review, and undertake in writing to comply with, all CCO regulations, standards of practice, policies and guidelines, including but not limited to CCO Standard of Practice S-014 Prohibition of a Sexual Relationship with a Patient and CCO Standard of Practice S-002: Record Keeping;

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

iii. successfully complete, at his own expense, a course or courses in professional boundaries approved in advance by the Registrar.

b. Requiring the Member to be peer assessed at his own expense within six months of returning to practice after the lifting of the Suspension.

4. Directing the Registrar to suspend one month of the Suspension if the Member satisfactorily completes the Conditions set out in Paragraph 3a. by August 14, 2021.

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

6. Requiring the Member to pay $15,000.00 to the CCO to partially pay for its costs of the investigation, and the costs and expenses of the hearing and of legal counsel, as follows:
   a. $7,500.00 to be paid by June 10, 2021; and

b. $7,500.00 to be paid by December 31, 2021, with the Member to provide post-dated cheques for the amount by June 10, 2021.

Administration of Reprimand

It was noted on the record that the Joint Submission on Penalty (Exhibit 3) contained an Undertaking[3] marked as Exhibit "A", that among other things expressly waived the right of the Member to appeal[4] any decision by the Discipline Committee in relation to the July 15, 2020 Notice of Hearing, (Exhibit 1). Further, the Panel confirmed that the Member was prepared for the oral reprimand to be administered immediately following the Hearing. Consistent with the necessity to conduct the Hearing via videoconference the Panel administered the oral reprimand in the same manner at the conclusion of the Hearing.

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

Mr. Robert MacKay, Chair

Date: June 3, 2021

Panel Members:

Ms. Robyn Gravelle
Dr. Steven Lester
Mr. Robert MacKay
Dr. Murray Townsend
Dr. Matthew Tribe

[3] Appendix "B" of this Decision and Reasons.
[4] Paragraph 4 Appendix "B"

Appendix "A"

Allegations contained in the Notice of Hearing, Regarding Dr. Gregory Nesterenko (Exhibit 1)

TAKE NOTICE THAT IT IS ALLEGED THAT:

1. You have committed an act of professional misconduct as provided by subsection 51(1)(b.1) of the Health Professions Procedural Code of the *Chiropractic Act, 1991*, S.O. 1991, c. 21, as amended, in that during the period December 2010 - 2014, while practicing as a chiropractor in North Bay, Ontario, on one or more occasions you sexually abused a patient known as "Patient A."

2. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the Health Professions Procedural Code of the *Chiropractic Act*, 1991, S.O. 1991, c. 21, as amended, and paragraph 1(2) of *Ontario Regulation 852/93*, in that on one or more occasions, while practicing as a chiropractor in North Bay, Ontario, you contravened a standard of practice of the profession or failed to maintain the standard of practice expected of members of the profession with respect to your assessment and/or treatment and/or documentation and/or conduct towards a patient known as "Patient A." during the period December 2010 – 2014.

3. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the Health Professions Procedural Code of the *Chiropractic Act*, 1991, S.O. 1991, c. 21, as amended, and paragraph 1(33) of *Ontario Regulation 852/93*, in that on one or more occasions while practicing as a chiropractor in North Bay, Ontario, you engaged in conduct or performed an act, that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional with respect to your assessment and/or treatment and/or documentation and/or conduct towards a patient known as "Patient A." during the period December 2010 – 2014.

Appendix "B"

UNDERTAKING
Exhibit "A"

To: The Registrar and General Counsel ("Registrar")
of the College of Chiropractors of Ontario ("CCO")

I, Dr. Gregory Nesterenko, undertake to the Registrar and agree to do the following:

1. On or before August 14, 2021, I will:

    a. review, and undertake in writing to comply with, all CCO regulations, standards of practice, policies and guidelines, including but not limited to: CCO Standard of Practice S-014 Prohibition of a Sexual Relationship with a Patient and CCO Standard of Practice S-002: Record Keeping; and

    b. provide written evidence to the Registrar that I have successfully completed the CCO's Legislation and Ethics Examination and have attended the CCO's Record Keeping Workshop at my own expense; and

    c. successfully complete, at my own expense, a course or courses in professional boundaries approved in advance by the Registrar.

2. I will be peer assessed within six months after I return to practice following the lifting of the suspension.

3. I will pay to the CCO a total of $15,000.00 for the partial payment of its costs and expenses related to the investigation, hearing and legal costs and expenses as follows:

    a. $7,500.00 by June 10, 2021;

    b. $7,500.00 by December 31, 2021, with post-dated cheques for that amount to be provided to the CCO by June 10, 2021.

4. I agree not to appeal or ask for a judicial review of the decision of the Discipline Committee so long as the panel of the Discipline Committee accepts the Joint Submission on Penalty and Costs contained in my Resolution Agreement with the CCO. In the event that the Joint Submission on Penalty and Costs is not accepted by the Discipline Committee, I reserve the right to request an adjournment, call evidence, and make additional submissions.

5. I acknowledge that failure to abide by any of the terms of this Undertaking could result in the referral of specified allegations of professional misconduct to the Discipline Committee.

6. I acknowledge that I have been advised by the CCO to obtain legal advice prior to executing this Undertaking and have obtained the advice of my counsel, Valerie Wise. I am executing this Undertaking freely and voluntarily after reading and understanding its contents.

Signed this day of , 2021

Dr. Gregory Nesterenko

Witness Signature

Received by E-mail
Jne 3, 2021

ITEM 1.1.2

DISCIPLINE COMMITTEE OF THE COLLEGE OF CHIROPRACTORS OF ONTARIO

26

PANEL:	Mr. Robert MacKay (Chair)	Public Member
	Dr. Steven Lester	Professional Member
	Mr. Shawn Southern	Public Member
	Dr. Murray Townsend	Professional Member
	Dr. Matthew Tribe	Professional Member

BETWEEN:	Appearances:[1]
COLLEGE OF CHIROPRACTORS OF ONTARIO	Mr. Chris Paliare and Ms. Karen Jones for the College of Chiropractors of Ontario
- and -	
DR. SHAWN ROSSI (Registration #5392)	Ms. Valerie Wise for Dr. Rossi
	Heard: May 27, 2021

DECISION AND REASONS

[1] Also in attendance at the hearing were: Mr. Colin Stevenson, Independent Legal Counsel to the Panel; Ms. Jo-Ann Willson, Registrar and General Counsel CCO; and Ms. Sheila Finlay, Court Reporter.

DECISION AND REASONS

Introduction

This was a hearing before a panel of the Discipline Committee (the "Panel") of the College of Chiropractors of Ontario (the "College") held on May 27, 2021 (the "Hearing"). The College has a mandate to regulate the practice of the chiropractic profession and to govern its members and, in so doing, serve and protect the public interest.

The Hearing was held virtually using video conferencing with the consent of the parties to comply with Provincial physical distancing recommendations.

The Allegations

The allegations against Dr. Shawn Rossi (the "Member") were set out in the Notice of Hearing, dated August 10, 2020. The Notice of Hearing was entered as Exhibit 1 at the Hearing and the allegations contained in the Notice of Hearing are attached as Appendix "A" of the Decision and Reasons of the Panel.

Mr. Paliare on behalf of the College stated that discussions with the Member had resulted in a Resolution Agreement. The College and the Member would therefore be jointly presenting an Agreed Statement of Facts and, if that were accepted by the Panel, a Joint Submission as to Penalty and Costs would then be made.

Agreed Statement of Facts

The Agreed Statement of Facts[2] which had been signed by the parties was entered as Exhibit 2. During the course of the submissions that followed, Mr. Paliare reviewed the

[2] The evening before the Hearing, exhibits 2 and 3 were delivered to the Panel members in the interests of hearing economy and on consent of the parties.

Agreed Statement of Facts in its entirety. The Agreed Statement of Facts, Exhibit 2, provided as follows:

Background

1. Dr. Shawn Rossi ("Member") became a member of the College of Chiropractors of Ontario ("CCO") in 2007. He has no complaint or discipline history at the CCO.

2. At the relevant time, the Member practiced chiropractic at Absolute Health ("Clinic") in Sudbury, Ontario.

The Claim for Orthotics

3. On May 2, 2018, the Member's wife attended at the Clinic to obtain orthotics. She had previously been assessed and obtained orthotics from a chiropractor at the Clinic, who had subsequently left the Clinic. As of May 2018, the Member was the only chiropractor at the Clinic.

4. The Clinic issued a Statement of Account dated May 2, 2018 to the Member's wife, which indicated the Member's wife had been assessed by the Member, and that he conducted a biomechanical gait analysis, diagnosed her as having Pes Planus, and made a custom mold for the orthotics using a multi-casting technique. According to the Statement of Account, the Member's wife had paid $85.00 for the assessment and $800.00 for two pairs of custom mold orthotics. Had the Member testified, he would have said he did not know his wife paid the Clinic $885.00 for an assessment and orthotics, or that she submitted a claim for them to their insurer.

5. An order form to an orthotic company was prepared by the Clinic on May 2, 2018 for the Member's wife's orthotics. That form indicated that the Member sent a prescription for orthotics, performed a biomechanical exam and gait analysis, and dispensed the orthotics. According to the order form, the orthotics were paid for in full on May 2, 2018 for a total of $885.00, and the orthotics were picked up. Had the Member testified, he would have said the prescription was issued by his wife's doctor, and not the Member. There is no prescription attached to the order form and there is no date on the form indicating when orthotics were dispensed.

6. On May 24, 2018, the Member's wife signed a claim form for an insurer, which included a claim for $885.00 for a gait analysis, assessment and the dispensing of two pairs of orthotics by the Member for his wife. Had the Member and his wife testified, they would have said they did not know a claim was submitted to the insurer for orthotics for the member's wife.

7. The insurer paid $885.00 for the gait analysis, assessment, and two pairs of orthotics by way of direct deposit to the Member's wife's bank account. Had the Member and his wife testified, they would have said they did not know that the claim had been paid by the insurer.

8. On May 29, 2018, the Clinic issued a receipt regarding goods and services provided to the Member's wife on May 2, 2018, namely an orthotics assessment and custom orthotics, and indicated payment of $885.00 had been received.

9. No orthotics were actually ordered for the Member's wife. Had the Member testified, he would have said that he had originally intended to provide his wife with orthotics but later changed his mind. As a result, he did not order or dispense orthotics for his wife.

10. Had the Member testified, he would have said he was unaware that Clinic staff had issued the Statement of Account, orthotic order form, and receipt.

11. Had the Member testified, he would have said that he did not provide any chiropractic services or treatment to his wife on May 2, 2018.

Admissions

12. The Member acknowledges that, pursuant to CCO Standard of Practice S-014, chiropractors are prohibited from having concurrent professional and sexual relationships with patients, and that it would have been a breach of that standard for him to treat his wife. In addition, members are prohibited from sexually abusing patients. Sexual abuse is defined in subsection 1.(3) of the Health Professions Procedural Code as follows:

> 1.(3) In this Code, "sexual abuse" of a patient by a member means:
>
> a) sexual intercourse or other forms of physical sexual relations between the member and the patient;
>
> b) touching, of a sexual nature, of the patient by the member; or
>
> c) behaviour or remarks of a sexual nature by the member towards the patient.

13. Had he testified, the Member would have said that the Statement of Account, orthotic order form, and receipt were erroneously issued by Clinic staff. Further, he would have said Clinic staff should not have

issued the documents because he did not order or dispense orthotics for his wife.

14. As the owner and operator of the Clinic, the Member accepts responsibility for the Clinic's documentation and billing. He therefore admits that he committed acts of professional misconduct, and in particular he:

    a. contravened a standard of practice of the profession or failed to maintain the standard of practice of the profession with respect to documentation regarding Patient A. as described in allegation 2 of the Notice of Hearing; and

    b. engaged in conduct or performed an act or acts, that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable and unprofessional with respect to documentation regarding Patient A. as described in allegation 3 of the Notice of Hearing.

Other

15. The CCO withdraws allegation 1. It also withdraws the particulars in allegations 2 and 3 related to the Member's assessment, treatment and conduct towards Patient A.

16. The Member successfully completed at his own expense the CCO's Record Keeping Workshop on December 3, 2020 and the Legislation and Ethics Examination on February 11, 2021.

17. The Member acknowledges that he received advice from his counsel, Valerie Wise prior to entering into this Resolution Agreement. The Member agrees that he is entering into this Resolution Agreement and signing the Agreed Statement of Facts freely and voluntarily.

Member's Plea

The Member admitted the amended Allegations contained in the Notice of Hearing (Exhibit 1) namely allegations 2 and 3. A plea inquiry was conducted by the Panel Chair. At the conclusion of that process, the Panel was satisfied that the admissions of professional misconduct by the Member were voluntary, informed, and unequivocal.

Decision

The Panel heard submissions by Mr. Paliare on behalf of the College, and Ms. Wise on behalf of the Member with respect to the Agreed Statement of Facts. During the course of those submissions the parties highlighted the admitted facts and invited the Panel to make findings against the Member. In addition, the Panel sought and obtained advice from its independent legal counsel, who reminded the Panel that only the Agreed Statement of Facts could form the basis for their findings at this hearing.

After deliberation, the Panel was satisfied that the admissions of professional misconduct made by the Member were supported by the agreed-upon facts contained in the Agreed Statement of Facts.

Consequently, we made findings of professional misconduct against Dr. Shawn Rossi in relation to the admitted allegations set out in the Notice of Hearing (Exhibit 1). In particular, the Panel found that the Member has:

i. contravened a standard of practice of the profession or failed to maintain the standard of practice of the profession with respect to documentation regarding Patient A. as described in allegation 2 of the Notice of Hearing; and

ii. engaged in conduct or performed an act or acts, that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable and unprofessional with respect to documentation regarding Patient A. as described in allegation 3 of the Notice of Hearing.

In reaching its decision the Panel reminded itself of s. 49 of the *Health Professions Procedural Code* and therefore relied exclusively on the evidence presented at the hearing as contained in the Agreed Statement of Facts (Exhibit 2). The Panel found the facts contained in it provided a sufficient foundation for the findings of professional misconduct.

Penalty and Costs

Counsel for the College advised the Panel that a Joint Submission as to Penalty and Costs had been agreed upon. The Joint Submission was entered as Exhibit 3. Mr. Paliare and Ms. Wise made submissions in support of the Joint Submission. In addition, the Panel sought and obtained advice from its independent legal counsel concerning the approach that discipline panels should take when joint submissions are placed before them.

The Joint Submission invited the Panel to make an order regarding penalty:

1. Requiring the Member to appear before the panel to be reprimanded.

2. Directing the Registrar and General Counsel ("Registrar") to suspend the

Member's certificate of registration for a period of four months ("Suspension"), with the Suspension to take effect on June 19, 2021.

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

    a. By August 19, 2021, the Member must review and undertake in writing to comply with all CCO regulations, standards of practice, policies and guidelines, including but not limited to CCO Standard of Practice S-014 Prohibition of a Sexual Relationship with a Patient; CCO Standard of Practice S-002: Record Keeping; CCO Standard of Practice S-012 Orthotics; and CCO Guideline G-008: Business Practices;

    b. Requiring the Member to be peer assessed at his own expense within six months of returning to practice after the lifting of the Suspension.

4. Directing the Registrar to suspend two months of the Suspension if the Member satisfactorily completes the Conditions set out in Paragraph 3a.

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

The College and the Member also requested that the Panel make the following order regarding costs:

1. Requiring the Member to pay $15,000.00 by December 31, 2021 to the CCO to partially pay for its costs of the investigation and the costs and

> expenses of the hearing and of legal counsel, with the Member to provide post-dated cheques for the costs by June 7, 2021.

The Joint Submission as to Penalty, which was signed by Dr. Rossi, also contained the following:

> Dr. Rossi acknowledges that he received advice from his counsel, Valerie Wise, prior to entering into this Resolution Agreement, and affirms that he is signing the Joint Submission on Penalty and on Costs freely and voluntarily.

Penalty Decision and Reasons

The Panel was of the view that the parties had come to a fair and equitable resolution, having carefully balanced the issues of protection of the public interest and remediation of the Member and his practice. Mr. Paliare stated that by agreeing to the facts the Member has accepted responsibility for his actions. Dr. Rossi has thereby reduced the delay and expense that would have been incurred in resolving the allegations at a contested hearing.

The Panel therefore made an order:

1. Requiring the Member to appear before the panel to be reprimanded.

2. Directing the Registrar and General Counsel ("Registrar") to suspend the Member's certificate of registration for a period of four months ("Suspension"), with the Suspension to take effect on June 19, 2021.

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

a. By August 19, 2021, the Member must review and undertake in writing to comply with all CCO regulations, standards of practice, policies and guidelines, including but not limited to CCO Standard of Practice S-014 Prohibition of a Sexual Relationship with a Patient; CCO Standard of Practice S-002: Record Keeping; CCO Standard of Practice S-012 Orthotics; and CCO Guideline G-008: Business Practices;

b. Requiring the Member to be peer assessed at his own expense within six months of returning to practice after the lifting of the Suspension.

4. Directing the Registrar to suspend two months of the Suspension if the Member satisfactorily completes the Conditions set out in Paragraph 3a.

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

6. Requiring the Member to pay $15,000.00 by December 31, 2021 to the CCO to partially pay for its costs of the investigation and the costs and expenses of the hearing and of legal counsel, with the Member to provide post-dated cheques for the costs by June 7, 2021.

Administration of Reprimand

It was noted on the record that the Joint Submission on Penalty (Exhibit 3) contained an Undertaking[3] marked as Exhibit "A", that among other things expressly waived the right of the Member to appeal[4] any decision by the Discipline Committee in relation to the August 10, 2020 Notice of Hearing, (Exhibit 1). Further, the Panel confirmed that the

[3] Appendix "B" of this Decision and Reasons.
[4] Paragraph 4 Appendix "B"

Member was prepared for the oral reprimand to be administered immediately following the Hearing. Consistent with the necessity to conduct the Hearing via videoconference the Panel administered the oral reprimand in the same manner at the conclusion of the Hearing.

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

Mr. Robert MacKay, Chair

Date: June 3, 2021

Panel Members:

Dr. Steven Lester
Mr. Robert MacKay
Mr. Shawn Southern
Dr. Murray Townsend
Dr. Matthew Tribe

Appendix "A"

Allegations contained in the Notice of Hearing, Regarding Dr. Shawn Rossi (Exhibit 1)

TAKE NOTICE THAT IT IS ALLEGED THAT:

1. You have committed an act of professional misconduct as provided by subsection 51(1)(b.1) of the Health Professions Procedural Code of the *Chiropractic Act, 1991*, S.O. 1991, c. 21, as amended, in that on or about May 2, 2018, while practicing as a chiropractor at Absolute Health in Sudbury, Ontario, you sexually abused a patient known as "Patient A."

2. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the Health Professions Procedural Code of the *Chiropractic Act*, 1991, S.O. 1991, c. 21, as amended, and paragraph 1(2) of *Ontario Regulation 852/93*, in that on or about May 2, 2018, while practicing as a chiropractor at Absolute Health in Sudbury, Ontario, you contravened a standard of practice of the profession or failed to maintain the standard of practice expected of members of the profession with respect to your assessment and/or treatment and/or documentation and/or conduct towards a patient known as "Patient A."

3. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the Health Professions Procedural Code of the *Chiropractic Act*, 1991, S.O. 1991, c. 21, as amended, and paragraph 1(33) of *Ontario Regulation 852/93*, in that on or about May 2, 2018, while practicing as a chiropractor at Absolute Health in Sudbury, Ontario, you engaged in conduct or performed an act, that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional with respect to your assessment and/or treatment and/or documentation and/or conduct towards a patient known as "Patient A."

Appendix "B"

UNDERTAKING
Exhibit "A"

To: The Registrar and General Counsel ("Registrar")
of the College of Chiropractors of Ontario ("CCO")

I, Dr. Shawn Rossi, undertake to the Registrar and agree to do the following:

1. On or before August 19, 2021, I will review, and undertake in writing to comply with, all CCO regulations, standards of practice, policies and guidelines, including but not limited to: CCO Standard of Practice S-014 Prohibition of a Sexual Relationship with a Patient; CCO Standard of Practice S-002: Record Keeping; CCO Standard of Practice S-012 Orthotics; and CCO Guideline G-008: Business Practices.

2. I will be peer assessed within six months after I return to practice following the lifting of the suspension.

3. I will pay to the CCO a total of $15,000.00 for the partial payment of its costs and expenses related to the investigation and hearing, and legal costs by December 31, 2021, and will providing post-dated cheques for that amount by June 7, 2021.

4. I agree not to appeal or ask for a judicial review of the decision of the Discipline Committee so long as the panel of the Discipline Committee accepts the Joint Submission on Penalty and Costs contained in my Resolution Agreement with the CCO. In the event that the Joint Submission on Penalty and Costs is not accepted by the Discipline Committee, I reserve the right to request an adjournment, call evidence, and make additional submissions.

5. I acknowledge that failure to abide by any of the terms of this Undertaking could result in the referral of specified allegations of professional misconduct to the Discipline Committee.

6. I acknowledge that I have been advised by the CCO to obtain legal advice prior to executing this Undertaking and have obtained the advice of my counsel, Valerie Wise. I am executing this Undertaking freely and voluntarily after reading and understanding its contents.

Signed this day of , 2020

Dr. Shawn Rossi

Witness Signature

Rose Bustria **41**

From: Jo-Ann Willson
Sent: Thursday, June 3, 2021 12:32 PM
To: Rose Bustria
Subject: FW: CCO Rossi
Attachments: 2021-05-27 Rossi Decision FINAL.pdf

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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From: Colin Stevenson <CStevenson@swlawyers.ca>
Sent: Thursday, June 3, 2021 12:28 PM
To: vwise@wisehealthlaw.ca; Chris Paliare <chris.paliare@paliareroland.com>; Karen Jones <karen.jones@paliareroland.com>
Cc: Jo-Ann Willson <jpwillson@cco.on.ca>
Subject: CCO Rossi

Please find attached the written reasons and Order of the Discipline Panel in this matter

STEVENSONWHELTON
BARRISTERS

Colin Stevenson | Offices
647.847.3811

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Rose Bustria **42**

From: Jo-Ann Willson
Sent: Thursday, June 3, 2021 12:32 PM
To: Rose Bustria
Subject: FW: CCO Nesterenko
Attachments: 2021-05-27 Nesterenko Decision FINAL.pdf

Jo-Ann Willson, B.Sc., M.S.W., LL.B.
Registrar & General Counsel
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From: Colin Stevenson <CStevenson@swlawyers.ca>
Sent: Thursday, June 3, 2021 12:27 PM
To: vwise@wisehealthlaw.ca; Chris Paliare <chris.paliare@paliareroland.com>; Karen Jones <karen.jones@paliareroland.com>
Cc: Jo-Ann Willson <jpwillson@cco.on.ca>
Subject: CCO Nesterenko

Please find attached the written reasons and Order of the Discipline Panel in this matter

STEVENSONWHELTON
BARRISTERS

Colin Stevenson | Offices
647.847.3811

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College of Chiropractors of Ontario
Fitness to Practise Committee Report to Council
June 16, 2021

43

Members: Ms Robyn Gravelle, *Chair*
Dr. Dennis Mizel
Dr. Julia Viscomi

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

Committee Mandate

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

Report

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

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

College of Chiropractors of Ontario
Inquiries, Complaints and Reports Committee Report to Council
June 16, 2021

44

Members: Dr. Sarah Green, *Chair*
Ms Anuli Ausbeth-Ajagu, *Public Member*
Dr. Colin Goudreau, *Elected Member*
Mr. John Papadakis, *Public Member*
Dr. Carolyn Wood, *non-Council*

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

Committee Mandate

- To respond to inquiries, complaints and reports in a manner consistent with CCO's legislative mandate under the *RHPA.*
- To review investigation reports carried out pursuant to s. 75 of the *RHPA,* and to make decisions concerning any further action, including the referral of specified allegations of professional misconduct or incompetence to the Discipline Committee and the imposition of interim terms, conditions or limitations on a member's certificate of registration.

Report

Since the report to Council, the Inquiries, Complaints and Reports Committee (ICRC) met on two occasions by zoom, we reviewed 30 complaints and three reports. ICRC made decisions on 18 complaints. Three 75(c) investigator appointments were requested by the ICRC. We conducted 1oral caution by zoom.

Mr. Richard Steinecke attended the April 27th Committee meeting and conducted an orientation with the Committee.

The Health Professions Appeal and Review Board (HPARB) upheld one Committee decision (attached).

Committee meetings have been scheduled to March 29, 2022 with a start time of 8:00 am.

We continue to work diligently to meet all time lines during the pandemic despite an unprecedented number of complaints.

Health Professions Appeal and Review Board

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

Ontario

In reply please quote: File # 20-CRV-0298)
(CHOE 20-MR-20

CONFIDENTIAL

May 11, 2021

RECEIVED
MAY 12 2021
COLLEGE OF CHIROPRACTORS OF ONTARIO

Dr. Ryan Armstrong — Applicant Complainant via email

Ms. Valerie Wise — Counsel for Respondent via email

Dear Dr. Armstrong and Ms. Wise,

RE: COMPLAINT REVIEW - CHIROPRACTIC
RYAN ARMSTRONG AND EVE CHOE, D.C.

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

While your file is now closed, please note that parties to Complaint Reviews of the Health Professions Appeal and Review Board have the right to request a judicial review of the Board's decision within 30 days of the date the decision was made[1]. You may wish to consider obtaining legal advice to determine what options are available to you. To request a judicial review contact the Divisional Court at 416-327-5100.

Yours sincerely,
HEALTH PROFESSIONS APPEAL AND REVIEW BOARD

N. Demyanenko

Natalya Demyanenko
Case Managemnt Coordinator

Encl: Decision dated May 11, 2021

c. College of Chiropractors of Ontario (CCOPRA File # CHOE 20-MR-20)

[1] Section 5 of the *Judicial Review Procedure Act*

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

Tel/Télé 416-327-8512
Toll free/Sans frais 1-866-282-2179
TTY/ATS 416-326-7TTY(889)
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Facsimile/Télécopieur 416-327-8524

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

File # 20-CRV-0298

HEALTH PROFESSIONS APPEAL AND REVIEW BOARD

PRESENT:

David Scrimshaw, Designated Vice-Chair, Presiding
Maria Capulong, Board Member
Cathy Loik, Board Member

Review held on May 5, 2021 in Ontario (by teleconference)

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

B E T W E E N:

RYAN ARMSTRONG

Applicant

and

EVE CHOE, DC

Respondent

Appearances:

The Applicant:	Ryan Armstrong
The Respondent:	Eve Choe, DC
For the Respondent:	Valerie Wise, Counsel Mina Karabit, Counsel
For the College of Chiropractors of Ontario:	Karen Jones Tina Perryman

DECISION AND REASONS

I. DECISION

1. The Health Professions Appeal and Review Board confirms the decision of the Inquiries, Complaints and Reports Committee of the College of Chiropractors of Ontario to recommend that, going forward, Eve Choe, DC confirm with the College through the

advertising committee that all social media items or advertisements are consistent with College standards before they are posted.

2. This decision arises from a request made to the Health Professions Appeal and Review Board (the Board) by Ryan Armstrong (the Applicant) to review a decision of the Inquiries, Complaints and Reports Committee (the Committee) of the College of Chiropractors of Ontario (the College). The decision concerned a complaint regarding the conduct and actions of Eve Choe, DC (the Respondent). The Committee investigated the complaint and decided to make the recommendation noted above.

II. BACKGROUND

3. On the evening of March 14, 2020, the Respondent, a chiropractor, posted the following information to a social media website:

> We care about you and love you!
>
> We are taking steps to maintain a healthy and safe environment
>
> ACTIONS WE ARE TAKING:
> 1. Asking unwell patients to stay home. Change in cancellation policy to accommodate this.
> 2. Hand sanitizers at front and in each room.
> 3. Lysol wipes in each room.
> 4. Consistently wiping down tables and common surfaces.
> 5. Fresh headrest paper and disposable used with each session.
> 6. Washing our hands.
>
> TIPS TO BOOST YOUR IMMUNE SYSTEM:
> 1. Get adjusted. Research has shown it boosts your immune system up to 200%
> 2. Wash your hands often.
> 3. Wipe your phones We touch it all the time!)
> 4. Avoid touching your face.
> 5. Take Vitamin D, C and stay hydrated.
> 6. Get your sleep.
> 7. Manage your stress. Stress increase levels of your stress hormone cortisol, reducing your immunity.
> 8. Be nice! We are in this together ❤🌎
>
> ...
>
> Chiropractic

Adjustments
BOOST YOUR
IMMUNE SYSTEM
UP TO 200%

4. On March 16, 2020, the College wrote a letter to the Respondent indicating it had been brought to the College's attention that she had made a posting on Facebook relating to the immune system. The letter recommended that she delete the "potential problematic posting" and confirm that she had done so.

The Complaint

5. In a letter dated March 19, 2020, the Applicant complained that the Respondent had been actively spreading misinformation relevant to the coronavirus (COVID-19) pandemic, or selling products or services deceptively claiming to benefit the immune system and included a copy of the posting described above.

The Response

6. The Respondent responded to the complaint and indicated that:

- The material posted to social media on the night of March 14, 2020 was posted to provide a positive message for existing practice members. At the time of posting, information regarding the COVID-19 pandemic was changing day to day.
- Upon reflection, and in light of new information regarding COVID-19, the posting was removed the next day, March 15, 2020.
- The Applicant apologized if the material in question created any misinterpretation or misunderstanding before its removal.

The Committee's Decision

7. The Committee investigated the complaint and decided to recommend that, going forward, the Respondent confirm with the College through the advertising committee that

all social media items or advertisements are consistent with College standards before they are posted.

8. The Committee considered a variety of College standards of practice and guidelines, various orders and directives from the provincial and federal governments. In addition, the Committee considered information published by the World Federation of Chiropractic on March 19, 2020 and the International Chiropractic Association on March 20, 2020 regarding the relationship between chiropractic and the immune system. The Committee stated:

> Both organizations concluded that there is no evidence that chiropractic can cure, treat, prevent or mitigate COVID-19. The World Federation of Chiropractic also noted the lack of credible, scientific evidence supporting claims of the effectiveness of spinal adjustments in boosting or strengthening the immune system. The International Chiropractic Association indicated research has shown there is a relationship between chiropractic spinal adjustments and the central nervous system, and that the nervous and immune systems affect each other. However, there is currently no scientific research that validates chiropractic stimulates a clinical immune response.

9. The Committee found the content of the Respondent's posting to be inconsistent with College Standard of Practice S-016: *Advertising*, College Guideline G-016: *Advertising*, and College Guideline G-012: *Use of Social Media*. The Committee stated that there is no credible, scientific evidence that chiropractic boosts the immune system up to 200% so the claim in the posting was not accurate, factual or verifiable. The Committee was concerned that posting such content during the pandemic could cause confusion or create the false impression that chiropractic can prevent or mitigate COVID-19.

10. The Committee found that the matter did not warrant a hearing. The Committee stated that this appeared to be an isolated event and noted that the Respondent does not have a prior history with the College. The Committee stated the Respondent demonstrated accountability and insight by reviewing the posting on her own accord and removing it the day after it was posted, before the Applicant's complaint was made.

11. The Committee was satisfied that the Respondent had learned from this experience and the Committee considered it unlikely that there would be a recurrence of this conduct.

III. REQUEST FOR REVIEW

12. In a letter received May 29, 2020, the Applicant requested that the Board review the Committee's decision.

IV. POWERS OF THE BOARD

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

    a) confirm all or part of the Committee's decision;

    b) make recommendations to the Committee;

    c) require the Committee to exercise any of its powers other than to request a Registrar's investigation.

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

V. ANALYSIS AND REASONS

15. Pursuant to section 33(1) of the *Health Professions Procedural Code* (the *Code*), being Schedule 2 to the *Regulated Health Professions Act, 1991*, the mandate of the Board in a complaint review is to consider either the adequacy of the Committee's investigation, the reasonableness of its decision, or both.

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

Adequacy of the Investigation

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

18. The Committee obtained the following documents:

- the Applicant's complaint;
- the Respondent's response;
- the Respondent's complaints history;
- the College President's Messages dated March 16, 2020, March 17, 2020, March 22, 2020, March 24, 2020 and April 2, 2020;
- the Ontario Ministry of Health's *COVID-19 Guidance: Primary Care Providers in a Community Setting,* Version 3, March 20, 2020 and other Ministry of Health directives and information;
- information published by the World Federation of Chiropractic on March 19, 2020 and the International Chiropractic Association on March 20, 2020 regarding the relationship between chiropractic and the immune system;
- College Standard of Practice S-001: *Chiropractic Scope of Practice;*
- College Standard of Practice S-016: *Advertising*;
- College Guideline G-016: *Advertising;* and
- College Guideline G-012: *Use of Social Media.*

19. The Applicant submitted that the investigation was not adequate because:

- The Committee did not investigate to what degree the Respondent had communicated misinformation beyond the identified posting by reviewing patient records to determine what patients had been told and investigating

whether the Respondent had posted other misinformation on her website and in her social media.

- The Committee did not seek information from the Respondent to understand what her beliefs, knowledge and understanding were regarding the relationship between chiropractic and the immune system.
- The Committee did not gather information on the broader context of misinformation and pseudoscience in the practice of chiropractic.

20. Counsel for the Respondent submitted that the investigation was adequate because the Committee gathered the essential information to assess the complaint.

21. The Board finds that it was not necessary for the Committee to investigate whether the Respondent had communicated misinformation beyond the identified posting.

22. The Board notes there is no information in the Record or before the Board to suggest that there was further miscommunication. In order for the Committee to investigate patient records when patients have not consented to the disclosure of their medical records, the Committee would be required to request that the College's Registrar appoint investigators under section 75(1)(c) of the *Code*. The Board finds that compromising patients' privacy would not be warranted in a case where there was no specific allegation of miscommunication and no information supporting that there was such miscommunication. In any case, the Board is precluded from requiring the Committee to request a Registrar's investigation.

23. The Board similarly finds that it was not necessary to conduct a broader investigation of the Respondent's website and social media. Although the Applicant submitted to the Board that there were other online examples of misinformation from the Respondent, the Applicant did not provide any of these examples to the Board. There is no information before the Board to indicate that there was such misinformation beyond that in the identified posting.

24. The Board further finds that the Committee was not required to further investigate the Respondent's beliefs, knowledge and understanding regarding the relationship between chiropractic and the immune system. As Counsel for the Respondent noted, it is the Respondent's conduct that is regulated, not her beliefs. Counsel for the Respondent further submitted that the Applicant's complaint related to a single instance of misinformation posted by the Respondent and did not justify a broad inquiry into her knowledge and understanding of practising chiropractic.

25. The Applicant made extensive submissions on problems in the practice of chiropractic with practitioners who endorse misinformation and pseudoscience and submitted that the Committee should have examined information on these issues in its investigation of this complaint. The Board finds that it was not necessary for the Committee to consider information beyond the information it did review in assessing the complaint. The Committee referred to ample documents from the College, government and the World Federation of Chiropractic and the International Chiropractic Association. This information addressed the relationship between chiropractic and the immune system and concluded that there is no evidence that chiropractic can cure, treat, prevent or mitigate COVID-19. This was the issue that was before the Committee.

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

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

Reasonableness of the Decision

28. In determining the reasonableness of the Committee's decision, the question for the Board is not whether it would arrive at the same decision as the Committee. Rather, the Board considers the outcome of the Committee's decision in light of the underlying rationale for the decision, to ensure that the decision as a whole is transparent, intelligible

and justified. That is, in considering whether a decision is reasonable, the Board is concerned with both the outcome of the decision and the reasoning process that led to that outcome. The Board considers whether the Committee based its decision on a chain of analysis that is coherent and rational and is justified in relation to the relevant facts and the laws applicable to the decision-making process.

29. The Applicant submitted that the Committee's decision is not reasonable because:

- The Committee did not consider the broad context of false claims made by chiropractors that demonstrate either gross incompetence or fraudulent activity and potentially put the public and their patients at risk.
- The recommendation given to the Respondent from the Committee was insufficient action in response to the Respondent's conduct.

30. The Applicant submitted that there is growing evidence the College is willfully failing its duty to protect the public and that this is not merely incompetence, but an effort to protect the interests of a minority of practitioners within the profession whose practices conform to a philosophy that is not compatible with the mandate to protect the public. The Applicant further submitted that the Committee did not consider the serious harm that could result from the Respondent's misinformation because a belief that chiropractic treatment had boosted the immune system could lead a patient to engage in unsafe practices during this global pandemic, such as not wearing masks or not practising social distancing.

31. Counsel for the Respondent submitted that the Committee's decision is reasonable. Counsel submitted that the Committee's decision was well-reasoned, as it directly considered and addressed the Applicant's concern and in issuing a recommendation, the Committee noted this was an isolated event, the Respondent had no relevant complaint history, and the Respondent had demonstrated accountability by reviewing the posting on her own accord and deleting it the day after she made it. Counsel further noted that the

Respondent deleted the material before the College contacted her or the Applicant had made the complaint.

32. The Board finds that in assessing the Applicant's complaint, the Committee considered the context of beliefs within the practice of chiropractic. The Committee referred to numerous documents and concluded that the Respondent had posted content that was inconsistent with College standards and guidelines. The Committee stated: "There is no credible, scientific evidence that chiropractic boosts the immune system up to 200% so the claim [was] not accurate, factual or verifiable." While the Applicant has broader concerns with the chiropractic community, the mandate for the Committee was to assess the specific complaint about the Respondent.

33. The Board finds that it was not necessary for the Committee to address the harm that could be caused by the misinformation posted by the Respondent. The Board notes that there are regulations, policies and guidelines proscribing misinformation by health professionals.

34. The Board further finds that the recommendation given to the Respondent was an appropriate remedial outcome that addressed the Committee's concerns with the Respondent's conduct, and in deciding on this remedial action, the Committee took the relevant factors into account.

35. The Applicant submitted that the Committee should not have considered that the Applicant demonstrated accountability and insight by reviewing and removing the posting on her own accord, because the Respondent should have published a correction and the Committee could not determine the Respondent's intent in removing the posting. The Applicant submitted that it could not be known if the Respondent removed the posting because she was showing insight or because she feared repercussions.

36. The Board finds that it was reasonable for the Committee to consider the removal of the posting to be a sign of insight and accountability on the part of the Respondent. As the Applicant submitted, it is impossible to know the thoughts of the Respondent when she removed the posting; however, it is an indication that she knew the posting was not appropriate. The Board further finds that it was reasonable for the Committee to consider the Respondent's lack of a history of similar complaints with the College to be a factor that mitigated against holding a discipline hearing.

37. The Applicant submitted that the Respondent should be required to undertake education to ensure that she does not promulgate false beliefs regarding chiropractic or use inappropriate techniques in her practice. However, the Board finds that it was reasonable for the Committee to not require further education on the part of the Respondent. The complaint and the Record provide no indication of issues of concern with the Respondent's practice. The Board notes that the Respondent is registered with the College and this means she has met the education and examination requirements for registration with the College.

38. The Board finds the Committee's decision to be reasonable. The decision as a whole is transparent, intelligible and justified. The Committee based its decision on a chain of analysis that is coherent and rational and is justified in relation to the relevant facts and the laws applicable to the decision-making process.

VI. DECISION

39. Pursuant to section 35(1) of the *Code*, the Board confirms the Committee's decision to recommend that, going forward, the Respondent confirm with the College through the advertising committee that all social media items or advertisements are consistent with College standards before they are posted.

ISSUED May 11, 2021

David Scrimshaw

Maria Capulong

"*Cathy Loik*"
Cathy Loik

College of Chiropractors of Ontario
Patient Relations Committee Report to Council
June 16, 2021

Members: Mr. John Papadakis, *Chair*
Ms Anuli Ausbeth – Ajagu
Dr. Colin Goudreau
Dr. Michelle Campbell, *non-Council member*
Dr. Ian Quist, *non-Council member*

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

Committee Mandate

- To develop and implement a program/guidelines to enhance the doctor–patient relationship.
- To develop and implement measures for preventing and dealing with sexual abuse of patients.
- To develop, establish and maintain programs to assist individuals in exercising their rights under the *RHPA*.

Report

Since the last Council meeting, the Patient Relations Committee met on May 21, 2021.

The Committee reviewed its terms of reference, relevant regulations, standards of practice, polices and guidelines. The Committee has no recommendations at this time.

The Committee reviewed the progress report on Chiropractic and Immunity being prepared by the Accessing Centre for Expertise (ACE), Institute of Health Policy, Management and Evaluation, Dalla Lana School of Public Health, University of Toronto. The Committee looks forward to reviewing the final version of this report at its next meeting, with consideration on how the report will help inform existing or new CCO standards, policies and guidelines, relevant to CCO's public interest mandate.

The Committee continues to monitor funding for therapy for victims of sexual abuse related to CCO Discipline and Inquiries, Complaints and Reports matters.

In light of the recent increase in discipline decisions related to sexual abuse of patients, the Patient Relations Committee is of the opinion that further communication and education efforts should be made by CCO to inform and educate students, applicants and members of the regulatory restrictions prohibiting the sexual abuse of patient. This could include a component in the record keeping workshop related to the prevention of sexual abuse of patients.

College of Chiropractors of Ontario
Quality Assurance Committee Report to Council
June 16, 2021

Members:
Ms Robyn Gravelle, Chair
Dr. Kyle Grice
Dr. Paul Groulx
Mr. Rob MacKay
Dr. Elizabeth Anderson-Peacock, non-council member

Staff:
Mr. Joel Friedman, Deputy Registrar
Dr. J. Bruce Walton, Director of Professional Practice
Ms. Jo-Ann Willson, Registrar and General Counsel

Committee Mandate

- To develop, establish and maintain:
  - programs and standards of practice to assure the quality of the profession;
  - standards of knowledge and skill and programs to promote continuing competence among members; and
  - standards of professional ethics.
- To develop mechanisms and protocols to assess the knowledge, skills and continuing competence of members.

Report

The Quality Assurance Committee has not met since the last meeting of Council. The Committee has scheduled a meeting for July 13, 2021, where it will review all of its standards of practice, policies and guidelines and continue with the ongoing work of the Committee.

The processing of Peer and Practice Assessment (PPA) continue to take place, with approximately 360 members being selected for PPA 1.0 and 260 members being selected for PPA 2.0.

CCO will be holding an online Record Keeping Workshop on June 22, 2021.

College of Chiropractors of Ontario
Registration Committee Report to Council
June 16, 2021

Members: Mr. Markus de Domenico, *Chair*
Mr. Gagandeep Dhanda
Dr. Kyle Grice
Dr. Julia Viscomi

Staff Support: Mr. Joel Friedman, *Deputy Registrar*
Ms Madeline Cheng, *Registration Coordinator*
Ms Jo-Ann Willson, *Registrar and General Counsel*

Committee Mandate

- To develop, establish and maintain standards of qualification for persons to be issued certificates of registration.
- To review applications for registration referred by the Registrar.
- To determine the terms, conditions or limitations, if any, for granting a certificate of registration to an applicant.

Report

The Registration Committee met on May 27, 2021.

The Committee reviewed the legislative excerpts from the *RHPA* related to the Registration Committee, as well as regulations, polices and by-laws related to the registration processes at CCO. The Committee has no recommendations at this time.

The Committee continues to review applications for registration referred to the Committee.

The Committee reviewed several pieces of feedback related to the Policy P-058: Policy on Considering Applications for Registration During the COVID-19 Pandemic, and corresponding application form. The current policy and application form, as amended on February 26, 2021, are applicable and available for applicants affected by the cancellation of the February 2021 CCEB examination Part C and postponement of the May 2021 CCEB Examination Part C to July 17-18, 2021. The Office of the Fairness Commissioner has identified the CCO policy on General (Provisional) certificates of registration as a best practice during the COVID-19 pandemic, as part of its May 2021 Newsletter (enclosed). Over 90 members have been registered in the General (Provisional) class of registration since the passing of this policy on August 12, 2021. The Registration Committee is not recommending any amendments to this policy at this time, but continues to monitor the availability of the CCEB examinations due to the changing regulations around COVID-19 for any future recommendations.

Current Member Status

61

Chart 1: Membership Statistics as at June 7, 2021

Status	Total
Active	4719
Inactive – Resident	231
Retired	149
All categories	**5099**

Chart 2: Change in Registration statistics for April 6, 2021 – June 7, 2021

Description	Total
New registrants	14
Female	9
Male	8

Chart 3: Colleges of Graduation for New Registrants

CMCC	4
NYCC	7
Life CC	1
Logan	1
Palmer – Iowa	1
U of South Wales	1
D'Youville	2

Joel Friedman

From: Office of the Fairness Commissioner <noreply@fairnesscommissioner.ca>
Sent: Monday, May 31, 2021 2:06 PM
To: cco.info
Subject: OFC May Newsletter - Bulletin de Mai du BCE

View this email in your browser

FAIRNESS COMMISSIONER
COMMISSAIRE À L'ÉQUITÉ

Newsletter - May 2021 Edition

Message from the Commissioner

In this, the fifth edition of our *Newsletter* publication for 2021, we explore two contemporary topics of interest. The first relates to the role that third party service providers (third parties) increasingly play in the assessment of candidates who wish to join a profession or skilled trade. Next, building on a previous *Newsletter* theme, we provide a spotlight on three innovative practices that Ontario regulators have adopted to increase the fairness and efficiency of their registration processes.

Project to Explore Relationships between Regulators and Third Party Service Providers

Increasingly, regulators in Ontario are devolving important components of their processes for assessing and testing the qualifications and/or competencies of applicants to third parties.

The nature of the services that these organizations provide, their interactions with regulators and applicants, and their operating practices can vary appreciably depending on the needs of the regulator and profession, and the occupational context.

The current COVID-19 pandemic has highlighted the importance of the services that third parties provide and the consequences to applicants when this work cannot be delivered in an effective and seamless fashion. The pandemic has also accentuated the need to ensure that robust frameworks are in place to help regulators manage their relationships with third parties, and for regulators to better understand the mandate and work that these organizations perform.

In the past, the Office of the Fairness Commissioner (OFC) has undertaken several initiatives to analyse the contribution of third parties and to explore the accountability relationships between regulators and these groups. For example, in 2009, the OFC published a document entitled *Study of Qualifications Assessment Agencies* to learn more about this topic.

The study was pivotal for two reasons. First, it confirmed that, for applicants seeking professional licensure, the qualification process can be lengthy, costly and difficult. This is the case particularly for internationally trained individuals.

Second, it highlighted a number of positive approaches that organizations have adopted to improve the fairness of their assessment processes. This document is posted in our website may be accessed by clicking here.

The OFC believes that there is a need to build on this foundational work given current challenges and the rapid evolution of the sector. On this basis, earlier this year, our agency launched a multi-stage project to further explore issues around regulator-third party relationships.

During the first phase of the project, the OFC consulted separately with representatives from three broad constituencies, whose interests would be impacted by this project. These were regulators, individuals from the immigration and settlement communities, and third party service providers. The object of these discussions was to define the key issues for consideration and to validate project goals. We found these discussions to be frank and extremely useful.

The project will now enter a second phase which will focus on solution-development, where the OFC will assemble a consolidated working group, made up of members from the three constituent groups noted above. Our objective is to develop work products to address the issues and gaps identified in the first phase of the exercise. These could include such tools as a fair assessment code of practice, a checklist of items that could be included in agreements between the parties, and more robust communications protocols to enable applicants to better understand the nature of assessment processes and how they impact them.

The OFC also plans to disseminate one or more pulse surveys to better analyze current trends and determine how it can best add value to this complex subject

area. If you would like further information about this project, please contact Peter Youssef at peter.youssef@ontario.ca. 65

Spotlight on Three Innovative/Best Practices

Chartered Professional Accountants of Ontario

Information on Mutual Recognition Agreements

It is CPA Ontario's practice to directly provide clear and detailed information to internationally trained accountants who are subject to a Mutual Recognition Agreement (MRA). There are several countries that have such agreements with CPA Ontario which list specific eligibility requirements for licensing. An accountant who is a member in good standing of a reciprocal membership body, may apply for membership under the Reciprocal Membership Body pathway.

Further information on program requirements, availability of resources and funding, registration timelines, fees and appeal rights for these MRAs are available on the CPA Ontario website. Please contact the CPA Ontario Customer Service Centre at 1-800-387-0735 if you wish to obtain further information about how this system works.

College of Kinesiologists of Ontario

Remedial Process for Applicants

The College has implemented a progressive remediation process for applicants who have twice failed the registration examination prior to making a third

Bulletin - Mai 2021

66

Message du commissaire

Ce cinquième numéro de notre *Bulletin* en 2021 aborde deux sujets d'actualité. Le premier concerne le rôle de plus en plus important joué par les tiers fournisseurs de services (TFS) dans l'évaluation des auteurs d'une demande qui souhaitent intégrer une profession réglementée ou un métier spécialisé. Ensuite, comme dans un précédent bulletin, nous présentons les pratiques novatrices adoptées par trois organismes de réglementation de l'Ontario pour améliorer l'équité et l'efficacité de leurs processus d'inscription.

Projet d'examen des relations entre les organismes de réglementation et les tiers fournisseurs de services

De plus en plus, les organismes de réglementation de l'Ontario confient à des TFS des volets importants de leurs processus d'évaluation et d'examen des qualifications et des compétences des auteurs d'une demande.

La nature des services fournis par ces TFS, leurs interactions avec les organismes de réglementation et les auteurs d'une demande et leurs pratiques opérationnelles peuvent varier sensiblement en fonction des besoins de l'organisme de réglementation et de la profession ainsi que du contexte professionnel.

attempt. Under this approach, the applicant will be required to undertake a self-assessment to better appreciate knowledge gaps that have been identified in previous examination attempts and how to bridge those gaps. The initiative has been successful in assisting applicants in identifying gaps in their knowledge and remediating those gaps, on average assisting between five and 10 applicants per year. For further information, please contact Keisha Simpson at Keisha.Simpson@coko.ca.

College of Chiropractors of Ontario

Provisional Registration

The College has created an interim policy during the Covid pandemic which allows applicants to obtain a provisional registration status, where they have been unable to complete examinations or other requirements during this time period. Under this scheme, the registrant is required to (1) practice under the direct supervision of a fully registered members and (2) complete any outstanding and other requirements at the earliest opportunity. This approach enables applicants to practice in their field while waiting for examinations to be scheduled. From August to October of 2020, 83 applicants were registered in this class. For further information, please contact Joel Friedman at JFriedman@cco.on.ca

If you have any comments about the *Newsletter*, have an innovative or best practice that you would like to feature, or other ideas on topics that this publication should canvass, please contact Kim.Bergeron@ontario.ca.

FAIRNESS COMMISSIONER
COMMISSAIRE À L'ÉQUITÉ

OFFICE OF THE FAIRNESS COMMISSIONER
595 Bay Street, Suite 1201, Toronto ON M7A 2B4

MEMORANDUM

To: **Registrars and/or Chief Executive Officers of Regulated Professions, Health Colleges and the Ontario College of Trades**

From: **Christopher Rosati, Director, Office of the Fairness Commissioner**

Subject: **New Compliance Analyst and Change of Portfolio Assignments**

Date: **May 26, 2021**

The Office of the Fairness Commissioner (OFC) is pleased to welcome a new member to our team. Effective immediately, **Bobby Tzonev** will join the office as a Compliance Analyst (CA). Bobby comes to the OFC from the Prevention Office of the Ministry of Labour, Training and Skills Development where he provided analytical, advisory, and administrative support in overseeing Ontario's mandatory and voluntary workplace health and safety training programs.

Bobby's arrival enables the office to operate once again with a full complement of three dedicated CA's. We are taking this opportunity to revise the Compliance Analyst portfolio list of regulators. (see attached list).

In doing so, we have bundled, to the extent we can, professions with similar features. For example, regulators of similar types of health professions or under the supervision of the same Ministry, will become the responsibility of the same

CA. We hope this will help narrow the focus of our CA's, enable the deepest possible understanding of each regulator they are assigned and improve the overall quality of their engagement for regulators.

Many of you will not be impacted as your assigned CA will not change. For those that are, your new CA will reach out to introduce themselves shortly. For our part, we will ensure that your CA is fully briefed on your file and optimally prepared to carry out their work with you.

We are very excited to welcome Bobby Tzonev to our team as with him comes increased capacity to improve the quality of our oversight and our ability to collaborate with you.

Please feel free to reach out either to me or your CA should you have any questions or concerns.

Kindest regards,

"Original signed by"

Christopher Rosati
Director, Office of the Fairness Commissioner

Attachment:
Compliance Analyst Portfolio Assignment

Compliance Analyst Portfolio Assignment as of May 31, 2021

#	James Mendel	Mercy Barzallo	Bobby Tzonev
1	College of Physicians and Surgeons of Ontario	Professional Engineers Ontario	College of Homeopaths of Ontario
2	College of Nurses of Ontario	Ontario Association of Architects	The Association of Ontario Land Surveyors
3	Royal College of Dental Surgeons of Ontario	Chartered Professional Accountant	Ontario Professional Foresters Association
4	College of Chiropractors of Ontario	Law Society of Ontario	The College of Midwives of Ontario
5	College of Denturists of Ontario	Ontario Association of Certified Engineering Technicians and Technologists	The College of Opticians of Ontario
6	College of Dental Technologists of Ontario	The College of Veterinarians of Ontario	The Human Resources Professionals Association
7	The College of Dental Hygienists of Ontario	College of Optometrists of Ontario	The Ontario College of Social Workers Social Service Workers
8	The College of Audiologists and Speech-Language Pathologists of Ontario	The College of Dietitians of Ontario	The Ontario College of Teachers
9	The Ontario College of Pharmacists	The College of Psychologists of Ontario	The College of Early Childhood Educators
10	College of Kinesiologists of Ontario	The College of Registered Psychotherapists of Ontario	The College of Respiratory Therapists of Ontario

May 25, 2021

11	The College of Massage Therapists of Ontario	The College of Chiropodists of Ontario	The Ontario College of Trades
12	The College of Physiotherapists of Ontario	The College of Occupational Therapists of Ontario	The College of Medical Laboratory Technologists of Ontario
13	The College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario	College of Medical Radiation and Imaging Technologists of Ontario	The College of Naturopaths of Ontario
14		Professional Geoscientists of Ontario	

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ITEM 1.6.3

72

April 22, 2021

Component C Examination ~ Date Change

Update to Component C Candidates, Volunteers and Stakeholders:

We regret to inform you that the May 29-30, 2021 administration of CCEB examination Component C is no longer viable due to the ongoing impacts of the global COVID-19 pandemic.

There is no impact on the Component A/B examination on May 15, 2021.

In order to provide for greater safety and certainty regarding this Component C administration, the examination has been moved to **July 17-18, 2021.**

At this time, the exam sites remain the same.

We recognize that this is extremely frustrating.

What you can do:

1. No action is required on your part. Your Component C application has been deferred to the new administration date.

2. Should you wish to cancel your examination application due to this change, please email exams@cceb.ca. Your application will be cancelled and a full refund issued.

3. We ask that, prior to calling the CCEB with questions or concerns, you read all of the communications and FAQ's available on our website.

What the CCEB has done:

The CCEB has been fortunate in that we have experienced testing success where others have not. We adapted early, releasing safety guidelines for safe testing in June of 2020 and distributing them to government agencies across the country in the hope that high stakes entry-to-practice testing would be recognized as an essential service in support of public health and protection. We prepared a host of additional resources and FAQ's all available on our website cceb.ca and have continued to reach out to governments for clarity and work collaboratively with other testing organizations to share resources and information.

In March 2021, we released a report on our response and the related outcomes 'COVID-19 Adaptations ~ rapid response and future direction', which reflected on our

successes while remaining mindful of the evolving landscape and our need to remain diligent and prepared for the future.

Adherence to public health guidance, along with our concerns for the safety of our candidates, staff, volunteers, site personnel, and the public at large, remains of paramount importance. Public health guidelines and regulations are changing frequently and are not universal. Each province has a unique approach to the COVID-19 response.

Ontario is our primary testing location and, as such, restrictions and exemptions in Ontario are monitored closely. We were initially heartened when we reviewed the current Ontario regulations which recognized professional licensure examination specifically and provided exemptions for such testing. However, the wording (see excerpt below) of the exemption left some question as to whether chiropractic was considered as a 'rehabilitation science' under point 15.

Excerpt from current regulation:

https://www.ontario.ca/laws/regulation/200263

Meeting and Event Space

> *4. (6) Subsections (1) to (1.2) do not apply to the rental of meeting or event space for the purpose of conducting in-person examinations for the registration, licensing or accreditation of persons in any of the fields or occupations described in subsection 2 (1.1) of Schedule 3 to Ontario Regulation 82/20 (Rules for Areas in Stage 1) made under the Act, so long as no more than 50 students are permitted to occupy the rented space.*

https://www.ontario.ca/laws/regulation/200082#BK9

> *(1.1) An instructional program referred to in sub-subparagraphs 1 iii A and 3 ii A of subsection (1) is an instructional program in any of the following fields or an instructional program to train an individual for any of the following occupations, as the case may be:*
>
> 1. *Diagnostic cardiac sonography.*
> 2. *Diagnostic medical sonography.*
> 3. *Diagnostic ultrasound.*
> 4. *Medical imaging.*
> 5. *Medical laboratory assistant.*
> 6. *Medical laboratory technician.*
> 7. *Medical radiation technology.*
> 8. *Medicine.*
> 9. *Mental health and addictions services, including psychology services, social work services and counselling services.*
> 10. *Nursing.*
> 11. *Paramedic.*
> 12. *Personal support worker, supportive care worker, home care worker or a similar occupation.*
> 13. *Pharmacy/pharmacy technician.*

14. *Public health inspector, if the program is accredited by the Canadian Institute of Public Health Inspectors.*
15. *Rehabilitation sciences (nutrition, speech language pathology, occupational science, and physiotherapy).*
16. *Respiratory therapy.*

We next sought clarity from the Office of the Chief Medical Officer of Health regarding the applicability to chiropractic. We were advised:

> *"We note that chiropractic is not one of the specified fields or occupations in the regulations (please refer to subsection 2 (1.1) of Schedule 3 under O. Reg 82/20: Rules for Areas in Stage 1). If you have questions about the application of the regulations to your particular situation, you may wish to seek legal advice."*

The legal opinion we sought determined that this regulatory exemption was not provided to chiropractic. As such, we are unable to rely on the regulation as a guide for our examination to proceed.

Next, we connected with the Office of the Fairness Commissioner (OFC) in Ontario, as they have been very proactive and engaged in the regulatory impacts created by the loss of the ability to conduct entry-to-practice examinations in many regulated professions. However, while the OFC was supportive and can be an advocate, they do not have the power to grant permission in the face of the existing regulations.

Finally, we sent a formal correspondence to multiple contacts in the Ministry of Health including the Hon. Christine Elliott, the Minister of Health in Ontario, indicating our desire to have all regulated health professions treated equally and having chiropractic, among the other omitted regulated health professions, added to the regulation. This letter was endorsed and supported by the College of Chiropractors of Ontario, for which we are appreciative.

At the date of writing, we have had no response from the ministry and the regulations currently in place in Ontario preclude us from testing at the current stage of opening as well as at the next, less restrictive, stage of opening. As Ontario has now also implemented travel restrictions, there is no certainty that the Ministry of Health would consider travel for the purposes of the CCEB examination to be essential and thus permitted. This precludes volunteers, staff, and candidates from being permitted to travel to attend the exam, or at the very least it lacks certainty.

The expanding, and now almost pan-Canadian, interregional travel prohibitions and restrictions create significant barriers to success for the CCEB examination at any site, including Montreal or Calgary. Our examination relies on the ability and permission for candidates, volunteers, and staff to travel inter-regionally. We had secured an alternate site in another province, as a contingency. However, with the most recent travel

prohibitions, including those announced in British Columbia earlier this week, we are simply unable to staff an exam of any size and there is a distinct lack of certainty as to the ability of candidates to be able to attend the exam while adhering to public health guidelines.

The CCEB clinical examination, in any location, requires the willing participation and interregional movement of hundreds of people including practicing chiropractors, standardized patients and site staff along with our own CCEB staff, unsurprisingly there is increasing reluctance, including from candidates, to participate given the current circumstances.

As the role of the CCEB is in support of public protection it is imperative that we remain vigilant in doing our part to support public health guidelines. Clearly, health regions across the country are concerned about interregional travel at this critical stage in the COVID-19 pandemic and, as a result, the CCEB has made the difficult decision to postpone the May 29-30 Component C administration to **July 17-18, 2021** when it is anticipated the situation will be more favourable.

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June 7, 2021

76

Component C Examination ~ Hamilton, Ontario ~ Location change

Update to Component C Candidates, Volunteers and Stakeholders:

We regret to inform you that the CCEB Component C examination scheduled for July 17–18, 2021 in **Hamilton, Ontario** must be **relocated** to Montreal, Quebec.

Candidates originally scheduled for Montreal, Quebec are not impacted.

What you can do:

1. No action is required on your part. Your Component C application remains valid and your exam will be held at the Montreal, Quebec examination site. You will have to travel to Montreal to take your exam on the scheduled date.

2. Should you wish to cancel your examination application due to this location change, please email exams@cceb.ca. Your application will be cancelled and a full refund issued.

3. We ask that, prior to contacting the CCEB with questions or concerns, you read all of the communications and FAQ's available on our website.

What the CCEB has done:

As you will recall from our April 22, 2021 communication, regulations in Ontario at that time specifically excluded chiropractic from the list of professions permitted to conduct examinations in Ontario in spite of public health restrictions related to COVID-19. It is important to understand the provision of examination services is not linked to the profession's ability to provide patient care. The April 22, 2021 communication explains the lengths that the CCEB has undertaken to influence the inclusion of chiropractic in this important Ontario regulation.

The Ontario government did make amendments to the regulation in late May 2021 and included an additional seven professions: dental hygiene, dentistry, medical laboratory technologist, midwifery, optometry, physician assistant, and veterinary medicine. Chiropractic, along with a number of other regulated health professions, has again been excluded without consultation or explanation. You may wish to review the complete current list: Schedule 3, 2. (1.1) in the following regulation https://www.ontario.ca/laws/regulation/200082#BK9.

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The CCEB has continued to attempt to inform the Ontario Government relative to this oversight. However, in spite of the combined efforts of the CCEB, the CCO and other stakeholders, we have been unable to secure a change at this time. While the efforts may continue, the time has come to provide greater certainty for candidates. As such, the CCEB has elected to move Hamilton candidates to the Montreal exam site.

Conducting an examination of this size takes significant staffing and logistics, all of which require sufficient time to ensure optimum success; as such, there is no option to return to the Hamilton site for the July 2021 administration should the government become aware of their oversight.

We recognize that this is extremely frustrating.

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7 juin 2021

Examen de la Composante C ~ Hamilton, Ontario ~ Changement de lieu

Mise à jour pour les candidats, les bénévoles et les parties prenantes de la Composante C :

Nous sommes dans le regret de vous informer que l'examen de la Composante C du CCEB prévu du 17 au 18 juillet 2021 à **Hamilton, Ontario** doit **avoir lieu** à Montréal, Québec.

Les candidats qui avaient l'intention d'aller à Montréal, Québec ne sont pas touchés par ce changement.

Ce que vous pouvez faire :

1. Aucune action est nécessaire de votre part. Votre demande de candidature pour la Composante C reste valide et votre examen aura lieu au site d'examen de Montréal, Québec. Vous devrez voyager à Montréal pour passer votre examen à la date fixée.

2. Si vous souhaitez annuler votre demande d'examen en raison de ce changement de lieu, veuillez envoyer un e-mail à exams@cceb.ca. Votre demande sera annulée et un remboursement complet sera fourni.

3. Nous demandons que, avant d'appeler le CCEB avec des questions ou des préoccupations, vous lisiez toutes les communications et FAQ disponibles sur notre site Web.

Le CCEB a fait le suivant :

Vous avez compris que notre communication du 22 avril 2021 que les règlements de l'Ontario à l'époque excluaient expressément la chiropratique de la liste des professions autorisées à procéder à des examens en Ontario sous les restrictions de santé publique liées à la COVID-19. Il est important de comprendre que la prestation de services d'examen n'est pas liée à la capacité de la profession à prodiguer des soins aux patients. La communication du 22 avril 2021 explique les efforts déployés par le CCEB pour influencer l'inclusion de la chiropratique dans cet important règlement https://www.ontario.ca/fr/lois/reglement/200082/#BK9.

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Le gouvernement de l'Ontario a apporté des modifications au règlement à la fin de mai 2021, incluant sept autres professions : hygiène dentaire, dentisterie, technologue de laboratoire médical, sage-femme, optométrie, adjoint au médecin et médecine vétérinaire. La chiropratique, ainsi qu'un certain nombre d'autres professions de la santé réglementées, a de nouveau été exclue sans consultation ni explication. Vous pouvez consulter la liste actuelle complète à l'Annexe 3, 2. (1.1) du règlement suivant https://www.ontario.ca/fr/lois/reglement/200082/#BK9.

Le CCEB continue ses efforts d'informer le gouvernement de l'Ontario de cette omission. Cependant, malgré les efforts du CCEB, du CCO et d'autres intervenants, nous n'avons pas été en mesure d'obtenir un changement pour le moment. Bien que les efforts puissent se poursuivre, le moment est venu d'offrir une plus grande certitude aux candidats. À ce titre, le CCEB a décidé de déplacer les candidats de Hamilton vers le site d'examen de Montréal.

La conduite d'un examen de cette envergure nécessite un personnel et une logistique importants, qui nécessitent tous suffisamment de temps pour assurer un succès optimal; en tant que tel, il n'y a pas d'option de retour sur le site de Hamilton pour l'administration de juillet 2021 si le gouvernement décide de ne plus omettre la chiropratique de sa liste.

Nous reconnaissons que c'est extrêmement frustrant.

ITEM 1.7

Generated Internally

College of Chiropractors of Ontario
Advertising Committee Report to Council
June 16, 2021

Members:	Dr. Jarrod Goldin, *Chair* Mr. Gagandeep Dhanda Dr. Julia Viscomi Dr. Colleen Pattrick, *non-Council member*
Staff Support:	Mr. Joel Friedman, *Deputy Registrar*

Committee Mandate

- To review proposed advertisements by members to ensure compliance with CCO's Standard of Practice S-016: Advertising and Guideline G-016: Advertising.

Report

The Advertising Committee met on June 7, 2021.

The Committee reviewed its standards of practice, policies and guidelines, as well as processes and procedures related to the review of advertisements submitted to CCO.

The Committee continues to review proposed advertisements submitted by members for review, which include websites and electronic media.

ITEM 4.1

Generated Internally

College of Chiropractors of Ontario
Executive Committee Report to Council (Virtual)
June 16, 2021

Members:	Mr. Rob MacKay, *President* Dr. Dennis Mizel, *Vice-President* Ms Robyn Gravelle, *Treasurer* Dr. Jarrod Goldin Dr. Sarah Green Dr. Steven Lester Mr. John Papadakis Mr. Markus de Domenico (alternate)
Staff Support:	Mr. Joel Friedman, *Deputy Registrar* Ms Jo-Ann Willson, *Registrar and General Counsel*

Mandate

- To exercise the powers of Council between meetings of Council with respect to any matter requiring immediate attention other than the power to make amend or revoke a regulation or by-law
- To provide leadership in exercising CCO's mandate to regulate chiropractic in the public interest

Report

I Introduction

- Welcome to everyone on Council. We are fully constituted, and I look forward to your support and guidance as we continue to regulate chiropractic during an unprecedented time.

- I would like to start my report with acknowledging and celebrating the many CCO core responsibilities that continue to function well, including the:
    - processing of an unprecedented number of complaints;
    - timely disposition of referrals of specified allegations of professional misconduct referred to the Discipline Committee by the Inquiries, Complaints and Reports Committee (ICRC);
    - identification by the Office of the Fairness Commissioner of CCO as one of three colleges as having a best practice relating to transparent, fair, and impartial registration practices, and in particular referencing Council's approval of P-058: Provisional Certificates;
    - registering and renewing of applicants and corporations in a timely manner;
    - launching of the Peer and Practice Assessment component of the Quality Assurance program in both a virtual and in person format; (while complying with government orders and directives);
    - receipt of most of the projected income by May 31, 2021, while continuing to operate consistent with Council's approved budget;
    - continuing good health and safety of staff and council while we try to exercise CCO's important public interest function during unprecedented times;

- Further, and importantly, the CCO membership by and large is reviewing and complying with government orders and directives, and the ongoing President's Messages which provide guidance and support.

- I acknowledge and outline these various successes in part as a reminder about the importance of proportionality in focusing on high priority regulatory matters, as outlined in our various training sessions by Deanna Williams, Richard Steinecke and Rebecca Durcan. More specifically, most of the time, effort, and resources of CCO should be expended on doing core regulatory functions. This is an aspect at which CCO is excelling during a very difficult time for everyone.

III Ministry of Health – College Performance Measurement Framework (CPMF)

A. College Performance Measurement Framework (CPMF)

- An important discussion for Council at the June 16, 2021, Council meeting, is a review of the CPMF action plan which arises from CCO's CPMF Report submitted on March 31, 2021. This includes a consideration of CCO's existing policies, and practices as well as any new ones required to give force and effect to items identified in the action plan. CCO's CPMF submission was previously circulated to Council and posted on CCO's website. I would like to ensure Council has an appropriate opportunity to discuss the action plan and to provide feedback, to enable CCO to implement measures that demonstrate to government and stakeholders that we are committed to ensuring we meet and exceed expectations concerning colleges' performance measures. In particular I think it would be helpful to identify what we can do quickly, what needs to be prioritized, and what may reasonably be considered as part of a longer roll out plan through the lens of public protection.

- The materials in the Council information package are organized in a manner consistent with the CPMF Report. For example, one of the general principles CCO supported in its submission was that Council members have the requisite knowledge, skills, and competencies to serve on Council. CCO has several documents, policies and processes that support that overall principle, including for example the undertaking members sign to declare their candidacy for election. One improvement in the process for the next set of elections, is that effective March 2022, candidates who are nominated will be required to undergo an orientation process to enhance their understanding of CCO's public interest role and the duties and responsibilities of Council members. Currently, the session is for successful candidates only.

- Helpful feedback from Council members will include what changes if any should be made to the existing document and processes, and what further initiatives are required to give effect to the spirit and intent of CCO's CPMF submission. Please know that council training modules are in development, and any feedback about what should be included would be appreciated. One topic that will be incorporated is mentoring, and how to ensure newer council members are mentored appropriately to enable them to take on responsibilities consistent with their knowledge, skills, and interests.

- It is difficult at this time to determine when CCO and other regulators will be returning to in person meetings. We currently have some dates set aside for Council training and strategic planning, and we may take advantage of the scheduled dates for training modules if for example in person strategic planning is not possible. Specifically, the dates of Saturday, September 11, 2021, and Sunday, September 12, 2021, as well as Friday, November 26, 2021.

- One aspect that needs more work and consideration is appropriate evaluation of Council. The Council Meeting Evaluation Form relied upon several years ago seems inadequate and no longer fit for purpose.

- I look forward to hearing from all of you as we devote the next several months to implementing the CPMF action plan. Please know that CCO is simultaneously participating with other regulators who are members of the Health Profession Regulators of Ontario (HPRO) in a working group which is developing consistent approaches and sharing best practices relating to the Ministry's expectations.

- Once feedback from Council has been compiled, the Committee will review all relevant information and may have recommended changes to documents and processes for Council's further consideration. Thank you very much for your feedback and new ideas to ensure CCO's efforts to comply with the CPMF are well considered and actioned.

B. New Government Legislation/Directives/Orders

- CCO is also monitoring and responding to other government initiatives. For example, on May 20, 2021, Sean Court, ADM, Ministry of Health, sought feedback relating to the Healing Arts Radiation Protection Act and the use of emerging technology. Given the time response, a high-level response was provided on June 8, 2021.

- More recently, Mr. Court has requested input on the governance reform proposals that several colleges have submitted pre pandemic. A response is being considered. In principle, CCO has supported CNO's governance reform proposals i.e., moving to a model based on competencies, and a more nimble way of managing college core functions. HPRO is also anticipated to prepare a response on behalf of all member colleges.

IV Institute of Health Policy, Management and Evaluation, University of Toronto, Accessing Centre for Expertise (ACE)

- Included in the Council information is the background information concerning the literature and research review being conducted by ACE, including the information that has been included in prior public information packages. ACE, which previously did a review to facilitate the work of the Registration Committee, is in the process of conducting a review to facilitate CCO's consideration of existing standards, policies, and guidelines.

- There is some misinformation being distributed about the study, but I emphasize that at this time, CCO does not have the report, which will first be considered by the Patient Relations Committee, as well as the Executive Committee. Further, and importantly, the report and any recommendations arising from Council's consideration of the report will continue to be discussed in an open and transparent matter. The Patient Relations Committee will be taking an important lead on the work because that is the committee charged with the responsibility of ensuring patients are considered in CCO's regulatory work. The ACE group has completed several key informant interviews already, including interviews with patients as well as chiropractic stakeholders.

- Included by way of background in the information package is the cv of the lead investigator on the project, as well as background information about ACE. Although the ACE group is very accomplished, experienced with scientific research, well connected to several faculties and levels of government, *it will be up to Council* to determine what action should be taken arising from ACE's independent review. Any action will be appropriately communicated with all stakeholders including members at the same time and in the same way. Thank you to all council members and others who have forwarded relevant research and papers, all of which have been provided to ACE.

- Council should expect to have comprehensive discussions about the work done by ACE and how it can be relied upon to further CCO's duties, mission, vision, and strategic objectives. CCO's strategic planning session has been deferred until CCO Council and staff can safely meet in person. Other topics to potentially discuss include emergency preparedness plan, Core Competencies for Council Members/Evaluation (as a follow up to the July 24, 2020, training session), in addition of course to a SWOT analysis relating to the learnings from conducting business during a pandemic. If there are other topics of interest, please forward them to Ms Willson and me.

V Annual Review of Standards, Guidelines and Policies

- Every committee, including the Executive Committee, is charged with the responsibility of reviewing policies from the committee and recommending any amendments to Council for approval. At the May 14, 2021, meeting, the Committee reviewed the standards, guidelines, and policies, including the internal policies, and determined they do not require amendments at this time. Because these documents do not require action by Council, they are included for your reference in the compendium volume of material. If you have any comments or feedback relating to these, please forward them for the Executive's consideration.

- The by-law amendments approved by Council on April 14, 2021, will come into effect on June 16, 2021 (after the minutes are approved). The Committee will have some by-law amendments for Council's consideration at a future date, but all the amendments are being compiled so they are presented to Council at one time. The amendments relate to various matters including the advisability of shortening the election time period now that elections are done electronically and requiring a fee to be imposed on an application for reinstatement. Only Council has the authority to approve by-law amendments and we look forward to having all the amendments for Council's consideration at a future meeting.

VI Other Chiropractic/Health Related Stakeholders

- During my presidency to date, I have made a conscious effort to attend meetings of stakeholders, and to reach out to Presidents of other chiropractic organizations to ensure we have open lines of communication, and that I have a fuller understanding of all CCO's important stakeholders. I have attended meetings of the FCC, CCRF, CCBC and FCLB, and have had personal communications with the Presidents of FCC, OCA, AFC and the CCPA. Further meetings are pending. It is my firm belief that although chiropractic organizations have different roles and mandates, by understanding each other, knowing more about our differing roles and responsibilities, and having personal relationships facilitates all our work. I have been heartened by the positive reception I have received, and I intend to continue my efforts, and my reporting to Council on the informal and formal meetings with stakeholders.

VII Conclusion

- This has been an interesting an intense time to be CCO President. I thank all of you for your ongoing commitment and support, and I look forward to the opportunity to have an in-person meeting in CCO's new office premises as soon as it is safe to do so. I also would like to acknowledge the staff who have been maintaining the operations of the college while working remotely to the extent possible. Thank you all for your extraordinary efforts.

Respectfully submitted by,

Mr. Robert MacKay,
President

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www.cco.on.ca

March 31, 2021

Via Email (allison.henry@ontario.ca)

Ms Allison Henry
Director, Health Workforce Regulatory Oversight Branch
Strategic Policy, Planning and French Language Services Division
Ministry of Health
Ministry of Long-Term Care
438 University Avenue, 10th Floor
Toronto ON M5G 2L1

Dear Ms Henry:

Re: College Performance Measurement Framework (CPMF)

CCO is pleased to submit its self-assessment using the CPMF Reporting Tools.

The tools were useful in facilitating a baseline assessment of CCO's performance against the criteria being measured. CCO is looking forward to reviewing the Summary Report highlighting key findings and learning about the experiences of other Colleges.

Through its strategic planning process, CCO has been considering aspirational targets beyond minimally acceptable standards that it hopes to measure its performance against in parallel with future CPMF assessments and share with other Colleges at existing roundtables.

Thank you for leading this initiative.

Yours Truly,

Jo Ann Willson

Ms Jo-Ann Willson
Registrar and General Counsel

College of Chiropractors of Ontario
College Performance Measurement Framework (CPMF) Reporting Tool
Executive Summary

March 31, 2021

As a self-regulating organization, the College of Chiropractors of Ontario (CCO) treats its statutory obligations to regulate the practice of chiropractic in the public interest with utmost seriousness. CCO is committed to continuously improving the delivery of its core functions to ensure that Ontario's chiropractic patients have access to safe, quality, ethical care and that the province's chiropractors are held accountable to the highest professional standards as healthcare practitioners.

CCO is pleased to submit its inaugural College Management Performance Framework document, which serves as baseline against which to measure the College's current performance and future enhancements.

The year 2020 was challenging for all members and stakeholders as a result of COVID-19, and yet was met with resilience and innovation as CCO adapted to COVID-19's impact on essential workplaces and chiropractic services in the province. CCO worked to support the Ministry of Health and other Public Health directives while adopting creative remote solutions for the important business of the College and its committees in facilitating registrations, performing quality assurance, responding to inquiries and complaints, holding discipline hearings, conducting elections, liaising with health system partners, administering sound fiscal practices, and more. Many of these adaptive innovations, including virtual complaints and discipline committee processes, the creation of a provisional class of registrants, and an increased cadence of public communications in the form of President's Messages, are detailed in the CPMF Reporting Tool.

Other initiatives had to be modified or delayed because of the pandemic response. For example, CCO was unable to hold its annual strategic planning session, or to address intended agenda items which included revisiting the College's mission, vision, values, and strategic objectives and also evaluation frameworks for Council and committees. As part of any future strategic planning/topic focused meetings, CCO is planning to engage outside consultants to assist in the assessment of Council effectiveness and will be reviewing its evaluation process for council and committee meetings going forward.

Some other areas for development identified in the course of completing the CMPF correspond to initiatives that are partially underway, such as the publishing of Council Minutes. CCO has recently approved an internal policy on the taking and publishing of minutes which would make Council minutes public, once they are approved (except for those minutes that reflect the in-camera portion of the Council meeting.) Similarly, CCO begins every Council and committee meeting with a declaration of any real or potential conflict of interest in relation to any agenda item. CCO has already reviewed and considered questionnaires on conflict of interest; however, has not yet implemented a specific questionnaire for use at every meeting. CCO will continue to review its conflict of interest practices for Council and committee meetings in 2021, based on current CCO policy and codes of conduct. CCO will continue to work on developing policies related to operation and financial planning.

Likewise, while responding to all inquiries and complaints within five business days and most often within two days, CCO has always prioritized high-risk complaints. Going forward, CCO will undertake to formalize its policy of prioritizing high-risk complaints, and related decision-matrix supports, into an approved policy.

CCO welcomes the opportunity the CMPF provides and looks forward to further dialogue with the Ministry on the specific measures identified within.

ITEM 4.1.14

DRAFT

COLLEGE OF CHIROPRACTORS OF ONTARIO

MEMORANDUM

To: Ms Jo-Ann Willson, Registrar and General Counsel

From: Mr. Joel Friedman, Deputy Registrar

Date: May 3, 2021

Re: Summary of College Performance Measurement Framework (CPMF) Objectives for the Year 2021

The chart in this document summarizes the measures and required evidence from CCO's 2020 CPMF where CCO reported on partially fulfilling the listed measures. For each measure that was partially fulfilled, is summarized proposed objectives, relevant committees and target dates for addressing each measure, with a goal to having these areas identified as fulfilled for the 2021 CPMF Report.

CPMF Measure	CPMF Required Evidence	CCO Objective	CCO Committee	Target Date (approval by Council or other implementation)
Where possible, Council and Statutory Committee members demonstrate that they have the knowledge, skills, and commitment prior to becoming a member of Council or a Statutory Committee.	Professional members are eligible to stand for election to Council only after: i. meeting pre-defined competency / suitability criteria, and ii. attending an orientation training about the College's mandate and expectations pertaining to the member's role and responsibilities.	• Review and consider amendments to CCO By-law 6 and Notice of Election Document for pre-defined competencies and suitability criteria. • Review Cayton Report and other Ontario health regulatory colleges for best practices to guide by-law review. • Require orientation training for candidates for election to CCO Council (motion passed by Council in April 2021).	Executive	November 2021
Where possible, Council and Statutory Committee members demonstrate that they have the knowledge, skills, and commitment prior to becoming a member of Council or a Statutory Committee.	Statutory Committee candidates have: i. met pre-defined competency / suitability criteria, and ii. attended an orientation training about the mandate of the Committee and expectations pertaining to a member's role and responsibilities.	Review and consider amendments to By-law 7 to include nominations working group and process that takes into account interest, skills, competencies and a mix of experienced and new Council members on committees, that was done in April 2021.	Executive	November 2021

CPMF Measure	CPMF Required Evidence	CCO Objective	CCO Committee	Target Date (approval by Council or other implementation)
Council regularly assesses its effectiveness and addresses identified opportunities for improvement through ongoing education.	Council has developed and implemented a framework to regularly evaluate the effectiveness of: i. Council meetings; ii. Council	Review, update and implement Council meeting evaluation tool.	Executive	September 2021
Council regularly assesses its effectiveness and addresses identified opportunities for improvement through ongoing education.	The framework includes a third-party assessment of Council effectiveness at a minimum every three years.	Direct third-party assessment of Council effectiveness as part of next strategic planning.	Executive	Dependent on COVID-19 pandemic

CPMF Measure	CPMF Required Evidence	CCO Objective	CCO Committee	Target Date (approval by Council or other implementation)
All decisions related to a Council's strategic objectives, regulatory processes, and activities are impartial, evidence-informed, and advance the public interest.	The College has a conflict of interest questionnaire that all Council members must complete annually. Additionally: i. the completed questionnaires are included as an appendix to each Council meeting package; ii. questionnaires include definitions of conflict of interest; iii. questionnaires include questions based on areas of risk for conflict of interest identified by Council that are specific to the profession and/or College; and iv. at the beginning of each Council meeting, members must declare any updates to their responses and any conflict of interest specific to the meeting agenda.	Develop conflict of interest questionnaire for Council based on current conflict of interest policy, code of conduct and other relevant documents.	Executive	September 2021

CPMF Measure	CPMF Required Evidence	CCO Objective	CCO Committee	Target Date (approval by Council or other implementation)
Council decisions are transparent.	Council minutes (once approved) are clearly posted on the College's website. Attached to the minutes is a status update on implementation of Council decisions to date (e.g., indicate whether decisions have been implemented, and if not, the status of the implementation).	Implement Internal Policy on Minutes (already passed by Council in February 2021).	Council	June 2021
The College demonstrates responsible stewardship of its financial and human resources in achieving its statutory objectives and regulatory mandate.	The College: i. has a "financial reserve policy" that sets out the level of reserves the College needs to build and maintain in order to meet its legislative requirements in case there are unexpected expenses and/or a reduction in revenue and furthermore, sets out the criteria for using the reserves; ii. possesses the level of reserve set out in its "financial reserve policy".	Develop internal policy on financial reserve, based on current practices and input from CCO's financial officer and auditor.	Executive	September 2021

CPMF Measure	CPMF Required Evidence	CCO Objective	CCO Committee	Target Date (approval by Council or other implementation)
The College demonstrates responsible stewardship of its financial and human resources in achieving its statutory objectives and regulatory mandate.	Council is accountable for the success and sustainability of the organization it governs. This includes ensuring that the organization has the workforce it needs to be successful now and, in the future (e.g. processes and procedures for succession planning, as well as current staffing levels to support College operations).	Develop policy regarding processes and procedures for staffing levels, college operations and succession planning.	Executive	November 2021
The College supports registrants in applying the (new/revised) standards of practice and practice guidelines applicable to their practice.	Provide examples of how the College assists registrants in implementing required changes to standards of practice or practice guidelines (beyond communicating the existence of new standard, FAQs, or supporting documents).	Build on current workshops and webinars to include implementation of new and amended standards of practice.	Quality Assurance	November 2021

CPMF Measure	CPMF Required Evidence	CCO Objective	CCO Committee	Target Date (approval by Council or other implementation)
The College effectively administers the assessment component(s) of its Quality Assurance (QA) Program in a manner that is aligned with right touch regulation[1].	The College has processes and policies in place outlining: i. how areas of practice that are evaluated in QA assessments are identified in order to ensure the most impact on the quality of a registrant's practice; ii. details of how the College uses a right touch, evidence informed approach to determine which registrants will undergo an assessment activity (and which type if multiple assessment activities); and iii. criteria that will inform the remediation activities a registrant must undergo based on the QA assessment, where necessary.	Review "Right Touch" Regulation document and implement best practices as part of Quality Assurance program.	Quality Assurance	November 2021

[1] "Right touch" regulation is an approach to regulatory oversight that applies the minimal amount of regulatory force required to achieve a desired outcome. (Professional Standards Authority. Right Touch Regulation. https://www.professionalstandards.org.uk/publications/right-touch-regulation).

CPMF Measure	CPMF Required Evidence	CCO Objective	CCO Committee	Target Date (approval by Council or other implementation)
The College addresses complaints in a right touch manner.	The College has accessible, up-to-date, documented guidance setting out the framework for assessing risk and acting on complaints, including the prioritization of investigations, complaints, and reports (e.g., risk matrix, decision matrix/tree, triage protocol).	Develop risk matrix, decision matrix/tree, triage protocol for ICR Committee for assessing risk and acting on complaints based on best practices and "Right Touch" regulation principles.	Inquiries, Complaints and Reports Committee	September 2021
The College demonstrates that it shares concerns about a registrant with other relevant regulators and external system partners (e.g., law enforcement, government, etc.).	The College's policy outlining consistent criteria for disclosure and examples of the general circumstances and type of information that has been shared between the College and other relevant system partners, within the legal framework, about concerns with individuals and any results.	Develop policy on disclosure about concerns related to members with relevant regulators and external system partners, based on privacy requirements and best practices.	Inquiries, Complaints and Reports Committee	September 2021

CPMF Measure	CPMF Required Evidence	CCO Objective	CCO Committee	Target Date (approval by Council or other implementation)
Council uses Key Performance Indicators (KPIs) in tracking and reviewing the College's performance and regularly reviews internal and external risks that could impact the College's performance.	• Outline the College's KPI's, including a clear rationale for why each is important. • Council uses performance and risk information to regularly assess the College's progress against stated strategic objectives and regulatory outcomes. • Where relevant, demonstrate how performance and risk review findings have translated into improvement activities. • Performance results related to a College's strategic objectives and regulatory activities are made public on the College's website.	Develop annual Key Performance Indicators for annual College performance and process for assessing performance and risk.	Executive	November 2021

UNDERTAKING TO THE CCO REGISTRAR FROM CANDIDATE

College of Chiropractors of Ontario (CCO) January 2021

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

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

1. **Districts 1, 4 and 5**

   (a) I am not a member of faculty at CMCC. ☐

   – AND – **AND**

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

   – OR – **OR**

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

   District 7

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

   - AND- **AND**

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

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

3. If applicable, I have attached to this undertaking a copy of all letters of resignation from my position as an employee, officer or director of any professional chiropractic association or an officer, director or administrator of any chiropractic educational institution such that a real or apparent conflict of interest may arise. ☐

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

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[1] The effective date on which the candidate must not be an employee, officer or director of any professional chiropractic association, or an officer, director or administrator of any chiropractic educational institution such that a real or apparent conflict of interest may arise, is the closing date of nominations and any time up to and including the date of the election (i.e., before the election results are known). Copies of relevant letters of resignation must be filed with CCO, along with the candidate's nomination papers. The candidate should take all reasonable and necessary steps to ensure he/she is not reflected in any documents or on any websites as an employee, officer or director of any professional chiropractic association, or an officer, director or administrator of any chiropractic educational institution, such that a real or apparent conflict of interest may arise.

[2] The effective date on which the candidate must not be a faculty member of CMCC (except for District 7) is the closing date of nominations and any time up to and including the date of the election (i.e., before the election results are known).

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

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

7. A finding of professional misconduct, incompetence or incapacity has not been made against me in the preceding three years. ☐

8. I confirm I have reviewed my active personal and business communications, including those on social media, and there is no current content that could embarrass or harm the reputation of CCO or give cause to consider that I am unable or unwilling to comply with CCO's mission, vision, values, strategic objectives and by-laws, and the duty to be fair and impartial in all considerations. ☐

9. I undertake to: ☐
   - review and comply with CCO's provisions, including the Code of Conduct, CCO Internal Policy I-015: Policy to Avoid Abuse, Neglect and Harassment and CCO's mission, vision, values and strategic objectives,
   - review CCO's orientation material and attend any relevant training workshop,
   - participate in CCO's Peer and Practice Assessment Program within six months of my election (if I have not already been peer assessed by that time), and
   - participate as a member of a discipline panel or fitness to practise panel if selected by the Chair of the Discipline or Fitness to Practise Committee, unless I have a conflict of interest.

10. I confirm that I have access to and agree to use the following confidential e-mail address for any and all CCO matters:

    _____

11. I recognize that, if I were to resign from Council, it will not be properly constituted. Therefore, if if elected, I undertake not to resign from Council without first giving 60 days written notice to the President and Registrar so that the Council can take steps to ensure that Council can remain properly constituted at all times. ☐

12. I **confirm** all the information in this undertaking is accurate, complete and true. ☐

13. I further undertake to advise the Registrar forthwith of any change in the above-noted statements. ☐

14. I understand it is an act of professional misconduct to fail to comply with an undertaking to the Registrar. ☐

Candidate's Name	Candidate's Signature	Date
Witness' Name	Witness' Signature	Date

ELECTION NOMINATION PAPER – ELECTIONS FOR DISTRICTS 1, 4 AND 5 AND BY-ELECTIONS FOR DISTRICT 4 (ONE YEAR TERM) AND DISTRICT 7 (TWO YEAR TERM)

College of Chiropractors of Ontario (CCO) January 2021

The Election Nomination Paper must be received with the Candidate Undertaking Form at CCO by 4 p.m. on February 12, 2021. Please type or print neatly, using black ink. Forms may be emailed to CCO at cco.info@cco.on.ca, faxed to CCO at 416-925-9610.

Please note: There are elections for Districts 1, 4 and 5 (three year terms) and by-elections for District 4 (one year term) and District 7 (two year term). The election and by-election in District 4 will run as one election, with the candidate getting the most votes receiving a three year term and the candidate getting the second most votes receiving a one year term.

We, the undersigned members of CCO, eligible to vote in Electoral District _____,

nominate _____ of _____
(Name of Candidate) (City / Town)

as a candidate for the March 2021 election to CCO Council.

Candidate's Registration Number: _____

Business Phone: ( ) _____

Business Address: _____

Confidential E-mail Address: _____

	Nominator's Name[1] (please print)	City / Town	Registration Number	Signature
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

CANDIDATE'S CONSENT: I consent to allow my name to stand for election as a member of CCO for the Electoral District of _____ and agree to serve if elected.

_____ _____ _____
Candidate's Name **Candidate's Signature** **Date**

[1] Minimum of 10 eligible members who support the nomination and who are eligible to vote in the electoral district is required.

Health Profession Regulators of Ontario (HPRO)
Suite 301 - 396 Osborne St, PO Box 244, Beaverton ON L0K 1A0
email: bakenny@regulatedhealthprofessions.on.ca
web: www.regulatedhealthprofessions.on.ca
Phone: 416-493-4076/Fax: 1-866-814-6456

ITEM 4.1.18

DISCIPLINE ORIENTATION WORKSHOP – Faculty: Richard Steinecke and Luisa Ritacca

Basic Session (9:00 a.m.-4:00 p.m.) – October 1, 2021

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

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

Advanced Session (9:00 a.m.-4:00 p.m.) – October 7, 2021

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

GOVERNANCE TRAINING FOR *RHPA* COLLEGES – Faculty: Richard Steinecke

Day 1 (9:00 a.m.-12:00 p.m.) – October 22, 2021

1. Introduction: Context: What Does A Regulator Do? What Does A Board Do?
2. Governance: Concept and Purpose
3. Fiduciary Obligations: Conflicts of Interest, Confidentiality, Conduct Unbecoming, Diligence, Respect

Day 2 (9:00 a.m.-12:00 p.m.) – October 29, 2021

4. Setting the Mission, Goals, and Strategies; Developing Policies
5. Selection of Board, Committees, Staff (existing processes)
6. Roles: Purpose of Roles, Board /Council Role, Individual Board/Council Member Role, Chair/President Role, Committee Role, Committee Chair Role, CEO/Registrar Role, Role Achievement
7. Conclusion

From: Jo-Ann Willson
Sent: Tuesday, March 30, 2021 2:30 PM
To: Rose Bustria
Cc: President
Subject: Expression of Interest in CCO Committees
Attachments: 21March30ComSelTemp.docx

Good afternoon:

This communication is being forwarded to the Council as it will be composed on April 14, 2021. At the last Executive Committee meeting on March 26, 2021, and consistent with the Ministry's college performance management framework (CPMF), the Executive directed that the Executive Officers try to come up with a slate of individuals for each of the committees effective April 15, 2021, relying on interest, skills, and experience *for Council's consideration*. In particular, Domain 1: Governance of the CPMF says the following:

Council and Statutory Committee members have the knowledge, skills and commitment needed to effectively execute their fiduciary role and responsibilities pertaining to the mandate of the College.

As a first step, it is important to know what committees (if any) Council members are interested in serving on. If for example you are very busy in practice and prefer to simply attend and participate at Council meetings, you can indicate that (say Council only this year). I've tried to include in the attached chart some information about approximate time commitments.

I realize that it will be difficult for the newest council members to complete this information until they have had the orientation session, but please feel free to reach out to the chairs or others on the committee if you want to learn more about any committee or its workload, and then file your form after the orientation session if you prefer.

Please note, 2020 was an unusual year, so it is difficult to predict workload at this point since CCO has been focused on essential functions only during the pandemic. However, core functions include ongoing discipline hearings, Executive Committee meetings, the registration of applicants, administration of the Quality Assurance Program, and meeting the time lines required for the Inquiries, Complaints and Reports Committee which has been reviewing an unprecedented number of complaints during the pandemic.

Please complete the attached form and return to me at your earliest convenience. Use a separate page if required. Thank you very much.

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

388

Committee Selection Template [1]
Version Date: March 30, 2021

389

All Council members are asked to complete this template for all College Committees, even those that are not your first choice. The first two columns are pre-filled. Please do not add to them. Please complete the other columns. Most Council members serve on two or three committees.

Council member's name: _____

Committee	Skills Helpful for this Committee	Would You Like to Serve on this Committee?[2]	Describe your Relevant Skills, Training and Experience for this Committee	List any Affiliations that might Sometimes Create a Conflict of Interest for this Committee	Workload (scale of 1 – 5)
Executive	Governance Policy Development Risk Management Managerial Human Relations Accounting and Financial				4 One meeting every two months (8:30 a.m. – 1:00 p.m.). More meetings when council not properly constituted.
Registration	Education Examination Entry-to-practise competencies				3 Monthly meetings to review applicants (usually 2 hours) plus one or two meetings annually to review

[1] To assist with the preparation of a slate for Council's consideration on April 15, 2021.
[2] Please note that it is strongly discouraged for anyone serving on both the Inquiries Complaints and Reports Committee while they serve on the Discipline or Fitness to Practise Committees. Other committee overlaps should be minimized, such as either the Quality Assurance Committee or the Advertising Committee and the Inquiries Complaints and Reports Committee.

Committee	Skills Helpful for this Committee	Would You Like to Serve on this Committee?[2]	Describe your Relevant Skills, Training and Experience for this Committee	List any Affiliations that might Sometimes Create a Conflict of Interest for this Committee	Workload (scale of 1 – 5)
					policies and standards.
Inquiries Complaints Reports	Legal Investigation Conflict Resolution Standards of Practice Addictions and Mental Health				4 Monthly meetings (approximately 5 hours per meeting). Preparation is intensive.
Discipline	Adjudication Chairing Legal				3 – 4 Contested hearings can be several days but most matters resolved by joint submission. Usually, one full meeting per year to review policies and standards. "demand driven" i.e., depending on referrals from ICRC.
Fitness to Practise	Adjudication Chairing Legal Addictions and Mental Health				0 – 1 Historically one meeting per year to review policies and standards. "demand driven" i.e., depending on referrals from ICRC.
Patient Relations	Communications				3

Committee	Skills Helpful for this Committee	Would You Like to Serve on this Committee?[2]	Describe your Relevant Skills, Training and Experience for this Committee	List any Affiliations that might Sometimes Create a Conflict of Interest for this Committee	Workload (scale of 1 – 5)
	Public Relations Conflict Resolution				Will be approximately one meeting every two months in view of research study being done by ACE at the U of T. One full meeting per year to review policies and standards.
Quality Assurance	Standards of Practice Policy Development Communications Risk Management				3 - 4 2020 an exceptional year, but usually one meeting every two months. Ongoing review and monitoring of CCO's QA program. Peer Assessor training day annually. Some challenging standards of practice being considered for recommendation to Council.
Advertising	Communications Social Media Legal				2 - 3 Most work done "online" as committee's policy development rests

Committee	Skills Helpful for this Committee	Would You Like to Serve on this Committee?[2]	Describe your Relevant Skills, Training and Experience for this Committee	List any Affiliations that might Sometimes Create a Conflict of Interest for this Committee	Workload (scale of 1 – 5)
					with the Executive Committee. Generally ongoing review of ads submitted by members with quick turn around expected (template provided)

406

Right-touch regulation

Revised

October 2015

professional standards authority

About the Professional Standards Authority

The Professional Standards Authority for Health and Social Care promotes the health, safety and wellbeing of patients, service users and the public by raising standards of regulation and registration of people working in health and care. We are an independent body, accountable to the UK Parliament.

We oversee the work of nine statutory bodies that regulate health professionals in the UK and social workers in England. We review the regulators' performance and audit and scrutinise their decisions about whether people on their registers are fit to practise.

We also set standards for organisations holding voluntary registers for people in unregulated health and care occupations and accredit those organisations that meet our standards.

To encourage improvement we share good practice and knowledge, conduct research and introduce new ideas including our concept of right-touch regulation. We monitor policy developments in the UK and internationally and provide advice to governments and others on matters relating to people working in health and care. We also undertake some international commissions to extend our understanding of regulation and to promote safety in the mobility of the health and care workforce.

We are committed to being independent, impartial, fair, accessible and consistent. More information about our work and the approach we take is available at www.professionalstandards.org.uk

Contents

Introduction 4

What is Right-touch regulation? 4

Right-touch regulation in practice 5

Right-touch regulation and responsibility in health and social care 7

Right-touch regulation and risk 11

Conclusion 13

Appendix: Case studies 14

References 17

Introduction

This revised paper sets out the Professional Standards Authority's refreshed thinking as we explore the role and value of regulation in controlling the risk of harm to the public. Common themes have emerged through our oversight of the health and care professional regulators, in our advice to Governments on areas of regulatory policy and in our development of accredited registers. Our original paper was published in 2010. Since then, we and others have applied it to a variety of problems in regulation both in the UK and internationally.

Right-touch regulation describes the approach we adopt in the work we do. It is the approach that we encourage regulators to work towards, and it frames the contributions we make to wider debates about the quality and safety of health and social care and the development of regulation. It also provides a framework for thinking about wholesale reform of existing regulatory arrangements.[a]

This paper reaffirms that this approach is the right one to take. It explains Right-touch regulation in practice and outlines the benefits it offers for professional regulation and to wider health and care delivery, as our area of expertise and experience.

In 2010, we hoped that other areas of regulation might find this approach useful too; in 2015, we know that others have tried it and found it so. We have drawn on these collective experiences, clarified some areas, expanded on the concept of risk, discussed responsibility, and defined Right-touch regulation more clearly. We have also provided some practical examples to illustrate the approach. The core principles, however, remain unchanged.

We continue to see this as a work in progress, and an approach to be debated and improved over time.

What is Right-touch regulation?

The concept of Right-touch regulation emerges from the application of the principles of good regulation identified by the Better Regulation Executive in 2000[2], to which the Professional Standards Authority has added agility as a sixth principle.[b] With this addition, the principles state that regulation should aim to be:

- **Proportionate**: regulators should only intervene when necessary. Remedies should be appropriate to the risk posed, and costs identified and minimised
- **Consistent**: rules and standards must be joined up and implemented fairly
- **Targeted**: regulation should be focused on the problem, and minimise side effects
- **Transparent**: regulators should be open, and keep regulations simple and user friendly
- **Accountable**: regulators must be able to justify decisions, and be subject to public scrutiny
- **Agile**[c]: regulation must look forward and be able to adapt to anticipate change.

These principles provide the foundation for thinking on regulatory policy in all sectors

[a] In our paper *Rethinking regulation*[1] we argue that the current regulatory arrangements are outdated, inefficient and ineffective. We suggest that the principles of Right-touch regulation should be used to help design a better, more coherent regulatory system.

[b] In their 2009 report on *Themes and Trends in Regulatory Reform*[3], The House of Commons Regulatory Reform Committee agreed with us that 'agility' is an important objective for the regulatory agenda.

[c] Agility in regulation means looking forward to anticipate change rather than looking back to prevent the last crisis from happening again. We consider that an agile regulator would foresee changes that are going to occur in its field, anticipate the risks that will arise as a result of those changes, and take timely action to mitigate those risks. At the same time, an agile regulator would not react to everything as changes may occur which do not need a regulatory response.

of society.[d] We see the concept of Right-touch regulation emerging naturally from the application of these six principles: bringing together commonly agreed principles of good regulation with understanding of a sector, and a quantified and qualified assessment of risk of harm. It is intended for those making decisions about the design of an assurance framework.

In practice this means we work to identify the regulatory force needed to achieve a desired effect. Our analogy is finding the right balance on a set of scales (Figure 1). When weighing something on balancing scales, nothing happens until you reach the desired weight, at which point the scales tip over. Once they have tipped any further weight added to the other side is ineffectual. So the right amount of regulation is exactly that which is needed for the desired effect. Too little is ineffective; too much is a waste of effort.

Our thinking is in line with what others have called better regulation,[5] or common sense or rational approaches to regulation, but it is categorically not 'light-touch'. For us, Right-touch neatly describes the role that regulation should play. It builds on an accurate and informed assessment and analysis of the sector and the risks in it; it is common sense in that it describes the role regulation should play, building on its strengths, staying true to its objectives, and working with the tools it has at its disposal. It recognises that there is no such thing as 'zero risk', and that all decisions about what and how to regulate will involve a trade-off between different risks and competing benefits.

Right-touch regulation recognises that there is usually more than one way

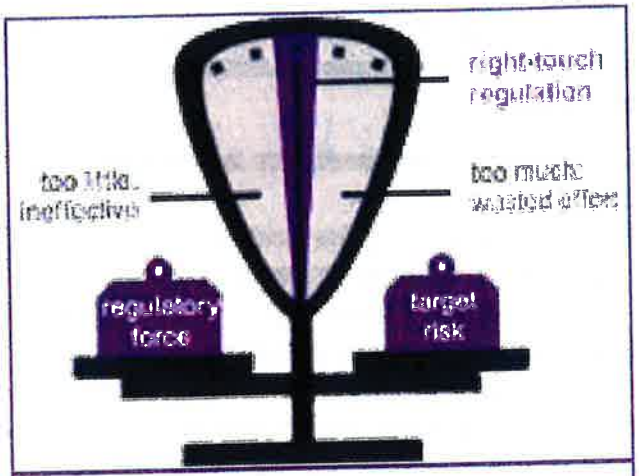


Figure 1. Regulatory force.

to solve a problem and regulation is not always the best answer. It may be more proportionate and effective, for instance, to strengthen employment practices or to foster professionalism. New regulations should be introduced only as a last resort. The regulator is usually furthest removed from the harms it is trying to prevent and as such regulation is a blunt instrument for promoting behaviour change. Today, more than ever given economic circumstances, the challenge is to find the most efficient, common sense solutions that are close to the problem.

Right-touch regulation is the minimum regulatory force required to achieve the desired result.

Right-touch regulation in practice

Through our work we have identified eight elements that sit at the heart of using the concept of Right-touch regulation in practice. Built into these elements are commitments to use evidence to identify and understand problems, and to draw on the roles and responsibilities of different parts of the system to deliver the best solution. The consequences of adopting this approach may be less regulation or more regulation, but should certainly mean better regulation.

[d]The idea that governments should have an over-arching policy for decisions about regulation was supported by the OECD in their 2012 report Recommendation of the Council on Regulatory Policy Governance.[4]

The appendix on page 14 contains a number of case studies illustrating this approach.

One: identify the problem before the solution

We need to identify the problem before we can determine whether any particular policy is the right one. Often in policy development the need for regulatory change, as a solution, is identified before the problem is properly described and understood. This can lead to inefficiencies as resources are spent developing a regulatory solution when the problem may be better dealt with in other ways. *See case study 1 in the appendix for a practical example.*

Two: quantify and qualify the risks

Once the problem has been identified, we need to understand it fully and quantify and qualify the risks associated with it. Quantifying risks means gauging the likelihood of harm occurring and its severity. Qualifying risks means looking closely at the nature of the harm, and understanding how and why it occurs.

Without this two-fold evaluation, which must be based on evidence, it is impossible to judge whether regulatory action is necessary, what type of regulatory response might be needed, or whether it would be better to use other means of managing the issues. Regulation should only be chosen when it clearly provides the best solution. Simply identifying a real or potential risk is not sufficient. We have to understand whether the risk is new or currently unmanaged. We provide more detail about the evaluation of risk on page 11. *See case study 1 in the appendix for a practical example.*

Three: get as close to the problem as possible

Once we have identified the problem and fully understood the risks, we must look for a solution that is as close to the problem as possible. Regulation is distant and removed from the point of care and problems are best solved near to where they occur. Targeted regulation needs to understand, both the range of hazards and the factors that increase or decrease the risk of them resulting in harm. In healthcare this means understanding the context in which the problem arises and the different tools that may be available to tackle the issues. We may need to work with organisations and individuals that are closer to the problem to bring about change. Some problems may be best tackled by regulatory measures applying to a whole profession, while others may require more targeted regulation or a non-regulatory approach. *See case studies 2 and 3 in the appendix for a practical example.*

Four: focus on the outcome

Adopting a Right-touch approach means staying focused on the outcome that we are looking to achieve, rather than being concerned about process, or prioritising interests other than public safety.

The outcome should be both tangible and measurable, and it must be directed towards the reduction of harm. Staying focused on the outcome helps identify the most appropriate solution. Having a clearly defined and measurable outcome also makes it easier to measure effectiveness. *See case studies 1 and 3 in the appendix for a practical example.*

Five: use regulation only when necessary

Once the problem has been considered, we may begin to examine whether a regulatory change is the right proposal, evaluating this

against the options of doing nothing and the risks and benefits of intervening. Making changes to regulation, especially statutory regulation, can be a slow process, so regulation should only be used as a solution when other actions are unable to deliver the desired results. A Right-touch regulatory solution must keep to the six principles of good regulation and should build on existing approaches where possible. This will often involve looking for solutions other than regulation and may require regulators to work with other organisations and people to bring about change. *See case studies 1 and 3 in the appendix for a practical example.*

Six: keep it simple

For regulation to work, it must be clear to those who are regulated, clear to the public, clear to employers, and clear to the regulator. If each cannot explain to the other what the purpose of a regulation is and why it will work, it is not simple. This is as true in health and social care, with such a wide variety of agencies and individuals involved, as it is in other sectors. Avoiding complexity will lead to a greater impact. A regulatory response should be as simple as it can be while achieving the desired outcome. *See case study 1 in the appendix for a practical example.*

Seven: check for unintended consequences

Assessing the probable impact of a particular solution is an essential step to help us avoid unintended consequences.[6] In a system as interconnected and complex as health and social care, it is inevitable that proposing a change in policy and practice will have consequences for other parts of the system. If regulations are not workable, people will work around them and in doing so create new risks. Regulating to remove one risk without a proper analysis of the consequences may create new risks or merely move the risk to a different place. *See case studies 3 and 4 in the appendix for a practical example.*

Eight: review and respond to change

We should build flexibility into regulatory strategy to enable regulation to respond to change. All sectors evolve over time, as a result of a range of different influences. Regulators must not be left managing the crises of the past, whilst ignoring or being unable to react to new evidence that calls for change. This is what we mean by agility. A programme of regular reviews, post-implementation evaluation and sunset clauses can all help here. *See case study 1 in the appendix for a practical example.*

The decision tree (Figure 2) shows how these eight steps translate into a decision-making process.

Right-touch regulation and responsibility in health and social care

In our work with regulators, accredited registers and others we formally define Right-touch regulation as follows:

'Right-touch regulation is based on a proper evaluation of risk, is proportionate and outcome focused; it creates a framework in which professionalism can flourish and organisations can be excellent'

The interests of patients and service users are at the heart of all our work, and this is clearly set out in our legislation.[7] Many health and care organisations share this aim, either explicitly or implicitly. They have a role to play to achieve this wider benefit.

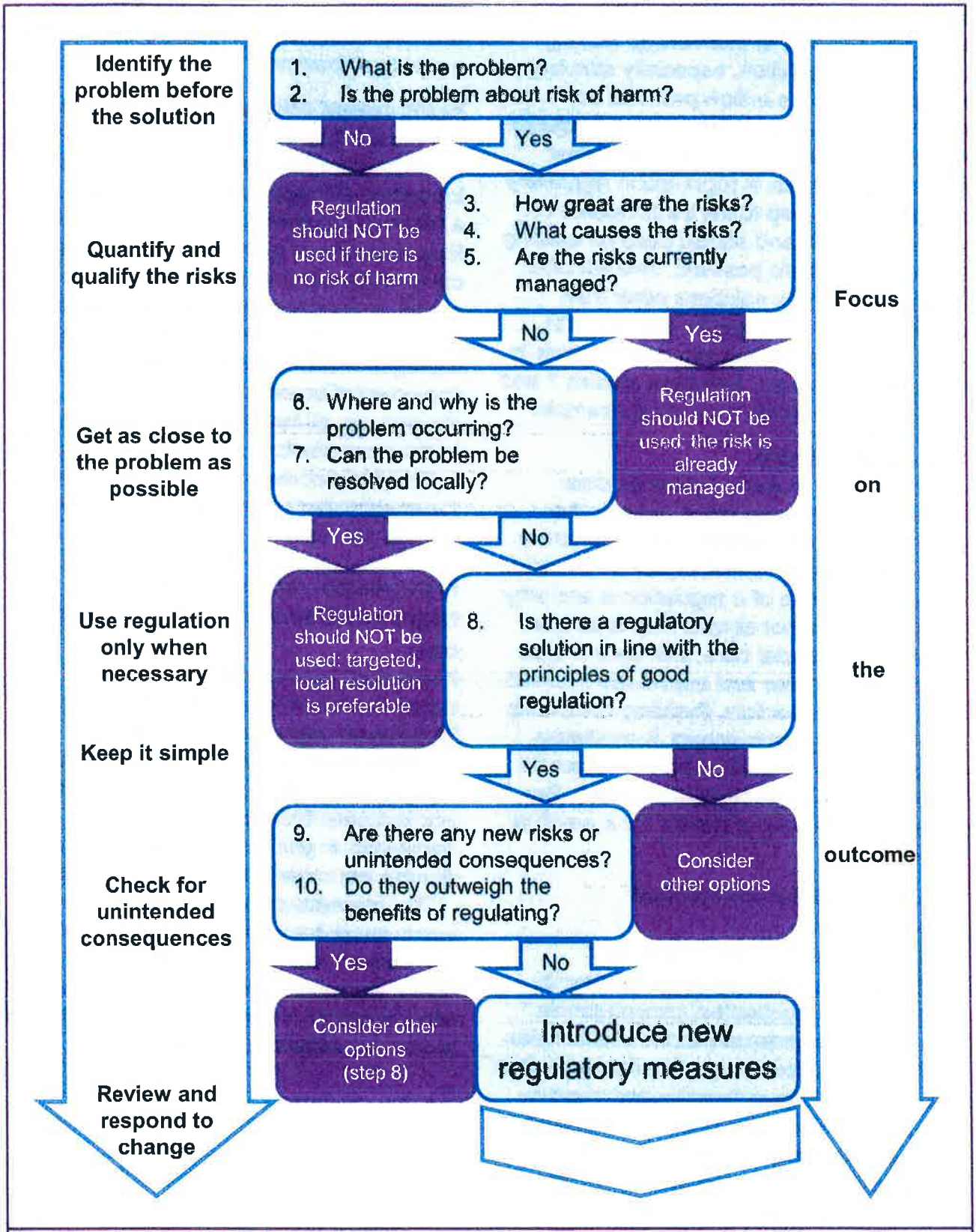


Figure 2. The Right-touch regulation decision tree.

The quality of care received by individual patients and service users is the end result of a wide range of decisions made by a number of different agents. For example:

- **People**: self-management decisions taken or not taken by people
- **Professionals**: education, training and continuing professional development
- **Providers**: their policies and guidance, and local clinical governance arrangements
- **Commissioners**: through contracting arrangements
- **Regulators**: setting and maintaining standards, controlling entry to the profession, and taking action in response to concerns
- **Other bodies**: any organisations who have an impact on standards of practice, such as accredited registers, professional organisations, royal colleges, arm's-length bodies, and government departments.
- **Legislation**: for example, human rights, equality, data protection, consumer protection, health and safety.

Regulation is part of a set of possible solutions to risks in a sector. This is recognised in our development of the accredited registers programme under the Health and Social Care Act 2012, which offers a new model of assured registration to manage risks associated with unregulated occupations.[8] All regulatory policy development should be seen in this context, and regulation will only be effective if this wider perspective is taken. It may be necessary for regulators to look for ways in which they can influence registrant behaviour through other organisations or people.

Right-touch regulation is about sharing the responsibility for mitigating the risk of harm between the different organisations and people involved in its management.We believe that it is primarily the professionalism of individuals that keeps the public safe, and in the case of health and social care also ensures the delivery of good care.

Professional regulation is working in the public interest when it supports professionalism and allows it to flourish. It does this through promotion of standards of competence and conduct, by taking action where these standards are breached, and through quality assuring education. It does not seek to address all aspects of risk. It cannot prevent every possible thing that could go wrong. Indeed over-regulation can give a false level of assurance and lead to increased risk.

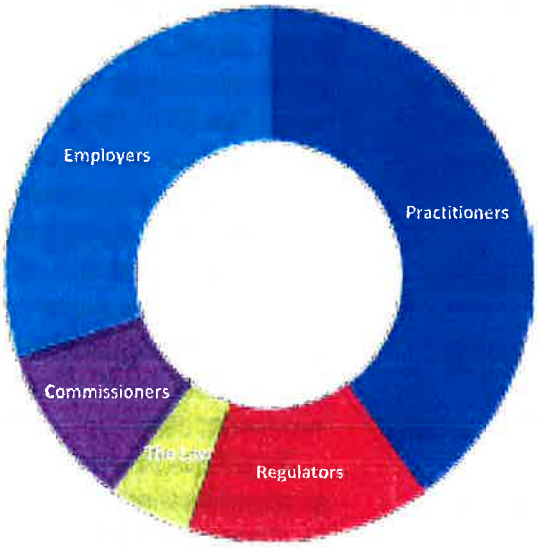
Right-touch regulation supports professionalism by:

- Discouraging the use of regulation if the risk can be addressed more effectively by the professionals themselves; and
- Encouraging the use of regulatory measures that support positive behaviour change and the exercise of professional judgement, rather than seeking to be overly prescriptive.

Patients and the public also have responsibility for managing risks, becoming involved in discussions about their treatment options, the different levels of risk involved, and the possible consequences for their health. For vulnerable people this responsibility is shared and extended to family, carers and advocates. People have a fundamental and essential contribution to make to high-quality healthcare. The concept of Right-touch regulation recognises the value and importance of the involvement of patients and service users in assessing risks for themselves and making appropriate choices. Right-touch regulation requires the active participation of patients and service user.

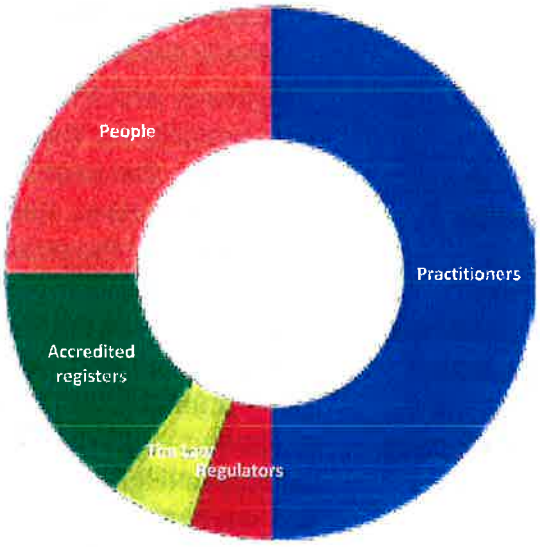
There is an inherent risk in all interventions in health and social care and

Paramedics



Paramedics practise in the relatively controlled environment of the NHS. Practitioners still bear a large share of the responsibility, but employers, commissioners, and regulators (both service and professional) between them play an important part in preventing harm. As paramedics work in emergency care, people do not have any significant control over the care a paramedic provides them.

Acupuncturists



The vast majority of acupuncturists work in private practices, and they are usually self-employed. Both practitioners and patients can therefore be expected to bear a larger share of the responsibility for preventing harm than in the previous example. Their premises are nevertheless inspected by local authorities and the products they use are subject to controls. Some are on registers accredited by the Authority, which are also responsible for preventing harm.

Figure 3. Indicative illustration of how different agents might share the responsibility for mitigating the risk of harm for two occupations in healthcare.

nothing can be said to be completely safe. For example, there is no such thing as an absolutely safe medicine, since someone will suffer an adverse reaction or side effect. Given the wide range of influences on care outcomes, it is neither proportionate nor targeted to expect regulation to act on every safety or quality concern (potential or actual) that may arise. Ultimately, the responsibility for managing risks in healthcare is shared between all parties.

Figure 3 illustrates how the share of responsibility for preventing harm might vary depending on the occupation. Each of these bears a greater or lesser share of the responsibility for mitigating risks. These examples indicate how the proportions might vary according to the respective contribution of each agent. In both examples, practitioners hold a large share of the responsibility. The share of people, employers, and regulators varies greatly. Commissioners also play a role.

Right-touch regulation and risk

When we talk about risk, we mean the risk of harm to the public that the regulator is there to reduce.

In the first version of Right-touch regulation we said that risks must be quantified. In reviewing how the approach has worked we now suggest that to understand a problem fully we must both quantify and qualify risks to enable us to see how frequently harm occurs, what impact it has, and what causes it. We recognise that risk quantification is complex and challenging, but it is essential if we are to make informed decisions about which harms to address. Risk qualification is equally important because it allows us to understand what causes the harm and how it could be prevented. Regulation should focus on identifying and addressing the causes of a risk of harm, rather than responding after the harm has occurred.[9,10]

This two-fold evaluation is essential if we want to describe regulation as 'risk-based'. The term 'risk-based regulation' should only be used when such an evaluation has taken place. Describing regulation as risk-based in the absence of a proper evaluation of risk is, in our view, misleading and can undermine wider confidence and trust in regulation.

Once a risk has been evaluated, a decision needs to be made about its tolerability. This is a difficult moral decision that will require clear justification. If the risk cannot be tolerated, action will need to be taken – although a further decision will need to be made about whether it can indeed be effectively addressed through regulatory means.

There is no justification for regulation when a risk has merely been identified but not quantified or qualified. In particular we should be cautious of justifying regulation on the basis of theoretical harm without a proper assessment of risk. In this way, Right-touch regulation runs counter to the 'precautionary principle', which is used as a licence to intervene before a risk has been evaluated and identified as meeting the threshold for action. The only exception to this is where the severity of the theoretical harm is very high, and it is not possible to quantify the risks robustly. The precautionary principle is distinct from the exercise of foresight, which we see as part of the agility principle – the ability to anticipate risks is essential to good regulation.

We find it helpful to separate hazards, risks and harms (Figure 4).[11] Hazards are the conditions or events that can lead to or contribute to harm. Risk is the likelihood of a harm materialising. In health and social care, harm is physical injury or psychological distress experienced by people through interaction with health or social care practitioners and services. In other sectors

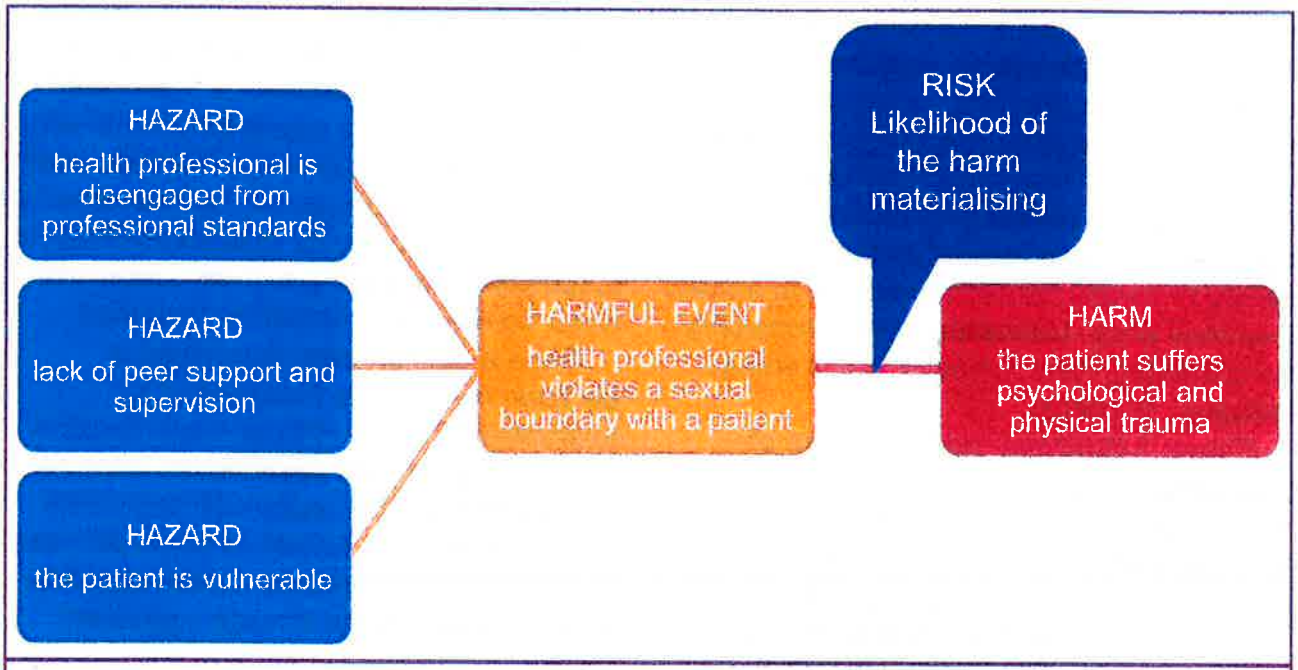


Figure 4. How hazards create the risk of harm – an example from healthcare.

harm may be defined differently.

Any regulatory response should be proportionate to the risks identified. We find it helpful to think of the range of possible responses on a risk-based continuum of assurance, with those providing the greatest regulatory force (e.g. for the highest-risk professions) at one end of the continuum, and decreasing amounts of regulatory force as the risk decreases. Regulation should only be used where the risk of harm is sufficient to warrant it and it is the most effective means of control.

Regulators need to understand the range of possible physical and psychological harms to patients and service users. In our sector, this focus is on harms that are caused by the actions of professionals.

They also need to understand the range of possible hazards and what increases and decreases risk. In health and care this means understanding the range of hazards created by problems with practitioners' conduct and competence – as well as those created by the working environment.[10]

Broadly speaking, these hazards can be categorised as follows:

- **Intervention**: the complexity and inherent dangers of the activity
- **Context**: the environment in which the intervention takes place
- **Agency**: service user vulnerability or autonomy.

In looking for categories of people who are statistically more likely to cause harm, caution must be exercised, particularly when using data about diversity characteristics.[e] Taking regulatory action based on an apparent statistical correlation between harmful behaviour and a group defined by, say its age or ethnicity, is likely to be discriminatory. It may also be ineffective and wasteful, because a correlation does not necessarily signify a causal link. Any correlation should therefore be examined

[e]Some regulators collect diversity data about their registrants and may use this to look for links between such characteristics and likelihood of harm.

more closely to discard the spurious[f] links and identify the circumstantial hazards that create an increased risk of harm.

One of the key strengths of risk-based regulation is that when used well, it provides a clear, transparent and rational basis for determining what and how to regulate. It can therefore be an effective means of pushing back against other pressures and justifying decisions about resource allocation. For risk-based regulation to be effective, regulators must communicate their approach clearly to the public, their registrants, and other stakeholders.

Conclusion

Right-touch regulation is an approach to regulatory decision-making. It means always asking what risk we are trying to address, being proportionate and targeted in regulating that risk or finding ways other than regulation to promote good practice and manage risks of harm. It allows the development of the appropriate contribution of the regulatory regime to the delivery of wider aims.

It promotes the creative use of existing mechanisms for the reduction of harm and supports professionalism and a joined-up approach to regulation. It is agile and responsive to the ever-changing circumstances and risks in which it operates

In practical terms, the benefits of Right-touch are seen in a number of ways:

- Outcomes are described in terms of the beneficiaries of regulation rather than the needs of others involved in delivery of health and social care, and policy development is devoted to achieving this aim
- It builds in the need for regular reviews to ensure that regulatory approaches and frameworks remain up to date and fit for purpose
- It provides a coherent framework for tackling a range of regulatory issues, such as managing new areas of practice and extending regulation to new groups
- Policy making is well informed, reflecting realities and the wider context, building on evidence and risk assessment.

We believe that this approach also yields broader benefits. The analogy (Figure 1) with weighing scales demonstrates the impact we want regulation to have. At the balancing point, regulation is having its most efficient impact on the problem being tackled. This will continue to be of vital importance as the costs of health and social care increase over time. Right-touch regulation forces us to be certain that the costs of regulation are worth the benefits they also bring. While patients and the public have the right to expect safe care, the cost of regulation is ultimately passed onto the public. Adopting the Right-touch approach will help regulation maximise the benefits.

The Right-touch approach can enhance trust and confidence. Recent, well-publicised 'failures of regulation' emphasise the value of public confidence in regulation. We need to make sure regulation remains relevant to the needs of today's society, and that it reacts appropriately to issues as they arise. We should also not exaggerate claims for regulation, implying that everything can be safe and nothing will go wrong. Adopting Right-touch regulation will allow people to feel confident that regulation is acting in the best way it can.

The Professional Standards Authority will continue to promote this approach, which we believe has already led to improvements in regulation in the UK and elsewhere. It provides a valuable set of guiding principles

[f]A spurious correlation is a false presumption that two variables are causally connected or correlated. Often the connection is the result of a third variable that has yet to be identified.

to help regulation work efficiently and to enhance confidence in the contribution of regulatory systems to society.

Appendix: Case studies

On page 6, we described eight elements that were key to putting Right-touch regulation into practice. The importance of each of these steps will depend on the regulatory question being asked. The following case studies show how particular elements of Right-touch regulation have been applied to individual pieces of work.

Case study 1: Transition to independent practice for dentists

The General Dental Council (GDC) had been considering whether or not there should be a period of provisional registration for dentists between their initial qualification and entry to the full dentists register. However, it was important to identify the problem before the solution first. So the dental regulator changed the policy question from 'Should we have a period of provisional registration?' to 'Is the problem about risk to patients and the public?' This meant the GDC could focus on the outcome of patient and public safety.

To inform the work, the regulator committed to use evidence and data to quantify and qualify the risks. This included a call for information and workshops with key stakeholders, a literature review and an analysis of fitness to practise and registration data. Although a substantial amount of information was collected, it was difficult to draw definite conclusions about risks posed specifically by new entrants to the dentists register. Since we should use regulation only when necessary, the GDC decided the evidence was simply not strong enough to support major regulatory change at that stage. Instead, its approach was to build on structures already in place, as outlined below.

Despite the inconclusive evidence, the regulator could not rule out that some risks might exist, since informed professional stakeholders had raised anecdotal concerns. In addition, a common theme across the various information-gathering exercises was that newly qualified healthcare professionals needed additional support or supervision in order to make the transition to independent practice. So, the GDC fostered a collaborative approach across the dental sector to ensure that all those involved in the early stages of a dentist's career worked together to deliver the common outcome of protecting patients and the public.

In practice and to keep things simple, this meant clearly setting out the roles of the various bodies who support dental students and new registrants and defining the linkages between them. The postgraduate dental deans developed their foundation training programmes, which were available to dentists after they qualify and join the register, in order to promote consistency and quality across training and assessment. The two bodies that represented undergraduate education and postgraduate training worked together on a 'clinical passport' for new UK graduates to take from their dental school into foundation training.

The GDC also worked collaboratively to facilitate information-gathering on any risks to patient and public safety. This, together with other initiatives to improve the quality of data and evidence available, provided the GDC with a robust mechanism to review the policy and respond to change, if necessary.

Case study 2: Handling complaints against doctors

In order to manage certain complaints, the General Medical Council (GMC) decided to get as close to the problem as possible.

The GMC has changed the way it deals with certain complaints that do not meet

the threshold for investigation.[g] Rather than opening a new investigation to look at each of the concerns and writing to all the doctors' employers, the GMC now shares this information with the doctor and his or her Responsible Officer (RO). The GMC asks the doctor to make the local complaints manager aware of the complaint and advises him or her that they must reflect on the complaint as part of their revalidation. If the RO or complaints manager identifies further issues, they can escalate the matter to the GMC for further consideration. The GMC's Employer Liaison Advisors are also available to follow up these letters and discuss them with the RO as required. This approach allows less serious matters to be dealt with closer to the actual problem, and is also a proportionate regulatory intervention.

Case study 3: The Cavendish Review[12]

The Francis Report and other reports highlighted poor care in health and social care. One possible response to these reports would have been to regulate healthcare assistants and support workers. However, the outcome of a review led by Camilla Cavendish showed how this vitally important part of the healthcare workforce could be developed though ways other than professional regulation.

The quality of care for patients and service users depends upon the skills, knowledge, experience and compassion of those on the front line. In the case of healthcare assistants and support workers, this can be achieved through effective local management processes, such as recruitment and training, delegation, appraisal and supervision. Therefore, the Review recommended that:

- Training and education be developed for healthcare assistants and support workers (for example, through a Certificate of Fundamental Care)
- Employers be supported to test values, attitudes and aptitude for caring at recruitment stage
- Caring be made a career (for example, through bridging programmes into pre-registration nursing and other health degrees)
- Healthcare assistants and support workers be developed through leadership, supervision and support in the workplace
- Healthcare assistants and support workers have the time to care (for example, local authorities should commission for outcomes and not by the minute).

In this case study, the problem, risks and context were considered and professional regulation was not the answer. Other solutions – closer to the point of care – were proposed in order to help achieve patient and service user safety (get as close to the problem as possible, focus on the outcome, use regulation only when necessary).

This approach may also have prevented an unintended consequence: if professional regulation had been adopted, the role of healthcare assistants and support workers may have become more tightly defined; the scope of their roles might then have become less flexible and less able to meet the needs of local populations.

Case study 4: Continuing fitness to practise of osteopaths[h]

On piloting its revalidation scheme, the General Osteopathic Council (GOsC) undertook to check for unintended consequences.

[g]While we support this approach in principle, its effectiveness has yet to be determined.

[h]While we support this approach in principle, its effectiveness has yet to be determined.

The initial scheme required a multi-layered self-assessment followed by the submission of a portfolio for review by GOsC appointed assessors. Throughout the pilot phase, nearly three quarters of participants reported that the completion of revalidation tools helped them to reflect on their current clinical practice. However, if the scheme were to be presented and administered in the way initially proposed, osteopaths would see it as a test that needed to be passed, rather than an opportunity for reflecting honestly on their practice. There was a risk that osteopaths would be cautious about admitting – especially to GOsC appointed assessors – that there were areas of practice in which they needed to improve. Ironically, the unintended consequence of a policy designed to support professionalism and protect patients and the public could be to discourage osteopaths from developing professionally through self-reflective learning.

The GOsC took on board this risk and proposed a new scheme based on peer review of CPD activity and sign-off by another healthcare professional. The aim was to support professionalism by enabling honest self-reflection and feedback amongst peers. In addition, it would reduce the isolation of osteopaths working on their own and so improve quality of practice in this way too.

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Sent: Thursday, May 20, 2021 1:32 PM
To: Rose Bustria
Cc: Joel Friedman; Bruce Walton
Subject: Fwd: Consultation on Healing Arts Radiation Protection Act to enable use of emerging technology without compromising patient safety
Attachments: Invitation Letter for Submission of Input to General Stakeholders.pdf

Exec council and QA.

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> **From:** "Court, Sean (MOH)" <Sean.Court@ontario.ca>
> **Date:** May 20, 2021 at 11:30:48 AM EDT
> **To:** "Court, Sean (MOH)" <Sean.Court@ontario.ca>
> **Cc:** "Francis, Robert (MOH)" <Robert.Francis@ontario.ca>, "Ziada, Hanna (MOHLTC)" <Hanna.Ziada2@ontario.ca>, "Tse, Leo (MOH)" <Leo.Tse@ontario.ca>, "Shaswary, Wayne (MOH)" <Wayne.Shaswary@ontario.ca>
> **Subject: Consultation on Healing Arts Radiation Protection Act to enable use of emerging technology without compromising patient safety**
>
> Dear Stakeholder;
>
> On April 15, 2021, the Government of Ontario announced new red tape and burden reduction measures intended to minimize existing barriers on businesses and support a long-term recovery plan. This included a commitment to consult on opportunities to enhance the *Healing Arts Radiation Protection Act (HARPA)* to better enable innovation and the use of new and emerging technology.

As you are aware, HARPA regulates X-ray machines in Ontario with a strong mandate of protecting patients, the public, and workers from unnecessary exposure to radiation. This consultation is an opportunity to review concerns from X-ray manufacturers and related associations with requirements under HARPA that impede the use of new and emerging technology. The Ministry of Health (the ministry) appreciates this consultation builds on previous reviews of HARPA.

As a key stakeholder, the ministry would like to invite you to **submit written input** clearly articulating your concerns and proposed recommendations. The ministry will consider recommendations for legislative and regulatory amendments that:

- better enable innovation and the use of new technology, or improve clarity and implementation of the legislation;
- can be implemented within the existing HARPA framework;
- are within the scope of the provincial government; and,
- do not compromise safety and quality standards.

The ministry will also be consulting with manufacturers, sector technical and safety experts as well as patient representatives.

Submissions should be made to Rob Francis at Robert.Francis@ontario no later than June 9, 2021.

We look forward to hearing from you.

Thank you,
Sean Court

Sean Court (he / him / his)
Assistant Deputy Minister
Strategic Policy, Planning and French Language Services Division
Ministry of Health

Invitation Letter for Submission of Input to General Stakeholders

Subject: Consultation on *Healing Arts Radiation Protection Act* to enable use of emerging technology without compromising patient safety.

Dear Stakeholder;

On April 15, 2021, the Government of Ontario announced new red tape and burden reduction measures intended to minimize existing barriers on businesses and support a long-term recovery plan. This included a commitment to consult on opportunities to enhance the *Healing Arts Radiation Protection Act (HARPA)* to better enable innovation and the use of new and emerging technology.

As you are aware, HARPA regulates X-ray machines in Ontario with a strong mandate of protecting patients, the public, and workers from unnecessary exposure to radiation. This consultation is an opportunity to review concerns from X-ray manufacturers and related associations with requirements under HARPA that impede the use of new and emerging technology. The Ministry of Health (the ministry) appreciates this consultation builds on previous reviews of HARPA.

As a key stakeholder, the ministry would like to invite you to **submit written input** clearly articulating your concerns and proposed recommendations. The ministry will consider recommendations for legislative and regulatory amendments that:

- better enable innovation and the use of new technology, or improve clarity and implementation of the legislation;
- can be implemented within the existing HARPA framework;
- are within the scope of the provincial government; and,
- do not compromise safety and quality standards.

The ministry will also be consulting with manufacturers, sector technical and safety experts as well as patient representatives.

Submissions should be made to Rob Francis at Robert.Francis@ontario no later than June 9, 2021.

We look forward to hearing from you.

Thank you,
Sean Court

College of Chiropractors of Ontario

L'Ordre des Chiropraticiens de l'Ontario

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ITEM 4.1.26

427

June 8, 2021

Via Email (Robert.Francis@ontario.ca)

Mr. Robert Francis
Director, Strategic Policy, Health and Long-Term Care
Ministry of Health
Ministry of Long-Term Care

Dear Mr. Francis:

Re: Consultation on *Healing Arts Radiation Protection Act* to enable use of emerging technology without compromising patient safety

Thank you for the opportunity to provide input on the consultation on *Healing Arts Radiation Protection Act, 1990 (HARPA)* to enable the use of emerging technology without compromising patient safety.

The College of Chiropractors of Ontario (CCO) is the regulator for chiropractors in Ontario, regulating over 5,100 chiropractors in the public interest in accordance with the *Regulated Health Professions Act, 1991 (RHPA).*

Chiropractors are authorized under *HARPA* to operate x-ray machines and order radiographs from an x-ray facility, in accordance with the chiropractic scope of practice. CCO Standard of Practice S-006: Ordering, Taking and Interpreting Radiographs establishes further regulatory requirements for taking and ordering radiographs to ensure that patient safety is prioritized. Among these requirements are that:

- Radiographs are only taken or ordered to assist in reaching a diagnosis or clinical impression within the chiropractic scope of practice;
- A history and examination are performed prior to the taking or ordering of radiographs, including the consideration of benefits, limitations, contraindications and risks;
- Reasonable efforts are made to avoid the unnecessary duplication of taking or ordering radiographs;
- The principle of "as low as reasonably achievable" (A.L.A.R.A) is applied;
- Safety and quality assurance protocols, equipment registration and compliance with *HAPRA* are required to be followed for those members who operate x-ray machines;
- Appropriate informed consent is obtained from the patient prior to the taking of a radiograph;
- Appropriate patient follow-up and treatment are provided.

CCO supports the Government of Ontario's commitment to better enable innovation and the use of new and emerging technologies by regulated health professionals in Ontario. CCO standards of practice, including Standard of Practice S-001: Chiropractic Scope of Practice, have several requirements for the use of diagnostic and therapeutic procedures which could be adaptable to the use of emerging technology without compromising patient safety. These requirements include, that a member of CCO must:

- have achieved, demonstrate and maintain clinical competency in a diagnostic or therapeutic procedure;
- use only diagnostic or therapeutic procedures that are taught at an accredited educational institution;
- only order or use a diagnostic or therapeutic procedure within the chiropractic scope of practice;
- obtain informed consent from the patient, in accordance with Standard of Practice S-013: Consent.

It may also be helpful to note that, since 2001, CCO has be conducting Peer and Practice Assessments on all members registered to practice in Ontario. Among the many elements of the assessments, each of the assessments has a component which reviews a member's demonstration of understanding and implementation of standards related to radiology.

CCO has also developed a draft standard of practice related to the ordering of advanced diagnostic tests related to the ordering of advanced diagnostic tests within the chiropractic scope of practice, in the event that regulatory amendments are made to the regulations under the *RHPA* authorizing chiropractors to order such tests. Although this authorization is under a different legislative authority than *HARPA*, it demonstrates CCO ability to pass standards of practice related to new and emerging technologies, that set requirements and protocols for practice, without compromising patient safety.

Given the time restraints, we are only able to provide a high level response, but would be pleased to work with you and other system partners as this initiative proceeds.

Yours Truly,

Mr. Joel Friedman
Deputy Registrar

Ministry of Health
Ministry of Long-Term Care

Assistant Deputy Minister
Strategic Policy, Planning & French Language Services Division

438 University Avenue, 10th floor
Toronto ON M7A 2A5

Ministère de la Santé
Ministère des Soins de longue durée

Sous-ministre adjoint
Division des politiques et de la planification stratégiques, et des services en français

438 avenue University, 10e étage
Toronto ON M7A 2A5

Ontario

June 8, 2021

158-2021-46

Dear College Presidents and Registrars/ Executive Directors

Over the past several months, we have seen the ongoing diligent and tireless contributions of all our health system partners in response to the COVID-19 pandemic.

As we prepare for a potential burden reduction Bill this Fall, the ministry is exploring opportunities for governance reforms under the *Regulated Health Professions Act, 1991* and your respective 26 health profession Acts that would increase your efficiency and your ability to respond swiftly to emerging needs.

I am aware that many colleges have expressed interest in governance changes since 2017. Since that time, there have been developments, namely, the ongoing pandemic and the introduction of Bill 283, which have added to the discussion on governance reform.

As I have noted in previous conversations, I would like to seek your input on whether previous advice to the ministry on governance reform has changed in light of the progress of time and recent experience with the COVID-19 pandemic, as well as, the government's introduction of legislation establishing a new framework for oversight.

I am requesting your feedback on possible governance reforms by June 30th.

I look forward to our continued partnership as we explore opportunities to improve and strengthen the oversight system for health professions in Ontario.

Sincerely,

Sean Court
Assistant Deputy Minister

Encl.

c. Allison Henry, Director

Ministry of Health

Office of the Deputy Premier
and Minister of Health

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

Ministère de la Santé

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

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

Ontario

April 22, 2021

Mr. Gagandeep Dhanda
3057 Ballad Drive
Mississauga ON L4T 1Z6

Dear Mr. Dhanda:

Congratulations on your reappointment to the Council of the College of Chiropractors of Ontario. Your experience has been a tremendous asset and I am looking forward to your continued service beginning April 9, 2021 until April 8, 2024.

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

I have enclosed a copy of the Order in Council which was approved on April 1, 2021.

Again, please accept my congratulations. I am confident you will continue to find this experience both interesting and rewarding.

Sincerely,

Christine Elliott

Christine Elliott
Deputy Premier and Minister of Health

Enclosure

c: Registrar
Deepak Anand, MPP

Ontario

Executive Council of Ontario
Order in Council

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

Conseil exécutif de l'Ontario
Décret

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

PURSUANT TO clause 6(1)(b) of the *Chiropractic Act, 1991*, **Gagandeep Dhanda** of Mississauga be reappointed as a part-time member of the Council of the College of Chiropractors of Ontario to serve at the pleasure of the Lieutenant Governor in Council for a period not exceeding three years, effective April 9, 2021.

EN VERTU DE l'alinéa 6 (1) b) de la *Loi de 1991 sur les chiropraticiens*, **Gagandeep Dhanda** de Mississauga est reconduit au poste de membre à temps partiel du Conseil de l'Ordre des chiropraticiens de l'Ontario pour exercer son mandat à titre amovible à la discrétion du lieutenant-gouverneur en conseil, pour une période maximale de trois ans à compter du 9 avril 2021.

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

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

Approved and Ordered: APR 0 1 2021
Approuvé et décrété le :

Administrator of the Government
L'administrateur du gouvernement

O.C. | Décret : 402/2021

Institute of Health Policy, Management and Evaluation
UNIVERSITY OF TORONTO

ITEM 4.1.29

432

ACE Accessing Centre for Expertise

Proposal for an Evaluation of Policy-Relevant Evidence on Regulatory Standards of Practice Regarding Claims of Health Benefits from Chiropractic Care

Accessing Centre for Expertise
Institute of Health Policy, Management and Evaluation
University of Toronto

19 October 2020

Proposal for an Evaluation of Policy-Relevant Evidence on Regulatory Standards of Practice Regarding Claims of Health Benefits from Chiropractic Care

Table of Contents

1. Introduction **3**

2. Background **3**

3. Proposal **4**

Component 1 – Scoping Review/Targeted Scan 4

Component 2 – Key Informant Interviews 5

Component 3 – Deliberative Dialogue 5

Alternative Methods 6

Summative Component – Final Report 7

4. Deliverables and Timeline **7**

5. ACE Team **7**

6. Budget **8**

7. Proposal Contact **9**

Proposal for an Evaluation of Policy-Relevant Evidence on Regulatory Standards of Practice Regarding Claims of Health Benefits from Chiropractic Care

1. Introduction

The Accessing Centre for Expertise (ACE) is pleased to submit this proposal to the College of Chiropractors of Ontario (CCO) to conduct an evaluation of policy-relevant evidence regulatory standards of practice regarding claims of health benefit from chiropractic care. Our proposal includes the following:

- Overview of the background for the proposal including our understanding of the problem (**Section 2**)
- Outline of our proposal including three main components (**Section 3**)
- Key deliverables and timelines (**Section 4**)
- Information about the ACE team (**Section 5**)
- Budget for conducting the work (**Section 6**)

2. Background

In development of this proposal, we draw on a discussion on 28 September 2020 between Jo-Ann Willson, Registrar and General Counsel (CCO) and Mark Dobrow, Director (ACE) as well as review of core responsibilities as set out in the *Regulated Health Professions Act (RHPA)* including the *Health Professions Procedural Code* (Schedule 2 to the *Regulated Health Professions Act)*, which, sets out the practical rules for the colleges regarding:

- registering members
- handling complaints
- conducting investigations
- carrying out discipline hearings
- handling fitness to practise hearings
- quality assurance program
- patient relations program
- mandatory reporting
- funding for victims of sexual abuse by members
- appeal processes regarding registration and complaint decisions

In the context of COVID-19, CCO has observed an increase in the number of complaints regarding chiropractors making health benefits claims (largely related to immunity benefits related to COVID-19) from chiropractic that are deemed to lack both a scientific evidence base and expert consensus. Based on the *RHPA*, chiropractors *"...assess conditions related to the spine, nervous system and joints. They diagnose, prevent and treat, primarily by adjustment: (a) dysfunctions or disorders arising from the structures or functions of the spine and the effects of those dysfunctions or disorders on the nervous*

system; and (b) dysfunctions or disorders arising from the structures or functions of the joints." In response to the observed health benefits claims, CCO has had to issue several cease and desist orders to chiropractors, which have been effective. However, the *RHPA* is not clear on the practical and legal considerations related to making health benefits claims for health professions. Therefore, CCO would like to develop a policy for how to address what is permissible and what is not permissible in relation to chiropractors making health benefits claims and in particular what constitutes a sufficient evidence base for and health benefits claims.

Based on this background, ACE understands that CCO is seeking evidence to inform the development of its policy on health benefits claims for chiropractic. CCO is seeking a review of a broad range of evidence types, including literature review and input from a range of experts/stakeholders (including patients/public representatives), that is integrated into a final report needed by the end of March 2021.

3. Proposal

This proposal is built on the ACE approach to providing evidence-informed policy guidance. We aim to provide three types of evidence, including **research evidence** (including scientifically produced and typically published in peer reviewed academic journals, original research such as surveys, and systematic reviews of published research), **contextual evidence** (including available practice, demographic, geographic and economic data as well as reports and other grey literature produced by a wide range of organizations with particular jurisdictional, practice or policy relevance) and **experiential evidence** (including knowledge and experience from key stakeholders and a range of local and global experts). This broad conception of evidence is well suited to the question CCO faces, and will also represent an analytic lens for assessing the evidentiary needs related to chiropractic health benefits claims. To identify and integrate these types of policy-relevant evidence, we propose to conduct three independent components, including a (1) scoping review/targeted scan, (2) key informant interviews, and (3) deliberative dialogue. Each are outlined below:

Component 1 – Scoping Review/Targeted Scan

Scoping reviews involve iterative search strategies, informed by ongoing results and expert consultation. As the intent of this review is to seek insight and guidance rather than comprehensive documentation of literature to form a broad evidence base to assess appropriate standards of practice regarding chiropractic health benefit claims, scoping review methodology is best suited for this project. The scoping review approach is both feasible and flexible and will allow us to identify key sources of evidence from which CCO can strengthen the evidence-informed rationale for its associated policy development.

The scoping review will be based on the six-phase methodology set out by Arksey and O'Malley (2005) and expanded and refined by Levac et al. (2010) and Daudt et al. (2013). Given the relevance of experiential evidence to the project objectives, phase six (consultation) will constitute a distinct component of the study (Component 2 – key informant interviews and Component 3 – deliberative dialogues).

We plan to search four databases (Medline, CINAHL, Google Scholar and Google) as well as a targeted scan of relevant health professional regulatory colleges and associated legislative frameworks in Canada and from comparable high income jurisdictions. We will also conduct a targeted scan of key social media sources (e.g., Facebook, Twitter) for examples and responses to chiropractic health benefits claims. We

will develop search strategies specific to each database, using a mix of subject headings and free keyword that are developed in consultation with CCO. Boolean operators will be used where possible. For the targeted scan, we anticipate reviewing up to 50 websites representing the range of organizations identified above. We will scan website content based on its structural organization and use their internal search functionality where available.

We will apply the following eligibility criteria:

- Documents published in the last 30 years (1990 to present) to capture period covered by Ontario's *RHPA*
- Documents published in English or French
- Documents published as original research, reviews, commentaries, reports, webpages

For Google and Google Scholar searches, we will screen the first 100 results for each search and then screen additional results in batches of 20 based on an ongoing saturation assessment. We will screen all title/abstracts for Medline and CINAHL results to determine the subset of documents that will be subjected to full-text review.

The main deliverable of Component 1 will be a short summary report that synthesizes the scoping review / targeted scan findings. We will also provide a complete database of all included documents considered in the review plus full-text PDFs or URLs for those articles where available.

Component 2 – Key Informant Interviews

Key informant interviews will be conducted for dual purposes, including consultation (phase six) for the scoping review and supplementing findings from the scoping review to address the broader objectives of the study. Key informant interviews are an important approach for generating experiential evidence and can be used as a form of data triangulation to strengthen the value of the scoping review /targeted scan findings. Qualitative interviews can contribute insightful perspectives from key stakeholders and experts with the opportunity to use anonymized quotes to create powerful narratives for explaining the findings and ultimately informing the rationale for CCO's policy development.

To identify key informants, we will draw on input from our faculty experts, the CCO teams, and the scoping review / targeted scan findings. We will also seek participation from key informants representing multiple jurisdictions in Canada and a small number of international participants. We anticipate conducting 15-20 interviews for this project.

All interviews will be conducted by experienced qualitative researchers, with all interviews audio-recorded (where permission is granted), transcribed verbatim and analyzed using thematic analysis methods. NVivo qualitative analysis software may be used to support the analysis. All participating key informants will be offered anonymity.

The main deliverable of Component 2 will be a short summary report that synthesizes the key informant interview findings.

Component 3 – Deliberative Dialogue

A deliberative dialogue is an important method that brings together a diverse range of stakeholders who hold different perspectives and insights to generate experiential evidence, assess and validate available

research and contextual evidence, and collectively integrate the diverse evidence base to inform policy. Deliberative dialogues are typically held in person and usually run for either a half or full day, depending on the topic, level of integration sought, and types of stakeholder participating. However, in the context of the COVID-19 pandemic, we propose that the deliberative dialogue would be conducted virtually (e.g., using Zoom or similar platform). This virtual format provides flexibility to include a broader range of Canadian and international participants than is normally possible.

While there are several deliberative dialogue designs that could be pursued, we outline three complementary options below.

- **Deliberative Dialogue 1** would involve a diverse range of stakeholders impacted by a policy on standards of practice for health benefits claims from chiropractic (e.g., recent graduates, chiropractors, patients/public representatives, regulatory college representatives, ministry representatives, insurance companies) and experts in conceptualizing evidence for policy (e.g., researchers)
- **Deliberative Dialogue 2** would involve stakeholders from regulatory colleges in Ontario representing many of the 28 health professions to provide inter-professional perspective from the same health system and regulatory context.
- **Deliberative Dialogue 3** would involve stakeholders from chiropractic regulatory bodies across Canada and internationally as well as a select group of research experts (identified through Components 1 and 2) with specific knowledge related to this topic to provide intra-professional perspective from different health system and regulatory contexts.

ACE and CCO would identify potential deliberative dialogue participants together, with ACE taking on responsibility for organization, logistics and conduct of the deliberative dialogue. ACE typically aims to limit the number of deliberative dialogue participants to approximately 20, as the ability to ensure active contributions from all participants is more challenging with numbers beyond that point. Each deliberative dialogue would involve pre-circulation of draft findings from Components 1 and 2 and a detailed agenda including objectives for the dialogue and proposed discussion questions. Each deliberative dialogue would be run by a dedicated facilitator (ACE team member) and conducted under Chatham House Rule whereby participants are asked to keep the nature of the discussion confidential and not to associate specific comments with any individual participant, thus allowing participants to engage in discussion more freely.

The main deliverable for Component 3 is the conduct of three deliberative dialogues. ACE will prepare a summary report of the findings. One or two members of CCO would also be expected to participate in the deliberative dialogue to gain direct insights.

Alternative Methods

Survey methods could be quite useful to address aspects of this question, in particular reaching out to larger numbers of key stakeholders including chiropractors and patients/public representatives. ACE has the capacity to conduct one-time surveys and could provide a quote for this work if of interest. An alternative consideration is the use of panel surveys (e.g., from vendors like Vox Pop Labs) whereby large panels of pre-vetted survey responders are used to respond to survey questions in short time frames. This approach can be costly and caution must be taken in generalizing the results, but it does represent a relatively quick way to expand the breadth of stakeholder feedback.

Summative Component – Final Report

ACE will produce a final summary report intended for a policy audience that will synthesize and integrate all evidence sources (i.e., research, contextual and experiential) gathered through Components 1 to 3.

4. Deliverables and Timeline

The key deliverables and associated timelines for our proposal are included in the table below. Please note that to meet these proposed timelines, we are assuming that an agreement to move forward could be fully executed such that we would be able to initiate work by the week of 07 December 2020. If there are delays in finalizing an agreement, we would need to revisit the deliverable timelines noted below.

Please note that we propose establishing a Project Steering Group representing CCO and ACE. The Project Steering Group would hold a project launch meeting at the outset of the project with up to three additional virtual meetings scheduled to discuss progress of the work and collect feedback on deliverables.

Component	Deliverable	Timeline
Project agreement	**Finalized/executed agreement**	**Week of 30 Nov 2020**
Component 1 – Rapid Review/Targeted Scan	Summary report	26 Feb 2021
Component 2 – Key Informant Interviews	Summary report	26 Feb 2021
Component 3 – Deliberative Dialogue	Summary report	15 Mar 2021
Summative Component	Final Report	31 Mar 2021

5. ACE Team

ACE is based in the Institute of Health Policy, Management and Evaluation, at the Dalla Lana School of Public Health, University of Toronto. The ACE mission is to make it easier for a diverse range of health organizations to connect to the breadth and depth of our multidisciplinary faculty and graduate student expertise. The Dalla Lana School of Public Health is the largest public health school in Canada and one of the largest in the world. Almost 800 faculty hold academic appointments in the School, training over 1,000 graduate students. Our research has an impact locally, nationally and globally. For more information on ACE, please visit: https://ace.ihpme.utoronto.ca.

This project will be led by Dr. Mark Dobrow (ACE Director) in collaboration with Dr. Rebecca Hancock-Howard and Dr. Lucas Dufour (both ACE Associate Directors). Their brief profiles are included below. ACE has experience conducting a range of projects for a range of public and private sector health organizations, including Health Quality Ontario, Cancer Care Ontario and Canada Health Infoway. Further, both Drs. Dobrow and Hancock-Howard led Converge3 – a Centre that provided evidence-informed policy guidance to the Ontario Ministry of Health and key health system stakeholders on a range of topics, including a review of regulatory college practices (accessible here: https://converge3.ca/publications/?fwp_series=health-workforce.

Mark Dobrow, PhD – Director, ACE
Dr. Dobrow is an Associate Professor in the Institute of Health Policy, Management and Evaluation. While always maintaining a foot in academia, Dr. Dobrow has held a number of positions that bridge health systems/policy research and leadership for national and provincial health agencies, including at the Health Council of Canada, Health Quality Ontario, and Cancer Care Ontario. Dr. Dobrow was also the inaugural Executive Director of Converge3 – a policy research centre that provides evidence-informed guidance to health system stakeholders. His primary research interests focus on developing evidence infrastructure and making connections between researchers and decision-makers more effective and efficient.

Lucas Dufour, PhD – Associate Director, ACE
Dr. Dufour is an Assistant Professor in Organizational Behavior at the Institute of Health Policy, Management and Evaluation. Dr. Dufour is an academic and a consultant. He is the co-founder of the company Performance Lab, which has worked with companies and institutions in France to support their transformational initiatives through scientific surveys. His research activities include the onboarding and talent management of healthcare employees as well as innovation and creativity.

Rebecca Hancock-Howard, PhD – Associate Director, ACE
Dr. Hancock-Howard is an Assistant Professor at the Institute of Health Policy, Management and Evaluation. Dr. Hancock-Howard is passionate about using health economic evidence to inform real world decision-making and policy. Rebecca has extensive experience in both the private and public sectors as a consultant and health economist. Dr. Hancock-Howard has conducted economic evaluations in a variety of clinical areas and settings, serving governments, local and global pharmaceutical companies, start-ups, device manufacturers, hospitals, and the academic community. As a senior health economist at the Ontario Ministry of Health and Long-Term Care, Dr. Hancock-Howard supported policy development for key priorities. Her research interests include health technology assessment and evidence-based policy.

6. Budget

The total budget for the proposal, including Component 1 (scoping review / targeted scan), Component 2 (key informant interviews), Component 3 (deliberative dialogue), and the Summative Component which includes the development of a final report that synthesizes and integrates findings from each component is **$49,920.00 CAD.** This assumes screening approximately 2000 articles for the scoping review, reviewing 50 websites for the targeted scan, and conducting up to 20 key informant interviews. If the search strategy necessitates a substantial increase in the number of articles to screen, the variable cost is $1,000 CAD per 250 additional articles screened. If the number of websites for the targeted scan increases above 50, the variable cost is $300 CAD per 10 additional websites scanned. If the number of key informant interviews is to exceed 20 interviews, the variable cost for increasing the number of interviews is $500 CAD per additional interview.

Item	Description	Amount ($CAD)
Component 1 Scoping Review / Targeted Scan	• Conduct a scoping review, searching four databases (Medline, CINAHL, Google Scholar and Google) and screening up to 2000 articles across the four databases.	$11,500

	• Conduct a targeted scan of chiropractic regulatory college (or equivalent) websites for policy documents specific to the issue of standards of practice for health benefits claims. • Preparation of a summary report that synthesizes the scoping review / targeted scan findings that are relevant for informing CCO's policy development • Preparation of a complete database of all included articles considered in the review/scan plus URLs and/or full-text PDFs where available	$8,700
Component 2 *Key Informant Interviews*	• Conduct 20 key informant interviews. • All interviews will be audio-recoded (were consent given), transcribed verbatim and analyzed using thematic analysis methods. • Preparation of a summary report that synthesizes the key informant interview findings.	$14,200
Component 3 *Deliberative Dialogue*	• Conduct three deliberative dialogues as outlined above. • Given COVID-19, each deliberative dialogue would be conducted virtually, • Includes costs of having two IHPME faculty members attend each of the deliberative dialogues	$7,200
Summative Component *Final Report*	• Preparation of a final summary report intended for a policy audience that synthesizes and integrates evidence sources (i.e., research, contextual and experiential) gathered through Components 1-3	$8,320
Overhead	• University of Toronto policy requires a minimum charge of 20% overhead on all projects. This includes indirect costs for use of internal administrative, computing, telecommunication and printing resources, office and meeting space, and access to library resources including electronic databases and electronic journal licenses (UofT has one of the most comprehensive digital libraries in the world)	
TOTAL AMOUNT		**$49,920**

7. Proposal Contact

We thank you for the opportunity to submit this proposal. For further information on this proposal or follow-up, please contact:

Mark J. Dobrow, PhD
Associate Professor
Director, Accessing Centre for Expertise
Institute of Health Policy, Management and Evaluation
University of Toronto
155 College Street, Room 484
Tel: 416-978-0558
Email: mark.dobrow@utoronto.ca

Accessing
Centre for
Expertise

ACE

Do you want to connect with academic experts for advice or to collaborate on a project?

Do you need help positioning your health organization within a changing health policy landscape?

Are you seeking the latest knowledge and insights on a key challenge faced by your organization?

ACE connects you with our health experts.

What is ACE?

The Accessing Centre for Expertise (ACE) is based in the Institute of Health Policy, Management and Evaluation, at the Dalla Lana School of Public Health, University of Toronto. The ACE mission is to make it easier for a diverse range of health organizations to connect to the breadth and depth of our multidisciplinary faculty and graduate student expertise.

The Dalla Lana School of Public Health is the largest public health school in Canada and one of the largest in the world. Almost 800 faculty hold academic appointments in the School, training over 1,000 graduate students. Our research has an impact locally, nationally and globally.

What ACE does

Interested in collaborating with an academic expert but not sure where to start?

ACE is a one-stop shop for accessing expertise and services from the Institute of Health Policy, Management and Evaluation and the broader Dalla Lana School of Public Health.

Our ACE team provides three main categories of service:

Navigation: ACE helps you connect with the right expertise through a variety of services and tools:

- Contact an ACE navigator to discuss your query and receive personalized support
- Search our expert database
- Search our research repository

Planning: ACE can work with you to review and refine your project objectives and questions, and outline project options

Collaboration: ACE can work directly with you to provide a range of services, including but not limited to strategic planning, program evaluation, evidence review/synthesis, evidence generation (e.g., surveys), data analysis/interpretation, and stakeholder dialogues

Why choose ACE?

Expertise: Drawing on a community of professors, senior fellows, postdoctoral fellows and graduate students, ACE provides access to incredible breadth and depth of expertise in all areas of health and health care.

Objectivity: ACE experts pursue non-partisan objectivity. Our aim is to inform discussion, debate and decisions through development of unbiased evidence to solve problems.

Rigour: ACE experts use the most appropriate scientific methods available to analyze your questions with rigour and relevance.

Customer-focused: ACE customizes services to fit your needs. ACE also provides complete administrative support and ensures that all collaborations are conducted in a timely and efficient manner.

Some of the organizations ACE has worked with

CCO Cancer Care Ontario

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

Dalla Lana School of Public Health

Who we are

In addition to expertise from across the Institute of Health Policy, Management and Evaluation, ACE is led by three faculty members:

Mark Dobrow, PhD – Director, ACE

Mark is an Associate Professor in the Institute of Health Policy, Management and Evaluation. While always maintaining a foot in academia, Mark has held a number of positions that bridge health systems/policy research and leadership for national and provincial health agencies, including at the Health Council of Canada, Health Quality Ontario, and Cancer Care Ontario. Mark is also the inaugural Executive Director of Converge3 – a policy research centre that provides evidence-informed guidance to health system stakeholders. His primary research interests focus on developing evidence infrastructure and making connections between researchers and decision-makers more effective and efficient. Read More

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Rebecca Hancock-Howard, PhD – Associate Director, ACE

Rebecca is an Assistant Professor at the Institute of Health Policy, Management and Evaluation. Rebecca is passionate about using health economic evidence to inform real world decision-making and policy. Rebecca has extensive experience in both the private and public sectors as a consultant and health economist. Rebecca has conducted economic evaluations in a variety of clinical areas and settings, serving governments, local and global pharmaceutical companies, start-ups, device manufacturers, hospitals, and the academic community. As a senior health economist at the Ontario Ministry of Health and Long-Term Care, Rebecca supported policy development for key priorities. Her research interests include health technology assessment and evidence-based policy. Read More

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From: Jo-Ann Willson
Sent: Wednesday, January 13, 2021 5:56 AM
To: Rose Bustria
Subject: Fwd: ace-ccorc2 - updated methods memo (v2)
Attachments: ace-ccorc2 methods memo 2021-01-13 (final).pdf

Exec and Council.

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

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Begin forwarded message:

> **From:** Mark Dobrow <mark.dobrow@utoronto.ca>
> **Date:** January 13, 2021 at 5:54:52 AM EST
> **To:** Jo-Ann Willson <jpwillson@cco.on.ca>, Joel Friedman <JFriedman@cco.on.ca>
> **Cc:** Jessica Bytautas <jessica.bytautas@utoronto.ca>
> **Subject: ace-ccorc2 - updated methods memo (v2)**
>
> Hi Jo-Ann/Joel,
>
> I've attached an updated methods memo (version 2). The intent is to use this document for our discussion on Friday at 1pm.
>
> Cheers,
> Mark

Institute of Health Policy, Management and Evaluation
UNIVERSITY OF TORONTO

445

ACE Accessing Centre for Expertise

Repeats - Immunity

Evaluation of Policy-Relevant Evidence on Regulatory Standards of Practice Regarding Claims of Health Benefits from Chiropractic Care: **Methods Memo (Version 2)**

Accessing Centre for Expertise
Institute of Health Policy, Management and Evaluation
University of Toronto

13 January 2021

Evaluation of Policy-Relevant Evidence on Regulatory Standards of Practice Regarding Claims of Health Benefits from Chiropractic Care: **Methods Memo (Version 2)**

Table of Contents

Preamble 3
Component 1: Scoping Review 3
Component 2: Targeted Scan 3
Component 3: Key Informant Interviews 5
Component 4: Deliberative Dialogues 5
Questions for Discussion during Meeting on 15 January 2021 6

Evaluation of Policy-Relevant Evidence on Regulatory Standards of Practice Regarding Claims of Health Benefits from Chiropractic Care: Methods Memo (Version 2)

Preamble

ACE has revised the Methods Memo based on the discussion at the meeting on 08 January 2021 between Jo-Ann Willson and Joel Friedman of the College of Chiropractors of Ontario (CCO) and Dr. Mark Dobrow, Jessica Bytautas, Dr. Rebecca Hancock Howard, and Dr. Lucas Dufour (ACE), as well as subsequent email correspondence. The intent of version 2 of the methods memo is to step back and ensure we have the appropriate aims for each component. We look forward to discussing this document at our meeting on 15 January 2021.

Component 1: Scoping Review

Aim:
To explore the scientific literature on standards of practice, policies, and guidelines regarding claims of health benefit from chiropractic care, specifically chiropractic scope of practice, vaccination and immunization, advertising, and social media.

Approach:
The following search strategy will be employed in MEDLINE, CINAHL, and Google Scholar databases: Chiropractic AND (standard of practice OR policies OR guidelines OR scope of practice OR vaccination OR immunization OR advertising OR social media OR health benefit OR effectiveness OR patient satisfaction OR patient reported outcome measures OR evidence-based practice).

Analysis:
Conceptual mapping of evidence regarding chiropractic health claims (i.e., scope of practice, vaccination and immunization, advertising, and social media) by publication type, jurisdiction, research question/aim, methodology, key findings.

Component 2: Targeted Scan

Aim:
To identify the evidence used, if any, to support peer chiropractic regulatory organizations' standards of practice, policies, and guidelines regarding claims of health benefit, specifically chiropractic scope of practice, vaccination and immunization, advertising, and social media.

Approach:
Google site search and manual site search of up to 50 chiropractic regulatory bodies, associations,

specialty colleges, and educational institutions across Canada and internationally for relevant standards of practice, policies, and guidelines.

Analysis:
Data extraction of (i) do peer chiropractic organizations publish relevant standards of practice, policies, and/or guidelines (i.e., scope of practice, vaccination and immunization, advertising, social media); (ii) do they cite supporting evidence and, if so, (iii) what evidence do they cite?

Organization	Type of organization	Jurisdiction
College of Chiropractic Orthopaedic Specialists	Specialty college	Canada - national
Canadian Chiropractic Examining Board	Educational institution	Canada - national
Canadian Chiropractic Specialty College of Physical and Occupational Rehabilitation	Specialty college	Canada - national
College of Chiropractic Radiologists	Specialty college	Canada - national
Fairness Commissioner	Regulatory body	Canada - national
Federation of Canadian Chiropractic	Regulatory body	Canada - national
Canadian National Alliance of Chiropractic	Association	Canada national
Ontario Chiropractic Association	Association	Canada - provincial/ territorial
College of Chiropractors of British Columbia	Regulatory body	Canada - provincial/ territorial
BC Chiropractic Association	Association	Canada - provincial/ territorial
Chiropractors' Association of Saskatchewan	Association	Canada - provincial/ territorial
Manitoba Chiropractors Association	Association	Canada - provincial/ territorial
Manitoba Chiropractors Association, Regulatory	Regulatory body	Canada - provincial/ territorial
New Brunswick Chiropractors Association	Association	Canada - provincial/ territorial
Newfoundland and Labrador Chiropractic Association	Association	Canada - provincial/ territorial
Newfoundland and Labrador Chiropractic Board	Regulatory body	Canada - provincial/ territorial
Nova Scotia College of Chiropractors	Regulatory body	Canada - provincial/ territorial
Prince Edward Island Chiropractic Association	Association	Canada - provincial/ territorial
Alberta College and Association of Chiropractors	Regulatory body/ Association	Canada - provincial/ territorial
Government of Yukon's Professional Licensing and Regulatory Affairs Branch in the Department of Community Services	Regulatory body	Canada - provincial/ territorial
Ordre des chiropracticiens du Québec	Regulatory body	Canada - provincial/ territorial
Association des chiropraticiens du Québec	Association	Canada - provincial/ territorial
European Chiropractors' Union	Association	Multi/International
La Federación Latino Americana de Quiropráctica	Association	Multi/International
Federation of Chiropractic Licensing Boards	Regulatory body	Multi/International
Council on Chiropractic Education Australasia	Educational institution	Multi/International
Council on Chiropractic Education	Educational institution	Multi/International
Councils on Chiropractic Education International	Educational institution	Multi/International
International Board of Chiropractic Examiners	Educational institution	Multi/International

Organization	Type of organization	Jurisdiction
World Federation of Chiropractic	Association	Multi/International
Association of Chiropractic Colleges	Association	Multi/International
Chiropractic and Osteopathic College of Australasia	Regulatory body	Multi/International
African Chiropractic Federation	Association	Multi/International
Eastern Mediterranean and Middle East Chiropractic Federation	Association	Multi/International
Asia-Pacific Chiropractic Doctors Federation	Association	Multi/International
International Chiropractic Association	Association	Multi/International
Australian Chiropractors Association	Association	AUS
Chiropractic Board of Australia	Regulatory body	AUS
British Chiropractic Association	Association	UK
General Chiropractic Council	Regulatory body	UK
United Chiropractic Association	Association	UK
American Chiropractic Association	Association	US
National Board of Chiropractic Examiners	Educational institution	US
Université du Québec à Trois-Rivières – Département de chiropratique	Educational institution	Canada
Canadian Memorial Chiropractic College	Educational institution	Canada

Component 3: Key Informant Interviews

Aim:
To explore the views of practicing chiropractors, policy-makers, and experts, and the expectations and understanding of patients, on standards of practice regarding claims of health benefits from chiropractic care, specifically chiropractic scope of practice, vaccination and immunization, advertising, and social media.

Approach:
Interviews with purposively sampled practicing chiropractors (8), ministry representative (2), experts (2), and patients (8) in Ontario. Interviews with patients will use vignettes to elicit patients' responses to fictionalized scenarios.

Analysis:
Qualitative description and thematic analysis; interviews will be audio recorded and transcribed, and coded using qualitative data management software (NVivo).

Component 4: Deliberative Dialogues

Aim:
To elicit stakeholder perspectives on CCO's standards of practice, policies, and guidelines regarding claims of health benefit from chiropractic care, specifically chiropractic scope of practice, vaccination and immunization, advertising, and social media

Approach:
Deliberative Dialogue 1: diverse range of stakeholders impacted by a policy on standards of practice for health benefits claims from chiropractors, including practicing chiropractors, regulatory college representatives, ministry representatives, insurance companies, experts in conceptualizing evidence for policy

Deliberative Dialogue 2: patient/ public representatives; participants will be recruited through CCO council members and via an open call on CCO's website, an open call on CCO's website, and ACE's Twitter account

Deliberative Dialogue 3: stakeholders from chiropractic regulatory bodies across Canada and internationally as well as a select group of research experts with specific knowledge related to this topic to provide intra-professional perspective from different health system and regulatory contexts

Analysis:
Qualitative description and thematic analysis; deliberative dialogues will be audio recorded and transcribed, and coded using qualitative data management software (NVivo)

Questions for Discussion during Meeting on 15 January 2021

1) Scoping review
    a. Confirm aim
    b. Note: based on our understanding from the last meeting, we've removed the news and social media component, which was intended as a proxy for patient engagement that has now been added as a primary data collection method

2) Targeted scan
    a. Confirm aim
    b. Confirm organizations
        i. Note: given revision to the aim, we've eliminated insurers, and non-chiropractic professional groups

3) Interviews
    a. Confirm aim
    b. Discuss patient recruitment strategy

4) Deliberative dialogues
    a. Confirm aim
    b. Discuss patient/public recruitment strategy

Rose Bustria

From: Jo-Ann Willson
Sent: Wednesday, March 17, 2021 10:33 AM
To: Rose Bustria
Cc: President
Subject: FW: ACE Key Informant Interviews - Invitations to be Distributed this Week

Dear Council Members:

Please see "heads up" below sent to stakeholders about invitations from ACE to be distributed this week. Thank you.

Jo-Ann Willson, B.Sc., M.S.W., LL.B.
Registrar & General Counsel
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59 Hayden St., Suite 800
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From: Jo-Ann Willson <jpwillson@cco.on.ca>
Sent: Wednesday, March 17, 2021 10:23 AM
To: Jo-Ann Willson <jpwillson@cco.on.ca>
Cc: President <President@cco.on.ca>
Subject: ACE Key Informant Interviews - Invitations to be Distributed this Week

Dear Stakeholder:

Please be advised that CCO has retained the Accessing Centre for Expertise, Institute of Health Policy, Management and Evaluation, Dalla Lana School of Public Health, University of Toronto (ACE) to conduct key informant interviews on behalf of a research project aimed to facilitate CCO's policy and standards development. Dr. Mark Dobrow, PhD, Associate Professor and Director, ACE, is spearheading the project. Information about the project has been included in a number of public information packages for Council meetings over the past several months. For consistency, invitations are being forwarded to the chairs of various stakeholders so I anticipate you will be hearing from various members of the chiropractic community as the invitations are distributed. We are excited about this project, and hope it will be informed by a broad range of stakeholder feedback. Thank you.

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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452

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ACE

Do you want to connect with academic experts for advice or to collaborate on a project?

Do you need help positioning your health organization within a changing health policy landscape?

Are you seeking the latest knowledge and insights on a key challenge faced by your organization?

ACE connects you with our health experts.

What is ACE?

The Accessing Centre for Expertise (ACE) is based in the Institute of Health Policy, Management and Evaluation, at the Dalla Lana School of Public Health, University of Toronto. The ACE mission is to make it easier for a diverse range of health organizations to connect to the breadth and depth of our multidisciplinary faculty and graduate student expertise.

The Dalla Lana School of Public Health is the largest public health school in Canada and one of the largest in the world. Almost 800 faculty hold academic appointments in the School, training over 1,000 graduate students. Our research has an impact locally, nationally and globally.

What ACE does

Interested in collaborating with an academic expert but not sure where to start?

ACE is a one-stop shop for accessing expertise and services from the Institute of Health Policy, Management and Evaluation and the broader Dalla Lana School of Public Health.

Our ACE team provides three main categories of service:

Navigation: ACE helps you connect with the right expertise through a variety of services and tools:

519

- Contact an ACE navigator to discuss your query and receive personalized support
- Search our expert database
- Search our research repository

Planning: ACE can work with you to review and refine your project objectives and questions, and outline project options

Collaboration: ACE can work directly with you to provide a range of services, including but not limited to strategic planning, program evaluation, evidence review/synthesis, evidence generation (e.g., surveys), data analysis/interpretation, and stakeholder dialogues

Why choose ACE?

Expertise: Drawing on a community of professors, senior fellows, postdoctoral fellows and graduate students, ACE provides access to incredible breadth and depth of expertise in all areas of health and health care.

Objectivity: ACE experts pursue non-partisan objectivity. Our aim is to inform discussion, debate and decisions through development of unbiased evidence to solve problems.

Rigour: ACE experts use the most appropriate scientific methods available to analyze your questions with rigour and relevance.

Customer-focused: ACE customizes services to fit your needs. ACE also provides complete administrative support and ensures that all collaborations are conducted in a timely and efficient manner.

Some of the organizations ACE has worked with

Atlas

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Canada Health Infoway | Inforoute Santé du Canada

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Husam Abdel-Qadir Assistant Professor (Status)	Atrial Fibrillation Cardiovascular Disease in Patients with Cancer
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Neill Adhikari Assistant Professor (Cross-appointment)	Acute Kidney Injury Critical Care in Low-Resource Settings Meta-Analysis Sepsis
Nadia Alam Lecturer (Status)	Access to Care Health Human Resources Health System Design Primary Care
Ana Carolina Alba Assistant Professor (Status)	Systematic Reviews
Mathieu Albert Associate Professor (Status)	Epistemology Higher Education Studies Interdisciplinary Studies Qualitative Social Analysis Social Theory Sociology of science and of the health professions
Dionne M. Aleman Associate Professor (Cross-appointment)	
Shabbir M.H. Alibhai Professor (Status)	Clinical Epidemiology Clinical Trials Geriatric Oncology Health Services Research Knowledge Translation Outcomes and Evaluation Prostate Cancer
Upton Allen Professor (Status)	
Sara Allin Assistant Professor (Status)	Comparative Health Policy and Systems Health Equity Health Services Research Health System Performance
Valerie Alston	Health Services Research

Lecturer (Adjunct)

David Alter
Associate Professor (Status)

Andre Carlos Kajdacsy-Balla Amaral
Associate Professor (Cross-appointment)
Implementation Science Quality Improvement Quality Measurement

Reshma Amin
Associate Professor (Status)
Clinical Epidemiology Patient Safety Quality

Eitan Amir
Associate Professor (Status)
Clinical Epidemiology Clinical Trials Health Services Research

Carlo Ammendolia
Assistant Professor (Status)
Chiropractic Treatment Health Services Outcomes and Evaluation Knowledge Translation Randomized Clinical Trials

Geoffrey M. Anderson
Professor (Tenure Stream)
Clinical Effectiveness Knowledge Translation Outcomes and Evaluation

James A. Anderson
Assistant Professor (Status)
Bioethics Genome Sequencing Research Ethics Translational Research Ethics

Meena Andiappan
Assistant Professor (Tenure Stream)
Corporate Wrongdoing Emotions Necessary Evils Qualitative Research Theory-Building Unethical Behavior Voice

Ada Andrade
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Pamela J. Angle
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Clinical Effectiveness Outcomes and Evaluation

Steinthor (Sten) Ardal
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Fred D. Ashbury
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Garry Aslanyan
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Clare Atzema
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Peter C. Austin
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Zubin Austin
Professor (Cross-appointment)
Health Human Resources

Laura Avila
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Renata Emily Axler
Assistant Professor (Status)
Bioethics Health Research & Innovation Policy Qualitative Research

Amir Azarpazhooh
Associate Professor (Cross-appointment)

David Bach
Lecturer (Adjunct)
Artificial Intelligence Digital Health Health Technology Assessment Systems Innovation

Brian Baigrie
philosophy of science

Associate Professor (Cross-appointment)

G. Ross Baker Professor (Tenure Stream) Academic Lead - Quality Improvement And Patient Safety (QIPS)	Health Services Research Quality Quality Improvement
Penny Janet Ballem Senior Fellow	
Carolina Barnett-Tapia Assistant Professor (Status)	Clinical Epidemiology Health Services Research Outcomes and Evaluation
Jan Barnsley Associate Professor (Emeritus)	Health Services Research Outcomes and Evaluation
Jon Barrett Professor (Cross-appointment)	Maternal Morbidity and Mortality Multiple Pregnancy Preterm Birth
Melanie Barwick Professor (Status)	e-Health Innovation Development and Evaluation Global Child Health Implementation Science Knowledge Translation Mental Health Systems Use of Social Media for KT
Andrea Baumann Professor (Status)	Health Services Research

523

1 2 3 4 5 6 7 › »

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Patients with Interrupted Aortic Arch Anusha Jegatheeswaran	Health And Environmental Sciences; Interrupted Aortic Arch; Multi-dimensional Outcomes;
A Multi-Methods Study of the Role of Middle Managers in Brokering Knowledge in Hospitals Faith Dawn Boutcher	Dissertation (Doctoral) Evidence-based Practice; Knowledge Broker; Knowledge Translation; Middle Manager;
A Novel Approach for Integrating Best Evidence and Patient Preferences Into Treatment Recommendations for Rheumatoid Arthritis Glen Stewart Hazlewood	Dissertation (Doctoral) Clinical Practice Guidelines; Discrete-choice Experiment; Health And Environmental Sciences; Network Meta-analysis; Patient Preferences; Rheumatoid Arthritis; Treatment Recommendations;
A Population Based Assessment of Primary Care Care Physician Visits and Acute Care Utilization Among Women Receiving Adjuvant Chemotherapy for Breast Cancer Sarah Jane Bastedo	Dissertation (Masters) Breast Cancer; Chemotherapy; Emergency Department; Health And Environmental Sciences; Primary Care;
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A Population-based Evaluation of Long-term Outcomes following Major Burn Injury Stephanie Mason	Dissertation (Doctoral) Burns; Epidemiology; Health Services Research; Outcomes;
A Population-based Study of Individuals with Schizophrenia and Correctional Involvement Mayuri Mahentharan	Dissertation (Masters) Health Services Utilization; Ontario; Provincial Correctional Involvement; Recidivism; Schizophrenia;
A Qualitative Investigation of the Mental Health Needs of Syrian Refugees and Immigrants Rosemary Yachouh	Dissertation (Masters) Immigrants; Mental Health; Psychology; Refugees; Social Support; Syrian;
A Qualitative Study of Ontario Cancer System Leaders' Views on the "Promises of Accountability" Jessica Bytautas	Dissertation (Masters) Accountability; Chronic Disease Management; Health And Environmental Sciences; Social Sciences;
A Quality Improvement Program to Standardize and Improve the Perioperative Management of Total Knee Arthroplasty Patients at St. Michael's Hospital in Toronto, Canada Sarah Elizabeth Ward	Dissertation (Masters) Orthopaedics; Quality Improvement; Surgery; total knee arthoplasty;
A research program on rapid reviews: where should we venture next? Andrea Tricco	Webinar
A Review of Dental Care Services for Adults in Receipt of Social Assistance in Ontario Aaron Burry, Ted Cohen, Carlos Quiñonez	Report
A Risk Stratification Model for Adult Patients with Obstructive Sleep Apnea: Development and Evaluation Tetyana Kendzerska	Dissertation (Doctoral) Apnea; Health And Environmental Sciences; Obstructive; Patients; Risk; Sleep; Stratification;
A scoping review identifies multiple emerging knowledge synthesis methods, but few studies operationalise the method Andrea Tricco	Webinar
A Synthesis of the Grossman and Becker-Murphy Models of Health and Addiction: Theoretical and Empirical Implications Andrew M. Jones, Audrey Laporte, Nigel Rice, Eugenio Zucchelli	Report

A Systematic Review and Appraisal of International Early Breast Cancer Guidelines for Systemic Therapy, and a Global Physician Survey Examining Practice Patterns by Resource Setting: Potential Implications for International Health Policy
Sonal Gandhi

Dissertation (Masters)

Adjuvant; Breast Cancer; Global; Guidelines; Health And Environmental Sciences; International; Low And Middle Income; Policy; Practice; Resources; Therapy;

A third of systematic reviews changed or did not specify the primary outcome: a PROSPERO register study
Andrea Tricco

Webinar

Access to Colorectal Cancer Screening in Canada: Does Immigrant Status Matter?
Cara Murphy

Dissertation (Masters)

Health And Environmental Sciences;

Access to Trauma Centre Care in Canada: A National Comparison
Andrea Dionne Hill

Dissertation (Doctoral)

Canada; Health And Environmental Sciences; Non-trauma Hospital Transfer; Patient Outcomes; Social Sciences; Trauma Centre Care;

Accountability in Ontario's Acute Care Hospital Sector and its Effect on Organizational Strategic Priorities
Seija Kristina Kromm

Dissertation (Doctoral)

Accountability; Acute Care; Health And Environmental Sciences; Hospital; Ontario; Organizational; Priorities; Sector; Social Sciences;

Accountability in the Home and Community Care Sector in Ontario
Carolyn Alice Steele Gray

Dissertation (Doctoral)

Accountability; Health And Environmental Sciences; Health Policy; Home And Community Care; Organizational Behaviour;

Accountable Care Organizations and the Canadian Context
Peckham, A, Rudoler, D., Bhatia, D., Fakim, S., Allin, S., & Marchildon, G.

Report

Accountable Care Organizations: Success Factors, Provider Perspectives and an Appraisal of the Evidence
Peckham A, Rudoler D., Allin S., Bhatia D., Abdelhalim R., Kavelaars RA., & Marchildon G.

Report

Accumulating Multimorbidity: the Role of Depression, Socioeconomic Status, and Other Factors
Allanah Li

Dissertation (Masters)

Depression; Multimorbidity; Socioeconomic Status;

Accuracy of Ontario Health Administrative Databases Identifying Patients with Rheumatoid Arthritis
Jessica Widdifield

Dissertation (Doctoral)

Canada; Health Administrative Database; Health And Environmental Sciences; Ontario; ORAD; Rheumatoid Arthritis;

Acute Kidney Injury in Patients Receiving Systemic Treatment for Cancer: A Population-based Cohort Study
Abhijat Kitchlu

Dissertation (Masters)

Acute Kidney Injury; Cancer; Dialysis; Nephrology; Systemic Treatment; Toxicity;

ADHD Misidentification in School: Causes and Mitigators
Jill Furzer, Elizabeth Dhuey, Audrey Laporte

Report

Adolescent Idiopathic Scoliosis and Adverse Events: A Canadian Perspective
Henry Ahn

Dissertation (Doctoral)

Adolescent Idiopathic Scoliosis; Adverse Event; Health And Environmental Sciences; Hierarchical Modeling; Icd-10; Mawt; Wait Time;

Adopting EMRs and Information Technology in Primary Care
Carbone S, Kurdina A., King M., Peckham A., Bhatia D., Ng R., Allin S., & Marchildon G.

Report

Dissertation (Doctoral)

Adoption and Use of High Technology Medical Imaging in Ontario Hospitals: The Determinants of Adoption and the Relationship between Use and Inpatient Mortality and Length of Stay
Guillermo Arturo Sandoval Garces

Adoption Of Technologies; Computed Tomography; Health And Environmental Sciences; Imaging Use; Magnetic Resonance Imaging; Quality And Efficiency; Value Of Imaging;

527

Adverse Cardiac Events among Older Patients on Venlafaxine: A Population-based Study
Joanne Ho

Dissertation (Masters)

Adverse Drug Safety; Cardiovascular; Health And Environmental Sciences; Social Sciences; Venlafaxine;

Alternative Level of Care and Delayed Discharge: Lessons Learned from Abroad
Bhatia D., Peckham A., Abdelhalim R., Kurdina A., Ng R., Allin S., & Marchildon G.

Report

An Analysis of the Prevalence and Predictors of Food Insecurity in Canadian Seniors
Natalie Thirakul

Dissertation (Masters)

Food Security; Seniors;

An Economic Evaluation of Conception Strategies for Heterosexual Serodiscordant Couples with HIV- Positive Male Partners
Michelle Letchumanan

Dissertation (Masters)

Health And Environmental Sciences;

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40 per page

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528

BIOGRAPHICAL INFORMATION

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Telephone (mobile)	647-267-1145
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1. Education

2003	**Ph.D., Health Outcomes and Evaluation**, Department of Health Policy, Management and Evaluation, University of Toronto, Toronto, Ontario, Canada, Supervisor(s): Vivek Goel, Louise Lemieux-Charles, Allan Detsky. Thesis entitled: *'Context-based evidence-based decision-making: Case study of evidence utilization in the development of cancer screening policy'.*
1998	**M.Sc., Epidemiology**, Department of Public Health Sciences, University of Edinburgh, Edinburgh, Scotland, Supervisor(s): Gordon Murray, John Forbes. Thesis entitled: *'Explicit priority setting in health care: Practical issues in determining priority through waiting'.*
1996	**B.Comm. (Distinction), Major in Health Care Administration**, College of Commerce, University of Saskatchewan, Saskatoon, Saskatchewan, Canada, Supervisor(s): Allen Backman, Rein Lepnurm.

2. Employment

Current Appointments

Mar 2014 – ongoing	Associate Professor (CLTA), Institute of Health Policy, Management and Evaluation, University of Toronto, Toronto, Canada.
May 2017 – ongoing	Director, Accessing Centre for Expertise, Institute of Health Policy, Management and Evaluation, University of Toronto, Toronto Canada.
May 2017 – ongoing	President, Justice Emmett Hall Memorial Foundation.
Apr 2018 – ongoing	Consultant, iPAAC (Innovative Partnership for Action Against Cancer, European Union Joint Action, Work Package 4, Sciensano, Brussels, Belgium.
Dec 2008 – ongoing	Affiliated Faculty, Munk School of Global Affairs and Public Policy (formerly School of Public Policy and Governance until 30 June 2018), University of Toronto, Toronto, Ontario, Canada.

Previous Appointments / Other Employment

Nov 2017 – July 2019	Executive Director, Converge3 (previously the Centre for Evidence and Health in All Policies), Institute of Health Policy, Management and Evaluation, University of Toronto, Toronto, Canada.
Feb 2014 – Feb 2017	Consultant, CanCon (European Guide on Quality Improvement in Comprehensive Cancer Control), European Union Joint Action, Work Package 4, Sciensano, Brussels, Belgium.
Nov 2014 – June 2015	Interim Vice President, Health System Performance, Health Quality Ontario (Secondment), Toronto, Canada.
July 2012 – Feb 2014	Associate Professor (status-only appointment), Institute of Health Policy, Management and Evaluation, Faculty of Medicine, University of Toronto, Toronto, Canada.

Nov 2011 – Oct 2013	Adjunct Scientist, Cancer Services & Policy Research Unit, Cancer Care Ontario, Toronto, Canada.
Nov 2011 – Jan 2014	Director, Analysis and Reporting, Health Council of Canada, Toronto, Canada.
Sept 2006 – Jun 2012	Assistant Professor (status-only appointment), Institute of Health Policy, Management and Evaluation, Faculty of Medicine, University of Toronto, Toronto, Canada.
July 2007 – Oct 2011	Scientist and Lead, Cancer Services & Policy Research Unit, Cancer Care Ontario, Toronto, Canada.
July 2009 – Oct 2011	Investigator, Canadian Centre for Applied Research in Cancer Control (ARCC), British Columbia Cancer Agency, Vancouver, Canada and Cancer Care Ontario, Toronto, Canada.
July 2009 – Oct 2011	Program Co-Lead, Health Services, Systems & Policy Program, Canadian Centre for Applied Research in Cancer Control (ARCC), British Columbia Cancer Agency, Vancouver, Canada and Cancer Care Ontario, Toronto, Canada.
Jan 2004 – June 2007	Scientist, Cancer Quality Council of Ontario Secretariat, Cancer Care Ontario, Toronto, Ontario, Canada.
Jan 2004 – Sept 2006	Lecturer (status-only appointment), Department of Health Policy, Management and Evaluation, Faculty of Medicine, University of Toronto, Toronto, Ontario Canada.
Jan 2003 – Jan 2004	Research Fellow, Health Services Research Unit, Department of Public Health and Policy, London School of Hygiene and Tropical Medicine, London, England.
July 1999 – Dec 2002	Research Assistant, Health Evidence Applications and Linkage Network (HEAL*Net*) and the Department of Health Policy, Management and Evaluation, University of Toronto, Toronto, Ontario, Canada.
May 1996 – Apr 1997	Research Assistant, Population Health Branch, Saskatchewan Department of Health, Regina, Saskatchewan, Canada.
Oct 1996 – Sept 1997	Project Coordinator, Saskatchewan Association of Health Organizations, Regina/Saskatoon, Saskatchewan, Canada.
May 1995 – Aug 1995	Health Care Administration Resident, Saskatchewan Association of Health Organizations, Regina, Saskatchewan, Canada.

3. Honours and Career Awards

Distinctions and Research Awards

Sept 2008 – Aug 2009	**Canadian Harkness Associate Fellowship Award**, International Program in Health Policy and Practice, The Commonwealth Fund, New York, USA. *Total Amount: 20,000 USD*
Jan 2003 – Jan 2004	**Postdoctoral Fellowship Award**, Economic and Social Research Council, Swindon, United Kingdom. *Total Amount: 28,000 GBP*
July 2001 – June 2004	**Doctoral Training Award**, Canadian Institutes of Health Research, Ottawa, Canada.
July 1999 – Dec 2002	**Doctoral Training Studentship**, Health Evidence Application and Linkage Network (HEAL*Net*), Toronto, Canada.
Sept 1998 – Aug 2002	**University of Toronto Open Fellowship**, University of Toronto, Toronto, Canada.

4. Professional Affiliations and Activities

Expert Panel Participation

June 2019 – ongoing	**Member**, Impact Working Group, Dalla Lana School of Public Health, University of Toronto, Toronto, Canada.
May 2017 – ongoing	**Board Member (ex officio)**, Canadian Association of Health Services and Policy Research (CAHSPR).
2015 – ongoing	**Member**, Informing Decision-Making – Impact Analysis Working Group, Canadian Health Services and

529

	Policy Research Alliance.
Sept 2016 – July 2019	**Co-Chair**, School Council. Dalla Lana School of Public Health, University of Toronto, Toronto, Canada.
Jan 2019 – May 2019	**Member**, Canadian Association of Health Services and Policy Research Conference Program Planning Committee.
Aug 2015 – 2017	**Member**, Delivering Quality Working Group of the System Quality Advisory Committee, Health Quality Ontario, Toronto, Canada.
Apr 2017 – May 2017	**Member**, Jack Boan Student Essay Competition Selection Panel, Justice Emmett Hall Memorial Foundation, Quebec, Canada (teleconference)
May 2016 – Sept 2016	**Member**, Ad Hoc Committee on Teaching Assistant/Research Assistant Support and University of Toronto Funding Package, Institute of Health Policy, Management and Evaluation, University of Toronto, Toronto, Canada.
Aug 2015 – July 2016	**Co-Chair**, Teaching Innovation Subcommittee of the Strategic Plan Steering Committee, Dalla Lana School of Public Health, University of Toronto, Toronto, Canada.
Apr 2016	**Member**, Jack Boan Student Essay Competition Selection Panel, Justice Emmett Hall Memorial Foundation, Quebec, Canada (teleconference)
Aug 2014 – Mar 2016	**Member**, Expert Advisory Committee, Canadian Institute for Health Information, Health System Efficiency Phase 3, Toronto, Canada.
24 Feb 2016	**Member**, Dragon's Den Panel, Canadian Institute for Health Information Health System Performance Workshop, Edmonton, Canada.
Dec 2015 – Jan 2016	**Member**, Review Committee for the selection of one associate professor for the academic discipline 13/B2 Management – Academic Field SECS-P/08 Management" at the Institute of Management Academic Class of Social Sciences of the Scuola Superiore di Studi Universitari e di Perfezionamento Sant'Anna di Pisa, Italy.
Mar 2014 – Mar 2017	**Member**, Guide Coordination Committee, European Union Joint Action on the Development of the European Guide on Comprehensive Cancer Control, Brussels, Belgium
2014 – 2015	**Member**, IDEAS Strategic Advisory Committee, Toronto, Canada.
Apr 2015 – June 2015	**Chair**, Long-Term Care Indicator Review Panel, Health Quality Ontario, Toronto, Canada.
Mar 2015 – June 2015	**Co-Chair**, Patient Experience Measurement Committee, Health Quality Ontario, Toronto, Canada.
Feb 2015 – June 2015	**Chair**, Performance Monitoring and Reporting Advisory Committee, Health Quality Ontario, Toronto, Canada.
Apr 2015	**Member**, Justice Emmett Hall Memorial Foundation Student Essay Competition Selection Panel, Quebec, Canada (teleconference)
Apr 2014	**Member**, Justice Emmett Hall Memorial Foundation Student Essay Competition Selection Panel, Quebec, Canada (teleconference)
Jun – Oct 2013	**Member**, 2013 National Symposium on Quality Improvement Planning Committee, Health Council of Canada, Toronto, Canada.
17 October 2013	**Participant**, McMaster Health Forum Dialogue on Supporting Optimal Screening Approaches in Canada, Hamilton, Canada.
May 2013 – Oct 2013	**Member**, Steering Committee, Supporting Optimal Screening Approaches in Canada, McMaster Health Forum, Hamilton, Canada
Sep 2011 – Oct 2011	**Member**, Prevention Working Group, Cancer Care Ontario and Public Health Ontario, Toronto, Canada.
Aug 2011 – Oct 2011	**Member**, Service Directed Research Working Group, Cancer Care Ontario, Toronto, Canada
July 2011 – Oct 2011	**Member**, Registered Nurse Flexible Sigmoidoscopy Program Review Group, Cancer Care Ontario, Toronto, Canada.

Feb 2011	**Member**, Contextual Evidence Panel. Evidence Project, Centre for Disease Control and Prevention, National Centre for Injury and Prevention and Control, Atlanta, Georgia, USA.
2010 – Oct 2011	**Member**, Diagnostic Assessment Program Evaluation Committee, Cancer Care Ontario, Toronto, Canada.
2007-2009	**Member**, Ontario Nurse Flexible Sigmoidoscopy Program Evaluation Internal Reference Group, Cancer Care Ontario, Toronto, Canada.
2007-2008	**Member**, Knowledge Transfer and Exchange Program Committee, Cancer Care Ontario, Toronto, Canada.

Professional Associations

2004 – ongoing	Canadian Association of Health Services and Policy Research (CAHSPR)
2015 – 2018	GreyNet International
2006 – 2010	AcademyHealth
2004 – 2008	Health Technology Assessment International (HTAi)

Peer Review Activities

EDITORIAL

Jan 2010 – Jan 2019	Editor, *Healthcare Policy*
May 2013 – Apr 2020	Editorial Advisor, *BMC Health Services Research*
Oct 2010 – Apr 2013	Associate Editor, *BMC Health Services Research*

GRANT REVIEWS

Peer Review Committee Member

June 2020	University of Toronto Community Partnerships Research Program – Review Panel.
Feb 2020	University of Toronto School of Graduate Studies (SGS) Canada Graduate Scholarships – Master's Program Review Committee.
May 2018	Canadian Institutes for Health Research – Health Policy & Systems Management Research Peer Review Committee.
Apr 2014	Canadian Institutes for Health Research – Partnerships for Health System Improvement Peer Review Committee.
Dec 2012	Canadian Institutes for Health Research – Health Policy & Systems Management Research Peer Review Committee.
Dec 2011	Canadian Institutes for Health Research – Health Policy & Systems Management Research Peer Review Committee.
June 2011	Canadian Centre for Applied Research in Cancer Control – Grant Review Committee.
May 2011	Canadian Institutes for Health Research – Health Policy & Systems Management Research Peer Review Committee.
Dec 2010	Canadian Centre for Applied Research in Cancer Control – Grant Review Committee.
Dec 2010	Canadian Institutes for Health Research – Health Services Evaluation & Interventions Research 3 Peer Review Committee.
June 2010	Canadian Centre for Applied Research in Cancer Control – Grant Review Committee.
May 2010	Canadian Institutes for Health Research – Health Services Evaluation & Interventions Research 3 Peer Review Committee.
Nov 2009	Canadian Institutes for Health Research – Health Services Evaluation & Interventions Research Peer Review Committee.

June 2009	Canadian Health Services Research Foundation – Public Engagement Review Panel (Commissioned Research Grant).
May 2009	Canadian Institutes for Health Research – Health Services Evaluation & Interventions Research – A Peer Review Committee.
Apr 2009	Canadian Institutes for Health Research – National Cancer Institute of Canada -- Behavioural/Psychosocial/Cancer Control Research Personnel Awards Panel (Scientific Officer).
Nov 2008	Cancer Care Ontario / Canadian Cancer Society – Cancer Services Innovative Partnership: Diagnostic Improvement Project Review Committee.
Apr 2008	Canadian Institutes for Health Research – National Cancer Institute of Canada -- Behavioural/Psychosocial/Cancer Control Research Personnel Awards Panel (Scientific Officer).

532

External Peer Reviewer for Operating Grant Applications

Sep 2020 – Oct 2020	French National Cancer Institute (INCa) Scientific Evaluation Committee for Population Health Intervention Research Operating Grant Competition
May 2020	Saskatchewan Health Research Foundation – Establishment Grant Program
Sep 2019 – Dec 2019	French National Cancer Institute (INCa) Scientific Evaluation Committee for Population Health Intervention Research Operating Grant Competition
Aug 2017 – Oct 2017	French National Cancer Institute (INCa) Scientific Evaluation Committee for Population Health Intervention Research Operating Grant Competition
May 2019 – June 2019	Saskatchewan Health Research Foundation – Establishment Grant Program
May 2016	KWF Kankerbestrijding (Dutch Cancer Society) – Operating Grant Competition
Aug 2012	Health Research Council of New Zealand – Request for Proposals (RFP) for the Better, Sooner, More Convenient Primary Health Care Initiative
Nov 2009	Canadian Institutes of Health Research – Meetings, Planning and Dissemination Grant Program
Sept 2009	Cancer Care Ontario – Patient Experience Proposal, Number of Reviews
Mar 2009	Canadian Institutes of Health Research – Meetings, Planning and Dissemination Grant Program
Nov 2008	Canadian Institutes of Health Research – Meetings, Planning and Dissemination Grant Program
Oct 2001	Canadian Institutes for Health Research – Operating Grants Competition
Apr 2001	Canadian Institutes for Health Research – Operating Grants Competition

External Peer Reviewer for Personnel Award Applications

Feb 2009	Ireland Health Research Board – Post-doctoral Research Fellowship Scheme, Number of Reviews: 1.

ACADEMIC HISTORY

1. Research Awards

PEER-REVIEWED GRANTS as Principal Investigator

Apr 2020 – Mar 2025 **Dobrow MJ (PI)**, Co-Investigators: Mashford-Pringle A, Berta W, Chatwood S, Milligan C. *Health System Learning from Knowledges and Evidence held within Indigenous Communities: A Multiple Case Study and Two-Eyed Seeing Review.* Canadian Institutes of Health Research Project Grant. $615,824

CDN.

Apr 2011 – Mar 2014 — **Dobrow MJ (PI)**, Sherar M (Principal Decision-Maker Applicant). Collaborators: Brouwers M, Burchett H, Elwood M, Fairclough L, Gagliardi A, Gilbert J, Hoch J, Levy D, McBride M, Olfert I, Peacock S, Rabeneck L, Sawka C, Sullivan T, Wright F. *Dynamic case studies and the impact on policy decision preparedness.* Canadian Institutes of Health Research Partnerships in Health System Improvement Grant. $325,000 CDN.

Apr 2009 – Mar 2013 — Urbach DR (PI). **Dobrow MJ (Co-PI)**. Collaborators: Darling G, Baxter N, Kennedy E, Wei A, Gagliardi A, Simunovic M, Coburn N, Sutradhar R, Maziak, D, Sundaresan S, Irish J, McLeod R, Hunter A, Sherar M, Ross J, Evans W. *Health evaluation of a health care policy intervention to change the organization and delivery of lung cancer surgery in Ontario.* Cancer Care Ontario / Ontario Institute for Cancer Research Health Services Research Network Project. $653,320 CDN.

July 2010 – June 2011 — **Dobrow MJ (PI)**. Collaborators: Hoch J, McBride M, Brouwers M, Gilbert J. ARCC-DCS *Dynamic case studies in cancer control.* Canadian Centre for Applied Research in Cancer Control Operating Grant (SUBG-09-043). $50,000 CDN.

July 2010 – June 2011 — Gagliardi AR (PI), Paige C (Co-PI), **Dobrow MJ (Co-PI)**. *Developing interprofessional knowledge exchange capacity for health services research.* Canadian Institutes of Health Research Planning Grant. $24,093 CDN.

May 2010 – Oct 2010 — **Dobrow MJ (PI)**. *Dynamic case studies.* Canadian Centre for Applied Research in Cancer Control Seed Grant. $6,145 CDN.

Sept 2007 – Sept 2009 — **Dobrow MJ (PI)**. Collaborators: Culyer AC, Chafe R., Lemieux-Charles, L. *Designing Deliberative Processes for the CHSRF Decision-Support Synthesis Program.* Canadian Health Services Research Foundation Operating Grant (CHS-1751-06). $149,097 CDN.

Sept 2008 – Aug 2009 — **Dobrow MJ (PI)**. *Clinical and corporate accountability for cancer system performance: a multiple case study.* The Commonwealth Fund Canadian Harkness Associate Fellowship Stipend. $20,000 CDN.

May 2006 – Apr 2009 — **Dobrow MJ (Co-PI)**, Lemieux-Charles L (Co-PI). Collaborators: Ritvo, P, Urbach, D, Wodchis, W. *Clinical Accountability and Value-Based Purchasing: Linking Funding to Quality of Care.* Canadian Institutes of Health Research Operating Grant (MOP-79552). $165,349 CDN.

Sept 2004 – Aug 2007 — Sullivan T (Co-PI), **Dobrow MJ (Co-PI)**. Collaborators: Lemieux-Charles L, Golden B, Brown A. *Monitoring Performance: the Impact of a Quality Council on Institutional Relationships in Ontario's Cancer System.* Canadian Institutes of Health Research Operating Grant (MOP-69068). $178,784 CDN.

PEER-REVIEWED GRANTS as Co-Investigator

Jun 2018 – May 2020 — Schwartz RM (PI), Finegood DT, Di Ruggiero EMC, **Dobrow MJ (Co-I)**, Price A, Marchildon G. *Strategies to alleviate social problems: from symbols to realities.* Social Sciences and Humanities Research Council Insight Grant. $59,751 CDN.

April 2018 – March 2020 — Squires JE (PI), Grinspun DR (Principal Knowledge User), Dr. S. Bornstein, Dr. S. Brien, **Dobrow MJ (Co-I)**, Dr. C. Estabrooks, Dr. I. Graham, Ms. M. Greenough, Dr. J. Grimshaw, Dr. M. Hillmer, Dr. T. Horsley, Dr. A. Katz, Ms. C. Krause, Prof. J. Lavis, Dr. W. Levinson, Dr. A. Levy, Docteure F. Légaré, Dr. S. Majumdar, Ms. M. Mancuso, Dr. S. Morgan, Mrs. L. NadalinPenno, Mr. A. Neuner, Dr. G. Teare, Dr. J. Tepper, Dr. A. Vandyk, Ms. D. Widmeyer, Dr. M. Wilson. *Inappropriateness of Health Care in Canada.* Canadian Institutes of Health Research Project Grant. $275,400 CDN.

June 2015 – Sep 2018 — Ivers N (Co-PI), Grimshaw J (Co-PI), Brown A (co-PI). Collaborators: Anderson G, Berta W, Bhatia S, Brehaut J, Dhalla I, **Dobrow MJ (Co-I)**, Evans J, Fairclough L, Glazier R, Lang A, Levinson W, Mamdani M, Martin D, Maybee A, Presseau J, Rochon P, Straus S, Talijaard M, Tepper J, Thavorn K, Tugwell P, Witteman H, Zwarenstein M. A Provincial Implementation Science Laboratory: sequential, pragmatic randomized trials and policy-oriented evaluations of large-scale quality improvement initiatives (Ontario Healthcare Implementation Laboratory (OHIL). Ontario SPOR Support Unit Impact Award. $1,867,000 CDN.

July 2013 – Jun 2017	Wranik D (PI), Hoch J (Co-PI), Levy A (Co-PI), Sabharwal M, Skedgel C, **Dobrow MJ (Co-I)**, Gambold L. *Appropriate eFfective eFficient Oncology Reimbursement Decisions*. Canadian Institutes of Health Research – Partnerships for Health System Improvement Grant. $369,375 CDN.
July 2013 – Jun 2016	Tinmouth J, Kewayosh A, Rabeneck L, Baxter N, Borkhoff C, Deber R, **Dobrow MJ (Co-I)**, Gesink D, Jackson S, Llovet D, Lofters A, MacKinnon M, Marrett L, Paszat L. *Improving Cancer Screening among First Nations and Metis*. Canadian Institutes of Health Research – Partnerships for Health System Improvement Grant. $558,891 CDN.
Apr 2011 – Mar 2016	Paszat L (PI). Collaborators: Rabeneck L, **Dobrow MJ (Co-I)**, Tinmouth J, Baxter N, Chiarelli A, Knight J, Adoulis I, Carroll J; Grunfeld E; King A, Krahn M; et al. *Ontario Cancer Screening Research Network. Cancer Care Ontario – Applied Cancer Research Unit* Infrastructure Grant. Cancer Care Ontario. $1,000,000 CDN.
Sept 2012 – Aug 2015	Coburn N (PI). Collaborators: Irish JC, Mcleod RS, Brar SS, Dixon ME, **Dobrow MJ (Co-I)**, Earle CC, Johnson A, Karanicolas PJ, Kiss AJ, Krahn MD, Law CH, Mahar AL, Paszat LF, Wright FC. *A population-based outcome and economic evaluation of interventions for gastric cancer.* Canadian Institutes of Health Research Operating Grant. $288,133 CDN.
Jun 2012 – May 2015	Gagliardi AR (PI). Collaborators: Stuart-McEwan T, Gilbert J, **Dobrow MJ (Co-I)**, Hoch J, Wright FC, Brouwers MC, Meertens E, Kaan M, Campbell B, McCready M, Waddell T, McKnight S, Lacourciere J, McFadyen C, Berry M, Kaune S, Doiron G. *Enhancing inter-professional collaborative care for cancer: Evaluation of diagnostic assessment programs.* Canadian Breast Cancer Foundation – Ontario Chapter. $ 431,306 CDN.
Apr 2013 – Apr 2014	Deber (PI). Collaborators: Barnsley J, Baumann A, Berta W, Brown A, **Dobrow MJ (Co-I)**, Gamble B, Peckham S, Veillard J. *Understanding and implementing best practices in accountability: strengths and challenges of different approaches across settings.* Canadian Institutes of Health Research – Health Renewal Policy Analysis. $150,000 CDN.
Apr 2011 – Mar 2014	Peacock S (PI). Collaborators: **Dobrow MJ (Co-I)**, Gibson J, Hoch J, Mitton C, Chesney E, Coldman A, Elwood M, Evans G, Sabharwal M, Sawka C, Schuckel V, Sullivan T. *Evidence, values and priority setting methods in cancer control.* Canadian Institutes of Health Research Partnerships in Health System Improvement Grant. $400,000 CDN.
Apr 2009 – Mar 2014	Peacock S (Co-PI), Hoch J (Co-PI). Collaborators: Barbera L, Barer M, Berry S, Browman G, Culyer, **Dobrow MJ (Co-I),** Doll R, Elwood M, Evans R, Fassbender K, Gallagher R, Gibson J, Hagen N, Harvey, B, Henry D, Hodgson D, Kapusta B, Krahn M, Lemieux-Charles L, McBride M, Mittmann N, Morgan S, Ringash J, Sawka C, Sullivan, T, Sutcliffe S, Upshur R. *Canadian Centre for Applied Research in Cancer Control.* Canadian Cancer Society Research Institute – Centre for Health Economics, Services, Policy, and Ethics (HESPE) Research in Cancer Control Grant. $3,600,000 CDN.
Jan 2010 – Dec 2013	Deber R (PI). Collaborators: Brown A (Co-Principal Decision-Maker), **Dobrow MJ (Co-Principal Decision-Maker)**, Burns J, Chafe R, Sawka C, Sherar M, Sullivan T, Baker GR, Barnsley J, Baumann A, Berta W, Gamble B, Laporte A, Lum J, Schwartz R, Williams P, Wodchis WP. *Approaches to Accountability: Implications of Goals, Governance, Services, and Sub-sectors.* Canadian Institutes of Health Research Partnerships in Health System Improvement Grant. $349,881 CDN.
May 2008 – Apr 2013	Denis JL (PI). Collaborators: Champagne F, Contandriopoulos AP, Langley A, Lehoux PN, Battista R, Bergeron P, Contandriopoulos D, **Dobrow MJ (Co-I)**, Dubois C, Farand L, Fulop N, Golden-Biddle K, Haggerty J, Lamothe L, Lavis J, Lemieux-Charles L, Pomey M, Reay P, Rouleau L, Roy D, Sicotte C, Sullivan T, Touati N. *CIHR Team in Reconfiguration of Health Care Organizations and Systems.* Canadian Institutes of Health Research Team Grant. $2,627,170 CDN.
Oct 2007 – Sept 2012	Rabeneck L (PI). Collaborators **Dobrow MJ (Co-I)**, Paszat L, Ritvo P, Stukel, T, Hilsden B, Baxter N, Rostom A, McGregor L, Bathe O, Hoch J, Brouwers M. *CIHR Team in Population-Based Colorectal Cancer Screening.* Canadian Institutes of Health Research Emerging Team Grant.. $2,500,000 CDN.
July 2009 – June 2011	Tinmouth J (PI). Collaborators: Angus H, Baxter N, Cohen L, **Dobrow MJ (Co-I)**, Jeejeebhoy K, Murray I, Nijhawan P, Paszat L, Rabeneck L, Sutradhar R. *Assessing the quality of colonoscopy: Validation of quality indicators.* Canadian Cancer Society Research Institute Operating Grant. $165,863 CDN.

July 2010 - June 2011	McBride M (PI). Collaborators: **Dobrow MJ (Co-I)**, Tyldesley S. *Cancer control geomapping.* Canadian Centre for Applied Research in Cancer Control Seed Grant. $4,625 CDN.
Oct 2007 – Sept 2010	Coyte P (PI). Collaborators: Sullivan T, Chafe R, Culyer AC, **Dobrow MJ (Co-I)**, Laing K, Morgan S, O'Reilly S, Peacock S, Sawka C, Smith S, Trudeau, M. *Factors influencing adoption of new cancer drugs within different institutional contexts.* Canadian Institutes of Health Research Partnerships in Health System Improvement Grant (MOP-79552). $150,000 CDN.
Sept 2009 – Mar 2010	Sussman J (PI). Collaborators: Levitt C, **Dobrow MJ (Co-I)**, Brouwers M, Evans W, Carter B, Sawka C. *Family Physician Integration with the Cancer System.* Ontario Institute for Cancer Research and Cancer Care Ontario Operating Grant. $120,000 CDN.
Sept 2004 – Aug 2007	Sullivan T (Co-PI), Brown A (Co-PI). Collaborators: Paszat L, Golden B, Holowaty E, **Dobrow MJ (Co-I)**. *Improving Continuity of Care in the Ontario Cancer Care System: Monitoring Cancer Services Integration* CHSRF Operating Grant. Canadian Health Services Research Foundation. PHS-73068. $100,000 CDN.
Jan 2005 – Dec 2006	Rabeneck L (PI). Collaborators: Sullivan T, Cooper MA, Paszat L, Preece M, Bell R, Malcolm N, Greenberg A, **Dobrow MJ (Co-I)**. *Building Colorectal Cancer Screening Capacity in Ontario: Development and Evaluation of New Training, Assessment and Licensing Processes for Non-Physician Endoscopists.* The Change Foundation Grants Program. $90,000 CDN.

PUBLICATIONS

PA: Principal Author; Co-PA: Co-Principal Author; CA: Co-Author; SRA: Senior Responsible Author (i.e., paper completed under my supervision or mentorship). Student contributions are underlined.

1. Peer-Reviewed Publications

JOURNAL ARTICLES

1. **CA.** Miller FA, Young S, **Dobrow MJ**, Shojania KG. (2020). The vulnerability of the medical product supply chain: The wake-up call of COVID-19. *BMJ Quality and Safety*. doi: 10.1136/bmjqs-2020-012133.
2. **CA.** Fowokan A, Frankfurter C, **Dobrow MJ**, Abrahamyan L, McDonald M, Virani S, Harkness K, Lee DL, Pakosh M, Ross H, Grace SL. (2020). Referral and Access to Heart Function Clinics: A Realist Review. *Journal of Evaluation in Clinical Practice*. doi: 10.1111/jep.13489.
3. **CA.** Half a century of Wilson & Jungner: Reflections on the governance of population screening. (2020). Steve Sturdy, Fiona Miller, Stuart Hogarth, Natalie Armstrong, Pranesh Chakraborty, Celine Cressman, **Mark Dobrow**, Kathy Flitcroft, David Grossman, Russell Harris, Barbara Hoebee, Kelly Holloway, Linda Kinsinger, Marlene Krag, Olga Löblová, Ilana Löwy, Anne Mackie, John Marshall, Jane O'Hallahan, Linda Rabeneck, Angela Raffle, Lynette Reid, Graham Shortland, Robert Steele, Beth Tarini, Sian Taylor-Phillips, Bernie Towler, Nynke van der Veen, Marco Zappa. *Wellcome Open Research,* https://wellcomeopenresearch.org/articles/5-158/v1.
4. **PA. Dobrow MJ.** (2020). Combining a systematic review with consensus methodology: Experiences from a study to consolidate the principles of screening. *SAGE Research Methods Cases*, doi: 10.4135/9781529743401.
5. **SRA.** Tobias JK, Tinmouth J, Senese LC, Jumah N, Llovet D, Kewayosh A, Rabeneck L, **Dobrow MJ.** (2020). Health Policy as a Barrier to First Nations Peoples' Access to Cancer Screening. *Healthcare Policy*, 15(3): 28-46.doi:10.12927/hcpol.2020.26132.
6. **PA. Dobrow MJ,** Bytautas JP, Tharmalingam S, Hagens S. (2019). Systematic review of the use and impact of interoperable electronic health records and health information exchanges. *JMIR Medical Informatics*, 7(2):e12607. doi: 10.2196/12607.
7. **CA.** Squires JE, Graham ID, Grinspun D, Lavis J, Legare F, Bell R, Bornstein S, Brien S, **Dobrow MJ**, Estabrooks CA, Greenough M, Hillmer M, Horsley T, Katz A, Krause C, Levinson W, Levy A, Mancuso M, Maybee A, Morgan S, Nadalin-Penno L, Neuner A, Rader T, Roberts J, Teare G, Tepper J, Vandyk A, Widmeyer D, Wilson M, Grimshaw JM. (2019). Inappropriateness of health care in Canada: A systematic review protocol. *Systematic Reviews,* 8(1): 50. doi: 10.1186/s13643-019-0948-1.
8. **CA.** Miller FA, Patton SJ, **Dobrow MJ**, Berta W. (2018). Public involvement in health research systems: a governance framework. *Health Research Policy and Systems*, 16(79): 1-16.

9. **CA**. Miller FA, Patton SJ, **Dobrow MJ**, Marshall DA, Berta W (2018). Public involvement and health research system governance: a qualitative study. *Health Research Policy and Systems*, 16(87): 1-15.
10. **PA**. **Dobrow MJ**, Hagens V, Chafe R, Sullivan T, Rabeneck L. (2018). Consolidated principles for screening based on a systematic review and consensus process. *CMAJ*, 190(14): E422-E429.
11. **CA**. Honein-AbouHaidar G, Hoch JS, **Dobrow MJ**, Stuart-McEwan T, McCready DR, Gagliardi AR. (2017). Cost analysis of breast cancer diagnostic assessment programs. *Current Oncology*, 25(5): e354-e360.
12. **CA**. Gagliardi AR, Honein-AbouHaidar G, Stuart-McEwan T, Smylie J, Arnaout A, Seely J, Wright FC, Dobrow MJ, Brouwers MC, Bukhanov K, McCready DR. (2017). How do the characteristics of breast cancer diagnostic assessment programmes influence service delivery: A mixed methods study. *European Journal of Cancer Care*, 27(2): e12727. https://doi.org/10.1111/ecc.12727.
13. **SRA**. Mery G, Majumder S, Brown A, **Dobrow MJ**. (2017). What do we mean when we talk about the Triple Aim? A systematic review of evolving definitions and adaptations of the framework at the health system level. *Health Policy*, 121(6): 629-636.
14. **PA**. **Dobrow MJ**, Miller FA, Frank C, Brown AD. (2017). Understanding Relevance of Health Research: Considerations in the Context of Research Impact Assessment. *Health Research Policy and Systems*, 15(1): 31.
15. **CA**. Honein-AbouHaidar GN, Stuart-McEwan T, Waddell T, Salvarrey A, Smylie J, **Dobrow MJ**, Brouwers MC, Gagliardi AR. (2017). How do organizational characteristics influence teamwork and service delivery in lung cancer diagnostic assessment programs? a mixed methods study. *BMJ Open*, 7:e013965.
16. **CA**. Mery G, **Dobrow MJ**, Baker R, Im J, Brown A. (2017). *Evaluating Investment in Quality Improvement Capacity Building: A Systematic Review*. *BMJ Open*, 7: e012431.
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21. **SRA**. Brien S, Gheihman G, Tse Y, Byrnes M, Harrison S, Wright C, Frank C, **Dobrow MJ**. (2014). A scoping review of appropriateness of care research activity in Canada from a health system level perspective. *Healthcare Policy*, 9(4), 48-61.
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38. **SRA.** Bak K, **Dobrow MJ**, Hodgson D, Whitton A. (2011). Factors affecting the implementation of complex and evolving technologies: Multiple case study of intensity-modulated radiation therapy in Ontario, Canada. *BMC Health Services Research*, 11(178).
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41. **SRA**. Umoquit MJ, Tso P, Burchett HED, **Dobrow MJ**. (2011). A multidisciplinary systematic review of the use of diagrams as means of collecting data: techniques, benefits and recommendations. *BMC Medical Research Methodology*, 11(11).
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44. **PA. Dobrow MJ**. (2010). Guest Editorial: Does evidence-based medicine represent a useful model for evidence-based policy? *Clinical Evidence*, 26 August 2010.
45. **SRA**. Look Hong NJ, Wright FC, Gagliardi AR, Brown P, **Dobrow MJ**. (2009). Multidisciplinary cancer conferences: exploring the attitudes of cancer care providers and administrators. *Journal of Interprofessional Care*, 23(6), 599-610.
46. **SRA**. Orchard M, **Dobrow MJ**, Paszat L, Jiang H, Brown P. (2009). Access to Electronic Health Records by care setting and provider type: perceptions of cancer care providers in Ontario, Canada. *BMC Medical Informatics*, 9(1), 38.
47. **PA. Dobrow MJ**, Paszat L, Golden B, Brown AD, Holowaty E, Orchard MC, Monga N, Sullivan. (2009). Measuring integration of cancer services to support performance improvement: the CSI survey. *Healthcare Policy*, 5(1), 35-53.
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49. **SRA.** Hagens V, **Dobrow MJ**, Chafe R. (2009). Interviewee transcript review: assessing the impact on qualitative research. *BMC Medical Research Methodology*, 9(1), 47.

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52. **Co-PA.** Chafe R, **Dobrow MJ.** (2008). Health services researchers within healthcare organizations: the intriguing sound of three hands clapping. *Healthcare Policy*, 4(2),30-38.

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55. **SRA.** Umoquit M, **Dobrow MJ**, Lemieux-Charles L, Ritvo P, Wodchis W, Urbach D. (2008). The efficiency and effectiveness of utilizing diagrams in interviews: a comparison of participatory diagramming and graphic elicitation. *BMC Medical Research Methodology*, 8(1), 53.

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57. **PA. Dobrow MJ.** (2007). Can health policy ever be evidence-based? (commentary). *Journal of Health Services Research & Policy*, 12(1), 63-64.

58. **PA. Dobrow MJ**, Goel V, Lemieux-Charles L, Black N. (2006). The impact of context on evidence utilisation: a framework for expert groups developing health policy recommendations. *Social Science & Medicine,* 63(7), 1811-1824.

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61. **Co-PA.** Sullivan T, **Dobrow MJ**, Thompson L, Hudson A. (2004). Reconstructing cancer services in Ontario. *HealthcarePapers*, 5(1), 69-80.

62. **PA. Dobrow MJ**, Goel V, Upshur, R.E.G. (2004). Evidence-based health policy: context and utilisation. *Social Science & Medicine*, 58(1), 207-217.

63. **PA.** Coyte PC, **Dobrow MJ**, Broadfield L. (2001). Incremental cost analysis of ambulatory clinic and home-based intravenous therapy for multiple myeloma. *PharmacoEconomics*, 19(8), 845-854.

BOOKS AND BOOK CHAPTERS

1. **PA.** Borras Andres JM, **Dobrow MJ**. Chapter 2: The EU Guide on Quality Improvement in Comprehensive Cancer Control: Context, Summary Recommendations and Appraisal. In CanCon Joint Action:CanCon – European Guide for Quality Improvement of Cancer Control. Editors Albreht T, Kiasuwa R, Van den Bulcke M. National Institute of Public Health (Slovenia) and Scientific Institute of Public Health, (Belgium). https://cancercontrol.eu/archived/guide-landing-page.html. 2017.

2. **CA.** Algashov N, Baranek P, Biscope C, Clarke K, **Dobrow MJ**, Gillani A, Koo I, Mah CL, McKenna B, Parent M, Scharf MA, Siddiqui S, Signal L, Wortzman R, Deber RB. Chapter 3: Making Canadians Healthier: Where Do We Start? In *Case Studies in Canadian Health Policy and Management, Volume 1* (2nd Edition), Editor Deber RB. University of Toronto Press. http://www.utppublishing.com/Case-Studies-in-Canadian-Health-Policy-and-Management-Second-Edition.html. 2014.

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REPORTS

1. **PA. Dobrow MJ**. Dufour L, Hancock-Howard R, Bytautas J, Shanmuganantha M, Chafe R, Vandermorris A. (2020). Coming of Age: Opportunities for Investing in Adolescent Health in Canada. An Accessing Centre for Expertise (ACE) White Paper. Accessing Centre for Expertise (ACE), University of Toronto. 25 October 2020.
2. **PA. Dobrow MJ**. Bytautas J, Hancock-Howard R, Dufour L. (2020). Evaluation of Policy-Relevant Evidence and Policy Responses to Delays in Professional Registration of Chiropractors due to the COVID-19 Pandemic. Accessing Centre for Expertise (ACE, University of Toronto. 31 July 2020.
3. **PA. Dobrow MJ**. (2020). Review of Policy Institutes or Think Tanks with Close Links to, or Embedded within, Universities: Final Report. Accessing Centre for Expertise (ACE), University of Toronto. 28 Jan 2020.
4. **PA. Dobrow MJ**. (2020). Review of Governance Structures and Operating Models for Policy Institutes with Close Links to, or Embedded within, Universities: Interim Report. Accessing Centre for Expertise (ACE), University of Toronto. 06 Nov 2019.
5. **PA. Dobrow MJ**, Gheihman G, Brown A. (2018). Evaluation of Research and Innovation Models for University and Hospital/Health Care Organization Consortia: Summary Report. Accessing Centre for Expertise, University of Toronto. 19 Nov 2018.
6. **PA. Dobrow MJ**, Gheihman G. (2018) Evaluation of Research and Innovation Models for University and Hospital/Health Care Agency Clusters: Phase 1 Interim Report – Summary of Targeted Scan. Accessing Centre for Expertise, University of Toronto. 16 July 2018.
7. **PA. Dobrow MJ**, Bytautus JP. (2018) Evaluation of Cancer Care Ontario's Corporate Strategy (2012-2018) – Summary Report. Accessing Centre for Expertise, University of Toronto. 23 Aug 2018.
8. **PA. Dobrow MJ**. Gagliardi AR. Assessment and Recommendations for a Standardized Approach to Topic Feasibility Assessments for Health Quality Ontario's Public Reporting Submitted to Health Quality Ontario (05 Mar 2018). Accessing Centre for Expertise, Institute of Health Policy, Management and Evaluation, University of Toronto.
9. **SRA**. Tso P, **Dobrow MJ**. Patient Access to Medical/ Health Records: A Rapid Review to Inform a Health Quality Ontario Feasibility Assessment. Submitted to Health Quality Ontario (22 Mar 2018). Accessing Centre for Expertise, Institute of Health Policy, Management and Evaluation, University of Toronto.
10. **PA. Dobrow MJ**. Assessment of a Proposal to Develop a Medical Campus in Markham Ontario Targeting Alternate Level of Care Challenges Across the Greater Toronto Area (29 Jan 2018). Accessing Centre for Expertise, Institute of Health Policy, Management and Evaluation, University of Toronto.
11. **SRA**. Cressman C, **Dobrow MJ**. Evidence Assessment on Health Provider Experience as a Topic for an HQO Specialized Report. Submitted to Health Quality Ontario (23 Jan 2018). Accessing Centre for Expertise, Institute of Health Policy, Management and Evaluation, University of Toronto.
12. **SRA**. Arpin E, **Dobrow MJ**. Evidence Assessment on the Topic of Pediatrics and Primary Care for HQO. Submitted to Health Quality Ontario (09 Feb 2018). Accessing Centre for Expertise, Institute of Health Policy, Management and Evaluation, University of Toronto.
13. **PA. Dobrow MJ**, Bytautas JP. Use/Impact of Interoperable Electronic Health Records – Systematic Review and Synthesis Summary Report. Submitted to Canada Health Infoway (03 Apr 2017). Accessing Centre for Expertise, Institute of Health Policy, Management and Evaluation, University of Toronto.
14. **CA.** Miller FA, Patton SJ, **Dobrow MJ**, Marshall D, Berta W. (2017). Public Involvement and Health Research System Governance: A Qualitative Description. 30 pp. Ontario SPOR SUPPORT Unit.
15. **CA.** Miller FA, Patton SJ, Kiflen R, **Dobrow MJ**, Berta W. (2016). Governing Public Involvement in Health Research Systems: A Governance Framework for Public Involvement in Health Research Systems. 46 pp. Ontario SPOR Support Unit.
16. **CA**. Mery G, **Dobrow MJ**, Baker R, Im J, Brown A. *Evaluating Quality Improvement Capacity Building: A Synthesis of the Literature*. Working Paper. Institute of Health Policy, Management and Evaluation, Toronto, 2015.
17. **PA. Dobrow MJ**, Miller FA, Frank C, Brown AD. Understanding Relevance of Health Research: Considerations in the Context of Research Impact Assessment. White paper submitted to the Ontario SPOR Support Unit (OSSU) (31 Aug 2015).
18. **PA. Dobrow MJ**, Chafe R, Burchett H, Culyer AC, Lemieux-Charles L. *Designing deliberative processes for combining*

heterogeneous evidence: a systematic review and qualitative scan. Canadian Health Services Research Foundation, Ottawa. 2009.

19. **PA. Dobrow MJ**, Chafe R, Burchett H. *Designing deliberative processes for combining heterogeneous evidence: Evaluation of the Canadian Health Services Research Foundation's Decision Support Synthesis Program*. Canadian Health Services Research Foundation, Ottawa, 2009.
20. **CA**. Gilbert J, Rabeneck L, Hughes E, Green E, LeClair I, **Dobrow MJ**, Cooper MA. *RN-Performed Flexible Sigmoidoscopy in a Pilot Project of Colorectal Cancer Screening: Interim Evaluation Report*. Cancer Care Ontario, Toronto, 2008.
21. **PA**. Sullivan T, Brown AD, **Dobrow MJ**, Golden B, Holowaty E, Paszat L. *Improving continuity of care in the Ontario cancer care system: monitoring cancer services integration*. Canadian Health Services Research Foundation, Ottawa, 2008.
22. **PA**. **Dobrow MJ**, Cooper MA, Gayman K, Pennington J, Matthews J and Rabeneck L. *Building Colorectal Cancer Screening Capacity in Ontario: Development and Evaluation of New Training, Assessment and Licensing Processes for Non-Physician Endoscopists: Evaluation Report*. Final report submitted to the Change Foundation, Toronto, 2007.

540

EDITORIALS

1. **PA. Dobrow MJ**, Abbott JG, Kitts J. Canada's healthcare system needs an unbiased watchdog. Toronto Star, 2014-04-01. https://www.thestar.com/opinion/commentary/2014/04/01/canadas_healthcare_system_needs_an_unbiased_watchdog.html.

SELECTED PRESENTATIONS AND SPECIAL LECTURES

1. International

05 Dec 2019	**PA. Dobrow MJ**. *The Future of Screening Criteria for Informing New Screening Programmes. Innovative Partnership for Action Against Cancer: New Openings of Cancer Screening in Europe.* Helsinki, Finland.
04 Dec 2019	**PA. Dobrow MJ**. *Principles and Criteria for Cancer Screening,* Innovative Partnership for Action Against Cancer: Work Package 5 Technical Meeting. Helsinki, Finland.
28 Jan 2016	**PA. Dobrow MJ**. *Evidence and policy: need for a #&@$€% map?* Laboratorio Management e Sanità (MeS), Istituto di Management, Scuola Superiore Sant'Anna. Pisa, Italy.
01 Sept 2015	**PA. Dobrow MJ**. *From clinical practice guidelines to health systems guidance: case study of colorectal cancer screening*. Scuola di Specializzazione in Igiene e Medicina Preventiva, Università di Bologna. Bologna, Italy.
14 Aug 2015	**PA. Dobrow MJ**. *Evidence-informed health policy: conceptual and practical perspectives on advancing health systems guidance*. ASEAN Institute for Health Development, Mahidol University. Bangkok, Thailand.
10 Aug 2015	**PA. Dobrow MJ**. *Evidence-informed health policy: from clinical practice guidelines to health systems guidance*. Faculty of Medicine, Khon Kaen University. Khon Kaen, Thailand.
10 July 2015	**PA. Dobrow MJ**. Context and utilisation: small group session 2. CanCon Joint Action Guideline Coordination Committee (Work Package 4) workshop. Brussels, Belgium.
09 July 2015	**PA. Dobrow MJ**. Context and utilization: small group session 1. CanCon Joint Action Guideline Coordination Committee (Work Package 4) workshop. Brussels, Belgium.
09 July 2015	**PA. Dobrow MJ**. *Evidence and context: considerations for optimizing the utility of a European cancer control guide.* CanCon Joint Action Guideline Coordination Committee (Work Package 4) workshop. Brussels, Belgium.
14 May 2013	**PA. Dobrow MJ**. *What do Canadians really think about their health care system?* The Commonwealth Fund Harkness Program Canadian Tour. Montreal, Quebec, Canada.
18-22 Oct 2014	**PA. Dobrow MJ**. *A systematic review and consolidation of decision principles for screening*. Poster

presentation at the 36th Annual Meeting of the Society for Medical Decision Making, Miami, Florida, USA.

22-26 Oct 2011 **PA. Dobrow MJ**. *Defining policy decision(s) and integrating contextual evidence: A multiple case study of colorectal cancer screening policy development*. 33rd Annual Meeting of the Society for Medical Decision Making, Chicago, Illinois, USA.

18-21 Aug 2010 **PA. Dobrow MJ**. *Posing the right questions: A systematic review of decision principles for screening*. World Cancer Congress, Shenzhen China.

20-23 Apr 2010 **PA. Dobrow MJ**. *Translating leverage: the impact of formal designations on quality of care*. Forum on Quality and Safety in Healthcare, Nice, France.

28-30 June 2009 **PA. Dobrow MJ**. *Clinical vs. corporate accountability for performance: A multiple case study of comprehensive cancer centers in the United States and Canada*. AcademyHealth Annual Research Meeting, Chicago, Illinois, USA.

11 June 2009 **PA. Dobrow MJ**. *Shared accountability for performance: A multiple case study of comprehensive cancer centers in the United States and Canada*. The Commonwealth Fund Harkness Program Final Reporting Seminar, New York, New York, USA.

22 Sept 2008 **PA. Dobrow MJ**. *Canada's health care system(s)*. The Commonwealth Fund's Harkness Orientation Seminar, New York, New York USA.

31 Mar 2004 **PA. Dobrow MJ** *International evidence and local contexts: a multiple case study of the role of health technology assessment in the development of cancer screening policy*. 2004 Health Technology Assessment International (HTAi) Annual Meeting, Krakow, Poland. Oral presentation.

2-4 Dec 2003 **PA. Dobrow MJ**. *Context-based evidence-based decision-making: evidence utilisation in the development of health policy*. National Institute of Clinical Excellence (NICE) 2003 Annual Conference, Birmingham, UK.

03 June 2003 **PA. Dobrow MJ**. *Context-based evidence-based decision-making: a framework for improving the utilisation of evidence in the development of health policy*. Health Services Research Unit Seminar, London School of Hygiene and Tropical Medicine, London, United Kingdom.

26-28 Feb 2003 **PA. Dobrow MJ**. *Context-based evidence-based decision-making: the impact of context on the utilisation of evidence*. Second Annual Campbell Collaboration Colloquium, Stockholm, Sweden.

2. National

29 May 2019 **PA. Dobrow MJ**. *Innovative Health Policy-Maker / Researcher Arrangements Based on a Disembedded Research Model.* Canadian Association of Health Services & Policy Research Conference. Halifax, NS. Canada. Oral presentation.

08 Feb 2016 **PA. Dobrow MJ**. *Evidence Review: An Historical Overview of Approaches and Methods for Health Systems and Policy.* Policy Rounds, Canadian Institute for Health Information, Toronto, Ontario, Canada.

29 October 2013 **PA. Dobrow MJ**. *Summary of Day One*. Health Council of Canada National Symposium on Quality Improvement. Allstream, Toronto, Ontario, Canada.

21 October 2013 **PA. Dobrow MJ**. *The Health Innovation Portal*. Masters of Health Administration Bearpit Session. Telfer School of Management, University of Ottawa, Ottawa, Ontario, Canada.

10 June 2013 **PA. Dobrow MJ**. Ritcey G. *Demonstrating the Health Innovation Portal: a new tool for identifying and sharing innovative practices in Canada.* National Health Leadership Conference. Niagara Falls, Ontario, Canada.

13 Mar 2012 **PA. Dobrow MJ**. *What are the home care priorities for seniors in Canada*. Canadian Institute for Health Information – Home and Continuing Care Forum, Ottawa, Ontario, Canada.

20 May 2010 **PA. Dobrow MJ**. *Making screening policy decisions and making screening policy decisions better: a multiple case study*. Canadian Partnership Against Cancer: National Colorectal Cancer Screening Network Quarterly Meeting, Toronto, Ontario, Canada.

13 May 2010 **PA. Dobrow MJ**. *Careers in Health Services Research – CAHSPR Student Work Group Panel Discussion*.

Canadian Association of Health Services & Policy Research Conference, Toronto, Ontario, Canada.

12 May 2010 **PA. Dobrow MJ**. *Accountability for performance of comprehensive cancer centres: leveraging the impact of formal designations for research and training to motivate improvements in patient care quality.* Canadian Association of Health Services & Policy Research Conference, Toronto, Ontario, Canada. Oral presentation.

22 Mar 2010 **PA. Dobrow MJ**. Context-based evidence-based decision-making: overview of a conceptual framework. Prenatal Record Revision Symposium, Ottawa, Ontario, Canada.

12 Mar 2010 **PA. Dobrow MJ**. *Deliberative methods for combining different types of evidence in the development of policy recommendations*. Journées annuelles de santé publique (JASP) [Annual Meeting of Public Health], Montreal, Quebec, Canada.

22 Sept 2009 **Co-PA. Dobrow MJ**, McBride M. *Update on the HESPE Health Services, Systems and Policy Research Program*. National Centre for Health Economics, Services, Policy and Ethics Research in Cancer Control, Toronto, Ontario Canada.

07 July 2008 **PA. Dobrow MJ**. *Deliberative methods for combining evidence in support of health policy decisions: a systematic review.* In parallel panel session entitled "Using deliberative processes to combine evidence and values: where science meets context". Health Technology Assessment International (HTAi) 5th Annual Meeting, Montreal, Canada.

27 May 2008 **PA. Dobrow MJ**. *Measuring integration: the Cancer Services Integration (CSI) Survey*. Canadian Association of Health Services & Policy Research Conference, Gatineau, Quebec, Canada. Oral presentation.

27 Apr 2008 **PA. Dobrow MJ**. *Deliberative methods for combining different types of evidence.* Canadian Agency for Drugs and Technologies in Health 2008 Invitational Symposium, Edmonton, Alberta, Canada.

23 Mar 2007 **PA. Dobrow MJ**. *The impact of context on evidence utilization: a framework for expert groups developing health policy recommendations.* Agence d'évaluation des technologies et modes d'intervention en santé (AETMIS), Montreal, Quebec, Canada.

23 June 2005 **PA. Dobrow MJ**. *Non-physician endoscopy – a proposal for increasing screening capacity for colorectal cancer in Ontario*. Health Council of Canada's National Health Human Resources Summit, Toronto, Ontario, Canada.

18 Feb 2000 **PA. Dobrow MJ**. *Impact of decision-making context on perceptions of evidence: case study of cancer screening*. Health Evidence Application and Linkage Network (HEAL*Net*) Workshop, Montreal, Quebec, Canada.

3. Provincial / Regional / Local

14 Oct 2020 **Co-PA.** Marchildon G, **Dobrow MJ.** *Increasing the Impact of DLSPH Research through a Policy Think Tank – Working Group on Impact.* Core Faculty Meeting, Institute of Health Policy, Management and Evaluation, Dalla Lana School of Public Health, University of Toronto, Toronto, Canada.

22 Nov 2019 **PA. Dobrow MJ.** *Policy guidance for addressing social determinants of health in Ontario: A Converge3 project.* Public Health Policy – Fall Institute: Prescribing for Health, Dalla Lana School of Public Health, University of Toronto, Toronto, Canada.

18 Nov 2019 **PA. Dobrow MJ.** *Dalla Lana School of Public Health consultation exercise: Applying a health systems lens to social determinants of health: Introduction and context setting.* Converge3, Dalla Lana School of Public Health, University of Toronto, Toronto, Canada.

22 Jan 2019 **PA. Dobrow MJ.** *Knowledge user dialogue on mental health and addictions treatment interventions for immigrant, refugee, ethno-cultural and racialized populations (IRER): Introduction and context setting.* Converge3, Institute of Health Policy, Management and Evaluation, University of Toronto, Toronto, Canada.

06 Nov 2018 **PA. Dobrow MJ.** *Knowledge user dialogue on assistive devices in Ontario: Introduction and context setting.* Converge3, Institute of Health Policy, Management and Evaluation, University of Toronto,

Toronto, Canada.

07 Mar 2016 **PA. Dobrow MJ.** *Evidence and policy: need for a #&@$€% map?* Institute of Health Policy, Management and Evaluation Health Policy Rounds, University of Toronto, Toronto, Canada.

31 Mar 2015 **PA. Dobrow MJ**. The new era of transparency: welcome to the nude beach. Panel session at the Ontario Long-Term Care Association and Ontario Retirement Communities Association Annual Convention and Trade Show. Metro Toronto Convention Centre, Toronto, Canada.

19 Jan 2015 **PA. Dobrow MJ**. *HQO's Performance Monitoring and Public Reporting Initiatives – A presentation to the TC-LHIN*. TC-LHIN Quality Table. Toronto Central LHIN, Toronto, Canada.

03 Dec 2014 **PA. Dobrow MJ.** *Health Quality Ontario: Government and Industry Perspectives on the Future of Research and Innovative Care*. William Osler Health System. Osler Research Program Development. Brampton Civic Hospital Auditorium, Brampton, Canada.

27 Nov 2014 **PA. Dobrow MJ**. Establishing a performance measurement framework for primary care in Ontario. Ontario College of Family Physicians – Annual Scientific Meeting 2014. Hilton Hotel, Toronto, Canada.

20 Nov 2014 **PA. Dobrow MJ.** *Putting Data in the Hands of Providers: Using Personalized Reports to Fuel Quality Care.* Health Quality Transformation 2014. Metro Toronto Convention Centre. Toronto, Canada.

15 May 2013 **PA. Dobrow MJ**. *Quality improvement in Canada: are we at a turning point?* Atlantic Learning Exchange meeting, Moncton, New Brunswick, Canada.

10 Apr 2013 **PA. Dobrow MJ**. *Which way to quality in Canada?* Inspire Health Care Quality Summit (Health Quality Council of Saskatchewan), Regina, Saskatchewan, Canada.

21 July 2010 **PA. Dobrow MJ**. Leveraging high performance by designating comprehensive cancer centers in the USA: Should Canada follow suit? Cancer Care Ontario's Lunch and Learn Seminar, Toronto, Ontario, Canada.

19 Nov 2007 **PA. Dobrow MJ**. *The impact of a quality council on organizational relationships in a health system: an institutional theory perspective*. Cancer Quality Council of Ontario, Toronto, Ontario, Canada.

23 Apr 2007 **PA. Dobrow MJ**. *Cancer Services Integration Survey (CSI-2): Preliminary Results.* Toronto Sunnybrook Regional Cancer Centre – Surgical Oncology Research Meetings, Toronto, Ontario, Canada.

17 Apr 2007 **PA. Dobrow MJ**. *Cancer services integration (CSI-2) survey: preliminary results*. Cancer Care Ontario's Executive Team, Toronto, Ontario, Canada.

09 Feb 2007 **PA. Dobrow MJ**. *Cancer services integration (CSI) survey: report on analysis of round 1 data*. Cancer Care Ontario's Clinical Council, Toronto, Ontario, Canada.

11 Dec 2006 **PA. Dobrow MJ**. *Cancer services integration (CSI) survey: report on analysis of round 1 data*. Cancer Quality Council of Ontario, Toronto, Ontario, Canada.

08 Dec 2006 **PA. Dobrow MJ**. *Cancer services integration (CSI) survey: report on analysis of round 1 data*. Cancer Care Ontario's Provincial Leadership Council, Toronto, Ontario, Canada.

19 Apr 2006 **PA. Dobrow MJ**. *Nurse Endoscopy: Building Colorectal Cancer Screening Capacity in Ontario*. Celebrating Innovations in Health Care Expo, Toronto, Ontario, Canada.

25 Apr 2001 **PA. Dobrow MJ**. *Impact of context on the interpretation of evidence: case study of cancer screening.* "Research Day", Department of Health Administration, University of Toronto. Toronto, Ontario, Canada.

22 Nov 2000 **PA. Dobrow MJ**. *Impact of context on the interpretation of evidence: case study of cancer screening.* Seminar Series, Department of Health Administration, University of Toronto. Toronto, Ontario, Canada.

MEDIA INTERVIEWS

1. Editorial boards

Editorial Board: Globe and Mail. 2013-10-17 approx. 1 hour. (to discuss Health Council of Canada`s summative report).

2. Print/informational interviews

Informational interview. CityNews (interviewed by Faiza Amin to discuss release of Cancer System Quality Index). 2016-05-18. 2.00pm.

Information interview. Healthydebate.ca (interviewed by Jeremy Petch to discuss Health Quality Ontario report entitled 'Looking for Balance: Antipsychotic medication use in Ontario long-term care homes'). 2015-05-28 9.30am.

Information interview: CBC News (Interviewed by Jaela Bernstein to discuss wait times at the Jewish General Hospital in Montreal). 2014-04-28. 1.15pm. (news story on multiple platforms)

Print Interview: Chronicle Journal (Thunder Bay) (interviewed by Carl Clutchey to discuss Health Council of Canada`s report on 2013 Commonwealth Fund survey data). 2014-01-21.

Print Interview: CMAJ news (Interviewed by Adam Miller to discuss the Health Innovation Portal) 2012-11-27. Story published in CMAJ on 2013-02-19 (vol. 185 no. 3; first published online January 28, 2013, doi: 10.1503/cmaj.109-4370).

Print Interview: Toronto Star (interviewed by Theresa Boyle to discuss Health Council of Canada`s report on 2013 Commonwealth Fund survey data) 2014-01-15. Story published in Toronto star on 2014-01-20 (http://www.thestar.com/news/canada/2014/01/20/family_doctor_availability_only_41_of_canadians_get_quick_appointments_report_finds.html).

3. TV interviews

TV Interview: Global TV BC (interviewed by Sonia Sunger to discuss Health Council of Canada`s report on 2013 Commonwealth Fund survey data). 2014-01-20 2.30pm (live Skype interview for TV approx. 4 min)

TV Interview: CTV news (interviewed by Jacqueline Milczarek to discuss Health Council of Canada`s report on 2013 Commonwealth Fund survey data). 2014-01-20 (live remote TV interview).

TV Interview: CBC The National (interviewed by Ron Charles to discuss Health Council of Canada`s report on 2013 Commonwealth Fund survey data). 2014-01-20 12.00pm (recorded TV interview approx. 20 min with excerpts shown on the National).

TV Interview: CBC News Network (interviewed by Suhana Meharchand to discuss Health Council of Canada`s report on 2013 Commonwealth Fund survey data). 2014-01-20 9.30am (live TV interview; approx. 5 min).

4. Radio interviews

Radio Interview: Radio Canada International (Interviewed by Lynn Desjardins to discuss Health Quality Ontario's report entitled 'Looking for Balance: Antipsychotic medication use in Ontario long-term care homes'). 2015-05-21 9.00am (recorded and posted online: http://www.rcinet.ca/en/2015/05/21/use-of-antipsychotic-meds-in-seniors-homes-varies).

Radio Interview: CBC Radio Syndication: Kitchener-Waterloo (Craig Norris), Corner Brook – West Coast Morning (Bernice Hillier), Saint John – Information Morning (Hance Colbourne), Yellowknife – The Trailbreaker (Loren McGinnis), Saskatoon – Saskatoon Morning, Whitehourse – A New Day (Sandi Coleman), Regina – The Morning Edition (Stefani Langenegger) to discuss Health Quality Ontario's report entitled 'Looking for Balance: Antipsychotic medication use in Ontario long-term care homes'). 2015-05-21 6.40-8.40am (live and recorded).

Radio Interview: Corus Radio Calgary (Interviewed to discuss Brian Sinclair Inquiry and general issues related to wait times for emergency departments in Canada). 2014-06-09 2.45pm. (Live radio interview).

Radio Interview: Corus Radio Calgary (Interviewed to discuss Health Council of Canada`s report on 2013 Commonwealth Fund survey data). 2014-01-23 4.00pm.

Radio Interview: 570 NEWS Kitchener (Interviewed by Glenn Pelletier to discuss Health Council of Canada`s report on 2013 Commonwealth Fund survey data). 2014-01-22 10.35am.

Radio Interview: Corus Radio Calgary (Interviewed to discuss Health Council of Canada`s report on 2013 Commonwealth Fund survey data). 2014-01-21 4.30pm.

Radio Interview: NEWS 95.7 Halifax, NEWS 88.9 Saint John, NEWS 91.9 Moncton – Todd Veinotte Show (Interviewed to discuss Health Council of Canada`s report on 2013 Commonwealth Fund survey data). 2014-01-21 2.15pm.

Radio Interview: CKTB St Catherines (Interviewed by Tim Dennis to discuss Health Council of Canada`s report on 2013 Commonwealth Fund survey data)– live radio interview 2014-01-21 7.50am

Radio Interview: Corus Radio Hamilton – The Matt Holmes Show (to discuss Health Council of Canada`s report on 2013 Commonwealth Fund survey data). 2014-01-20 7.30pm.

Radio Interview: CBC Radio Syndication: (Victoria, Vancouver, Edmonton, Winnipeg, Windsor, Toronto, Halifax, St John's to discuss Health Council of Canada's report on 2013 Commonwealth Fund survey data). 2014-01-20 6.00-8.00pm (live and recorded).

Radio Interview: Corus Radio Hamilton – The Bill Kelly Show (to discuss Health Council of Canada`s report on 2013 Commonwealth Fund survey data). 2014-01-20 11.35am.

Radio Interview: NewsTalk 1010 with Jerry Agar (to discuss Health Council of Canada`s report on 2013 Commonwealth Fund survey data)– 2014-01-20 11.00am (live radio interview) – approx. 15 min

Radio Interview: Concordia University radio with Naheela Bendali (to discuss Health Council of Canada`s report on 2013 Commonwealth Fund survey data)– 2014-01-20 10.50am (recorded radio interview) – approx. 5 min

Radio Interview: 1310 News with Ed Hand (to discuss Health Council of Canada`s report on 2013 Commonwealth Fund survey data)– 2014-01-20 10.30am (live radio interview) – approx. 10 min

TEACHING AND DESIGN

Sep 2020 – Dec 2020	**Co-Course Director**, Graduate (MHI) Course: *MHI2011H Performance Measurement in Health Care: Theory and Application.* Institute of Health Policy, Management and Evaluation, University of Toronto, Toronto, Ontario, Canada. Co-Course Director: Susan Brien.
May 2020	**Guest Lecturer**, *Case Study Research and Mixed Methods Research: Understanding the Overlap.* Graduate (MSc/PhD) Course: HAD5742H Mixed Methods in Health Services Research. Institute of Health Policy, Management and Evaluation, University of Toronto, Toronto, Ontario, Canada. Course Directors: Katie Dainty, Michelle Silver.
Jan 2020 – Apr 2020	**Course Director**, Graduate (MSc/PhD) Course: *HAD5781* Case Study Research for Health Services, Systems and Policy. Institute of Health Policy, Management and Evaluation, University of Toronto, Toronto, Ontario, Canada.
Jan 2020	**Guest Lecturer**, *Non-Conventional Approaches to Systematic Review: Scoping Review, Realist Review, Meta-Narrative Review, Critical Interpretive Synthesis, Grey Literature, Web Search..* Graduate (MSc/PhD) Course: HAD5779H Evidence Synthesis for Health Services, Systems and Policy Research. Institute of Health Policy, Management and Evaluation, University of Toronto, Toronto, Ontario, Canada. Course Directors: Lusine Abrahamyan, Petros Pechlivangoglou.
Sep 2019 – Dec 2019	**Co-Course Director**, Graduate (MHI) Course: *MHI2011H Performance Measurement in Health Care: Theory and Application*. Institute of Health Policy, Management and Evaluation, University of Toronto, Toronto, Ontario, Canada. Co-Course Director: Susan Brien.
Jan 2019 – Apr 2019	**Course Director**, Graduate (MSc/PhD) Course: *HAD5781* Case Study Research for Health Services, Systems and Policy. Institute of Health Policy, Management and Evaluation, University of Toronto, Toronto, Ontario, Canada.
Feb 2019	**Guest Lecturer.** *Governing health care systems: the case of Cancer Care Ontario.* Graduate (MSc/PhD) Course: HAD5020 Canada's Health Systems and Health Policy II. Institute of Health Policy, Management and Evaluation, University of Toronto, Toronto, Ontario, Canada. Course Director: Dr. F. Miller.
Jan 2019	**Guest Lecturer**, *Non-Traditional Approaches to Evidence Synthesis: Scoping Review, Realist Review, Meta-Narrative Review, Critical Interpretive Synthesis, Grey Literature.* Graduate (MSc/PhD) Course: HAD5779H Evidence Synthesis for Health Services, Systems and Policy Research. Institute of Health Policy, Management and Evaluation, University of Toronto, Toronto, Ontario, Canada. Course

	Directors: Lusine Abrahamyan, Petros Pechlivangoglou.
Sep 2018 – Dec 2018	**Co-Course Director**, Graduate (MHI) Course: *MHI2011H Performance Measurement in Health Care: Theory and Application*. Institute of Health Policy, Management and Evaluation, University of Toronto, Toronto, Ontario, Canada. Co-Course Director: Susan Brien.
Jan 2018 – Apr 2018	**Co-Course Director**, Graduate (MSc/PhD) Course: *HAD5779H Evidence Synthesis for Health Services, Systems and Policy Research*. Institute of Health Policy, Management and Evaluation, University of Toronto, Toronto, Ontario, Canada. Co-Course Directors: Lusine Abrahamyan, Petros Pechlivangoglou.
Sep 2017 – Dec 2017	**Co-Course Director**, Graduate (MHI) Course: *MHI2011H Performance Measurement in Health Care: Theory and Application*. Institute of Health Policy, Management and Evaluation, University of Toronto, Toronto, Ontario, Canada. Co-Course Director: Susan Brien.
June 2017 – Nov 2017	**Course Director**, Graduate (MSc/PhD) Course: *HAD7001* Case Study Research for Health Services, Systems and Policy. Institute of Health Policy, Management and Evaluation, University of Toronto, Toronto, Ontario, Canada.
Jan 2017 – Apr 2017	**Course Director**, Graduate (MSc/PhD) Course: *HAD7001H-S3 Evidence Review: Approaches and Methods for Health Policy and Systems*. Institute of Health Policy, Management and Evaluation, University of Toronto, Toronto, Ontario, Canada.
Sep 2016 – Dec 2016	**Course Director**, Graduate (MHI) Course: *MHI2011H Performance Measurement in Health Care: Theory and Application*. Institute of Health Policy, Management and Evaluation, University of Toronto, Toronto, Ontario, Canada
20 Oct 2016	**Guest Panel Member.** Graduate (MSc/PhD) Course: *HAD 5010: Canada's Health System and Health Policy: Institutions*, Institute of Health Policy, Management and Evaluation, University of Toronto, Toronto, Ontario, Canada. Course Director: Dr. K Kuluski and Dr. AP Williams.
Sep 2015 – Dec 2015	**Course Director**, Graduate (MSc/PhD) Course: *HAD7001H-F2 Evidence Review: Approaches and Methods for Health Policy and Systems*. Institute of Health Policy, Management and Evaluation, University of Toronto, Toronto, Ontario, Canada.
Apr 2015 – Jun 2015	**Course Director**, Graduate (MSc/PhD) Course: *HAD7001H-F2 Evidence Review: Approaches and Methods for Health Policy and Systems*. Institute of Health Policy, Management and Evaluation, University of Toronto, Toronto, Ontario, Canada. (course postponed to Fall 2015 after 3 sessions)
29 Oct 2015	**Guest Panel Member.** Graduate (MSc/PhD) Course: *HAD 5010: Canada's Health System and Health Policy: Institutions*, Institute of Health Policy, Management and Evaluation, University of Toronto, Toronto, Ontario, Canada. Course Director: Dr. K Kuluski and Dr. AP Williams.
16 Oct 2014	**Guest Panel Member.** Graduate (MSc/PhD) Course: *HAD 5010: Canada's Health System and Health Policy: Institutions*, Institute of Health Policy, Management and Evaluation, University of Toronto, Toronto, Ontario, Canada. Course Director: Dr. AP Williams.
Oct 2012	**Guest Lecturer**. Graduate Course: *Performance and Accountability in One Health System*. Laboratorio Management e Sanita, Scuola Superiore Sant'Anna, Pisa, Tuscany, Italy. Course Director: Dr A. Brown.
Nov 2011	**Seminar Leader**. Graduate (MSc/PhD) Course: CHL 5409H *Cancer Epidemiology: Seminar on Cancer Services Research*. Dalla Lana School of Public Health, University of Toronto, Toronto, Ontario, Canada. Course Directors: Dr A. Chiarelli and Dr J. Knight.
Feb 2011	**Seminar Leader**. Graduate (MSc/PhD) Course: *HSR1001H: Introduction to Qualitative Methods for Health Services & Policy Research*. Department of Health Policy, Management and Evaluation, University of Toronto, Toronto, Ontario, Canada. Course Directors: Dr. J. Sale and Dr. F. Webster.
Jan 2010 – Apr 2010	**Seminar Leader**. Graduate (MSc/PhD) Course: *HSR1001H: Introduction to Qualitative Methods for Health Services & Policy Research.* Department of Health Policy, Management and Evaluation, University of Toronto, Toronto, Ontario Canada. Course Directors: Dr. J. Sale and Dr. F. Webster.
Jan 2010	**Guest Lecturer.** Graduate (MSc/PhD) Course: *Health Care Ethics*, Joint Centre for Bioethics. Department of Health Policy, Management and Evaluation, University of Toronto, Toronto, Ontario,

	Canada. Course Director: Dr. F. Miller.
Nov 2009	**Seminar Leader.** Graduate (MSc/PhD) Course: CHL 5409H *Cancer Epidemiology: Seminar on Cancer Services Research*. Dalla Lana School of Public Health, University of Toronto, Toronto, Ontario, Canada. Course Directors: Dr A. Chiarelli and Dr E. Holowaty.
Sept 2009 – Dec 2009	**Faculty Tutor**, Graduate (MSc/PhD) Course: *Canada's Health Care System and Health Policy I.* Department of Health Policy, Management and Evaluation, University of Toronto, Toronto, Ontario Canada. Course Director: Dr. R. Deber.
May 2009 – June 2009	**Guest Instructor**, Graduate (MSc/PhD) Course: *Tools for implementation of Best Evidence.* Department of Health Policy, Management and Evaluation, University of Toronto, Toronto, Ontario Canada. Course Director: Dr. A. Gagliardi.
08 Mar 2007	**Guest Lecturer**. *How do we measure cancer services integration?* Graduate (MSc/PhD) Course: *Integrated Health Systems*, School of Health Policy and Management, York University, Toronto, Ontario, Canada. Course Director: Dr M Wiktorowicz.
Mar 2007	**Seminar Co-Lead**, Graduate (MSc/PhD) Seminar: *Ontario Training Program in Health Services and Policy Research Seminar: Career Planning*. Department of Health Policy, Management and Evaluation, University of Toronto, Toronto, Ontario Canada. Course Director: Rhonda Cockerill.
31 Oct 2005	**Guest Lecturer**. *Clinical Accountability and Value-Based Purchasing: Linking Funding to Quality of Care.* Graduate (MSc/PhD) Course: *Canadian Cancer System and Public Policy*, Queen's University, Kingston, Ontario, Canada. Course Director: Hugh Walker.
Apr 2003 – July 2003	**Teaching Assistant**, Graduate (MSc) Course: *Health Services Management Integrating Unit.* Department of Public Health and Policy, London School of Hygiene and Tropical Medicine, London, England. Course Director: Michael Traynor.
Jan 2002 – Apr 2002	**Teaching Assistant**, Undergraduate Course: *Research Methods*. Michener Institute of Applied Health Sciences and the University of Toronto, Toronto, Ontario, Canada. Course Director: Dr. G. Tolomiczenko.

RESEARCH SUPERVISION

1. Supervised Students

Jan 2020 – ongoing	**Thesis Committee Member**, Whiwon Lee, PhD Candidate, Institute of Health Policy, Management and Evaluation, University of Toronto. Supervisor: Robin Hayeems.
Sept 2018 – ongoing	**Primary Supervisor**, Brandon Maser, PhD Candidate, Institute of Health Policy, Management and Evaluation, University of Toronto.
Sept 2018 – ongoing	**Thesis Committee Member**, Jane Yao, PhD Candidate, Institute of Health Policy, Management and Evaluation, University of Toronto. Supervisor: Fiona Miller.
Jan 2018 – ongoing	**Thesis Committee Member**, Sobia Khan, PhD Candidate, Institute of Health Policy, Management and Evaluation, University of Toronto. Supervisor: Whitney Berta.
Jan 2018 – ongoing	**Thesis Committee Member**, Gillian Elliott, PhD Candidate, Institute of Health Policy, Management and Evaluation, University of Toronto. Supervisor: Whitney Berta.
Sept 2017 – ongoing	**Primary Supervisor**, Caitlan Gillan, PhD Candidate, Institute of Health Policy, Management and Evaluation, University of Toronto.
Sept 2017 – ongoing	**Primary Supervisor**, Crystal Milligan, PhD Candidate, Institute of Health Policy, Management and Evaluation, University of Toronto.
Nov 2017 – Oct 2020	**Thesis Committee Member**, Ashley Vandermorris, MSc Candidate, Institute of Health Policy, Management and Evaluation, University of Toronto. Supervisor: Whitney Berta.
Mar 2017 – Sept 2019	**Thesis Committee Member**, Renee Sloos, PhD Candidate, Institute of Health Policy, Management

	and Evaluation, University of Toronto. Supervisor: Anna Gagliardi, Thesis Committee Member: Whitney Berta.
Sept 2014 – Aug 2018	**Postdoctoral Mentor**, Joshua Tobias, Postdoctoral Fellow, Cancer Care Ontario. *Improving cancer screening among First Nations and Metis*. Postdoctoral fellowship funded by CIHR-PHSI.
May 2016 – Aug 2016	**Internship Faculty Advisor**, Abigail Veerasingham, Master of Public Policy degree candidate, School of Public Policy and Governance, University of Toronto.
Sept 2010 – ongoing	**Primary Supervisor**, Gunita Mitera, PhD Candidate, Department of Health Policy, Management and Evaluation, University of Toronto, Year 2. *Investigating Quality Improvement in Radiation Oncology*. Awards: CIHR-Terry Fox Foundation EIRR21 Research Training Program Award. Expected completion 2021. Gunita initially started as a full-time student, but then took on a full-time job and took two maternity leaves which has delayed completion of her PhD.
Sept 2009 – Aug 2016	**Primary Supervisor**, Peggy Tso. *Development of a decision aid for evidence-informed public health policy: a mixed methods study*. Awards: CIHR Master's Award. Student was on medical and maternity leaves for extended period of study. MSc completed in 2016.
Sept 2010 – Apr 2015	**Primary Supervisor**, Jessica Bytautas, Current Position: PhD candidate, University of Helsinki. *Promises and paradoxes: A qualitative study of the relationship between accountability, performance, and quality in Ontario's cancer services system*. MSc completed in 2015.
Sept 2008 – Aug 2010	**Thesis Committee Member**, Sarah Costa, Current Position: Senior Consultant – Policy Development and Implementation, Student's Current Institution: Ministry of Health and Long-Term Care, *Assessing Quality of Life for Colorectal Cancer Patients in Ontario Using a Mixed Methodology Approach*. MSc completed 2010.
Jan 2008 – Dec 2009	**Postdoctoral Mentor**, Roger Chafe, Current Position: Assistant Professor, Department of Pediatrics, Memorial University of Newfoundland. *Examining factors influencing the adoption of new cancer drugs within different institutional contexts across Canada*. Co-mentors: Peter Coyte, Terrence Sullivan. Postdoctoral fellowship completed 2009.
Sept 2007 – Oct 2009	**Primary Supervisor**, Kate Bak, Current Position: Research Associate, Cancer Care Ontario, *Diffusion of Technological Innovations: The Implementation of Intensity Modulated Radiation Therapy (IMRT) in Ontario*. MSc completed 2009.
July 2007 – July 2010	**Thesis Committee Member**, Helen Burchett, Current Position: Research Fellow, London School of Health and Tropical Medicine, *Perceptions of the Usefulness of Public Health Research for Policy in Ghana*. PhD completed 2010.

2. Examination of Student Dissertations

05 June 2020	**External Thesis Examiner**, Joshua Hamzeh, PhD Candidate. Department of Family Medicine, McGill University. *Contextualized Assessment of Organizational Participatory Research Partnerships in Health: A Mixed Methods Validation Study.*
22 Nov 2019	**Chair, Thesis Examination Committee**, Jennifer Shuldiner, PhD Candidate. Dalla Lana School of Public Health, University of Toronto. *A mixed-methods study of genetic information decisions and psychological implications of cancer panel testing in women at risk for ovarian cancer.*
03 Dec 2018	**Internal Thesis Examiner,** Kaileah McKellar, PhD Candidate. Institute of Health Policy, Management and Evaluation, University of Toronto. *Evaluating Extra-Organizational Communities of Practice.*
03 June 2016	**Chair, PhD Thesis Proposal Defence**, Eva Baginska, PhD Candidate. Institute of Health Policy, Management and Evaluation, University of Toronto. *Examining factors influencing successful implementation of insulin pump technologies among Type 1 diabetes patients in Ontario.*
07 April 2016	**External Thesis Examiner,** Elizabeth Alvarez, PhD Candidate, School of Graduate Studies, McMaster University. *Developing and evaluating the use of a workbook for contextualizing health systems guidance.*
23 July 2015	**External Thesis Examiner,** Denis Ako-Arrey, PhD Candidate, School of Graduate Studies, McMaster

	University. *Designing a knowledge translation tool for the development, appraisal and reporting of health systems guidance.*
25 Nov 2014	**Internal Thesis Examiner**, Karen Born, PhD Candidate, Institute of Health Policy, Management and Evaluation, University of Toronto.
22 Sep 2014	**External Thesis Examiner**, Daniel Patino, PhD Candidate, School of Graduate Studies, McMaster University. *Supporting the use of research evidence in the Colombian health system.*
11 Sep 2014	**Chair, Thesis Examination Committee**, Andrew Lustig, MSc Candidate. Institute of Health Policy, Management and Evaluation, University of Toronto.
21 Feb 2013	**External Thesis Examiner**, Robin Urquhart, PhD Candidate, Faculty of Graduate Studies, Dalhousie University. *Multi-level factors influence the implementation and use of complex innovations in cancer care: a multiple case study of synoptic reporting in Nova Scotia.*
15 Dec 2011	**Thesis Examiner**, Cheryl Ku, MSc Candidate, Department of Health Policy, Management and Evaluation, *Perceptions of Emergency Department Team Members on the Introduction of Change Through the Implementation of Clinical Decision Units.*
01 Dec 2010	**Thesis Examiner**, Tina Saryeddine, PhD Candidate, Department of Health Policy, Management and Evaluation, *Moving Patients across organizations: exploring the antecedents of effective and efficient patient referral processes.*
27 Sept 2010	**Thesis Proposal Examiner**, Karen Born, PhD Candidate, Department of Health Policy, Management and Evaluation, *The organizational context of care transition interventions: case studies from Ontario.*
11 Aug 2010	**Thesis Examiner**, Laura Quigley, MSc Candidate, Department of Health Policy, Management and Evaluation, *Care Transitions from the Patient Perspective: a focus on the communication of discharge instructions.*
16 July 2010	**Thesis Examiner**, Stephanie Soo, MSc Candidate, Department of Health Policy, Management and Evaluation, *The Role of Champions in the Implementation of Patient Safety Practice Change.*
22 May 2009	**Thesis Examiner**, Jennifer Donnan, MSc Candidate, Department of Health Policy, Management and Evaluation, *[Health Technology Assessment of Thiopurine Methyltransferase Genetic Testing for Guiding 6-Mercaptopurine Doses in Pediatric Patients with Acute Lymphoblastic Leukemia.*

Manitoba Chiropractors Association

ITEM 4.1.39

Manitoba Chiropractors Association Board Swiftly Asks for & Accepts Resignation of President, Effective Monday

Attendance at Anti-Mask Rally Runs Counter to Strong Commitment of Profession to Public Health Orders during Global Pandemic

April 28, 2021 – The Board of Directors of the Manitoba Chiropractors Association (MCA) took swift action Monday morning in requesting and accepting a letter of resignation from now former President and Board member, Dr. Steven Gall, D.C. following his decision to attend an anti-mask rally this past weekend at The Forks in Winnipeg.

"As a profession, the MCA does not condone or tolerate behaviour which stands in clear contravention of public health orders," said now Acting President, Dr. Gerald Chartier, D.C. "Throughout the pandemic, and as part of Shared Health's Essential Services Network, we have stood united with the provincial government in its fight to protect Manitobans. The MCA will continue to do so by mandating strict adherence by our members to all orders."

The MCA is both a self-regulating professional body and a member association that governs doctors of chiropractic in Manitoba, under the legislative and regulatory authority of The Chiropractic Act.

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989 Portage Avenue | Winnipeg, MB R3G 0R7 | Phone: (204) 942-3000 | Fax: (204) 942-3010 | Toll Free: 1 (855) 430-0383 | Email: info@mbchiro.org

WWW.MANITOBACHIROPRACTORS.CA

From: President
Sent: Monday, June 7, 2021 10:35 AM
To: Dr. Colin Goudreau
Subject: RE: News from BC

Thanks Colin,
I attended the CCBC EGM over the weekend on behalf of the CCO
Rob

Robert MacKay,
President

College of Chiropractors of Ontario
59 Hayden Street, Suite 800
Toronto, ON M4Y 0E7
Tel: (416) 922-6355
Fax: (416) 925-9610
E-mail: president@cco.on.ca
Web Site: www.cco.on.ca

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From: Dr. Colin Goudreau <goudreaudc@gmail.com>
Sent: June 6, 2021 5:43 PM
To: President <President@cco.on.ca>
Subject: News from BC

https://www.cbc.ca/news/canada/british-columbia/bc-chiropractors-extraordinary-general-meeting-1.6055112

If this could be put in the next council package, that would be appreciated. Vote for trying to overturn the radiography changes for the chiropractors in BC did not pass and the membership upheld the Colleges decision to move away from routine based imaging, as recommended by most evidence-based guidelines.

Thanks,

British Columbia

B.C. chiropractors divided over misleading claims, routine use of X-rays

Narrow majority votes to back recent policy changes during extraordinary general meeting

Bethany Lindsay · CBC News · Posted: Jun 06, 2021 12:53 PM PT | Last Updated: June 6

The College of Chiropractors of B.C. held an extraordinary general meeting on Saturday to consider resolutions addressing the future of the profession. (Shutterstock/Veres Production)

comments

If the results of an unusual meeting this weekend are any indication, B.C.'s chiropractors are deeply divided about the future of their profession, disagreeing on everything from false advertising to the use of routine X-rays.

Hundreds of chiropractors who attended an extraordinary general meeting of the College of Chiropractors of B.C. on Saturday were split nearly down the middle on a series of non-binding resolutions addressing actions the college has taken in recent years.

By the narrowest of margins, with at most 54 per cent support, the members voted in favour of the college's moves to limit the use of diagnostic X-rays and ban claims that aren't supported by scientific evidence.

The question that remains is who represents the bulk of the profession in B.C. — chiropractors advocating for what they describe as evidence-based practice targeting the musculoskeletal system, or "vitalists" who argue that chiropractic treatment can help with everything from immunity to brain function.

Those who spoke in favour of the college's policies described the vitalistic chiropractors fighting to overturn them as a "vocal minority" in B.C.

"It's a deliberate attempt to take over the college by a small group of chiropractors with no respect or knowledge of regulation ... funded by organizations out of the province and out of the country," Victoria chiropractor Clark Konczak told the virtual meeting.

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

But the vitalistic faction gained close to half the vote on every one of the six resolutions discussed during the meeting.

"We are the vocal majority," Joshua Korten of Kelowna contended.

'The smoothie episode'

Konczak painted Saturday's meeting as something of a crossroads for the profession, warning chiropractors risk losing the right to self-regulation if they don't follow the science.

"We have to work hard to come across as evidence-based," he said. "We have to position ourselves to look in a responsible and patient-centred way."

At issue was a series of policies the college introduced in the wake of what Konczak called "the smoothie episode."

He was referring to a video posted on Facebook in 2017 by then-vice chair of the college's board, Avtar Jassal, in which he falsely suggested fruit smoothies are better than vaccines at preventing the flu.

In November 2017, Vancouver chiropractor Avtar Jassal shared a video in which he suggested smoothies are more effective than vaccination at preventing the flu. (Facebook)

That statement was in direct violation of college policy, which forbids chiropractors from making recommendations about vaccination because they are not trained in infectious diseases. But no action was taken when a member of the public complained to the college, and Jassal's video wasn't removed from Facebook until CBC News pointed it out to the Health Ministry months later.

In response, government staff began looking into "what options we have when a college is not meeting its legal obligation," according to emails obtained by CBC News through a Freedom of Information request.

Not long after, the college began cracking down on misleading advertising by chiropractors, introducing a policy banning any claims of treating conditions like Alzheimer's disease, cancer and autism because of a lack of scientific evidence.

- **Investigation launched over misleading claims from board member at B.C. chiropractors' college**

The college has also developed a partnership with researchers at Ontario Tech University, who have performed reviews of scientific evidence on a number of issues.

That includes a review on the use of X-rays as a diagnostic tool. Earlier this year, the college introduced amendments that bar chiropractors from performing routine and repeat X-rays, saying radiography is only scientifically supported when there are red flags that something is seriously wrong.

'We risk tarnishing our reputation'

The policy change on X-rays was the flashpoint in the long-simmering tension within the profession.

A group of chiropractors have filed a petition in B.C. Supreme Court, alleging the college is preventing them from providing "safe, ethical, and effective care to their patients." Their legal action has backing from national and international vitalistic organizations.

During Saturday's meeting, a group of chiropractors argued unsuccessfully for the new X-ray policy to be tossed.

Some suggested that chiropractors who don't perform X-rays as a matter of routine are actually harming their patients.

Kelsey Bjola of Victoria alleged she has seen patients who were hurt by chiropractors adjusting parts of their spine that X-rays later revealed to be problematic.

But Victoria chiropractor Daniel Skinner described the routine use of X-ray for diagnosis as "archaic," and said by advocating for it, "We risk tarnishing our reputation amongst our colleagues."

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)

There were also suggestions of bias and conflict of interest among members of the college's board, but a motion to launch a full examination was voted down.

Kelowna's Mark Foullong alleged that legitimate complaints filed against board members have been "intercepted" by staff rather than investigated.

"Are they above the law?" he asked.

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

Kristine Salmon, a Victoria chiropractor who sits on the college's inquiry committee, said those accusing the board of bias and conflict of interest have presented no evidence.

"I feel like we're asking to see Obama's birth certificate here," Salmon said, referring to racist right-wing efforts to discredit the former U.S. president.

"Tactics like this and misleading advertising are the way we're going to lose the respect of the public."

- **B.C. chiropractor who advertised unproven 'brain balancing' treatment fined $200**

College registrar Michelle Da Roza wasn't able to provide a final number for how many chiropractors participated in Saturday's meeting, but quorum was called with about 545 in attendance, and she said "many more" joined after that. There are 1,357 fully licensed, practising chiropractors in B.C.

Another extraordinary general meeting has been called for July 20 to vote on resolutions calling for the removal of four college board members. College bylaws state these meetings must be held when requested by at least 15 per cent of registrants.

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Visitez Radio-Canada.ca

FOUR DIRECTIONS
CHIROPRACTIC COLLEGE

May 5, 2021

Dear Rob,

On behalf of the board of Four Directions Chiropractic College I would like to congratulate you on becoming the first public appointed member to become President of the College of Chiropractors of Ontario.

Given your experience and service to the CCO you are certainly well qualified to lead council as it continues it's excellent work of regulating the chiropractic profession in the public interest. Your appointment to the presidency by council speaks to the confidence that all council members have in you. Equally as important is that your election points to the value that all council members place upon our public appointed members.

The board of Four Directions looks forward to working with you over the course of your term.

Sincerely,

Dr. Peter Amlinger, DC

Rose Bustria

Subject: FW: FDCC

566

From: Jo-Ann Willson <jpwillson@cco.on.ca>
Sent: Wednesday, May 5, 2021 12:29 PM
To: Rose Bustria <RBustria@cco.on.ca>
Subject: FW: FDCC

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
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

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From: Peter Amlinger <dr.peteramlinger@icloud.com>
Sent: Wednesday, May 5, 2021 12:27 PM
To: Rob MacKay <mackayrob@tbaytel.net>; Jo-Ann Willson <jpwillson@cco.on.ca>
Subject: FDCC

Dr PJ Amlinger, DC
Chiropractor

ITEM 4.1.43

594

Canadian Chiropractic Association researching member attitudes about diversity, equity and inclusion

Association chiropratique canadienne | Canadian Chiropractic Association

NEWS PROVIDED BY
Canadian Chiropractic Association →
May 12, 2021, 09:00 ET

Ground-breaking survey will help improve access to healthcare for all Canadians

TORONTO, May 12, 2021 /CNW/ - Today the Canadian Chiropractic Association (CCA) launched a research study to gather and understand members' attitudes, knowledge and awareness of diversity, equity and inclusion (DEI) and their perspectives of DEI in their profession and within their own practices.

"Our goal is to improve access to safe, non-invasive treatments that can help Canadians live healthy, active lives, especially in underserved communities," says Alison Dantas, CEO of the CCA. "We will use the insights to develop evidence-based strategies to address inequality and discrimination."

The CCA recognizes that systemic racism and discrimination exist for Black, Indigenous, and People of Colour (BIPOC), members of the LGBTQ2S+ community, persons from various religious backgrounds, persons with disabilities, and women.

"We believe that embracing diversity, equity and inclusion is the best way to address these inequalities," said Alison Dantas. "Our goal is to create an inclusive and equitable environment where patients, chiropractors, board directors, CCA staff and members of the broader public are valued for their differences."

This research project is part of the CCA's DEI strategy, launched in October 2020, which includes a national DEI task force and free DEI training for members.

"Addressing healthcare inequities starts with awareness," says DEI expert Rima Dib, director of curriculum and training at Harmony@Work. Rima has led the CCA's DEI training for members, board members and staff. "Understanding what practitioners think about DEI is an important step towards a more inclusive society."

595

Researchers from the Centre for Disability Prevention and Rehabilitation at CMCC, Ontario Tech University and McMaster University are running the survey and analyzing the data.

As part of its DEI strategy, the CCA has committed to the following achievements:

- Increasing access to chiropractic care by ensuring underrepresented groups value and have access to chiropractic as a way to live healthy, active lives;
- Empowering CCA staff, board directors, and members to confront and dismantle systemic racism and discrimination;
- Sparking innovation, excellence and integrity in its work by increasing diversity, equity and inclusion in the profession's leadership roles;
- Fostering open and caring environments where dialogue about diversity, equity and inclusion can take place; and
- Valuing and promoting the competencies of cultural agility at all levels of the CCA, with stakeholders and with the profession.

About the Canadian Chiropractic Association

The Canadian Chiropractic Association represents Doctors of Chiropractic across Canada who treat and manage musculoskeletal conditions that impact the health of millions of Canadians. Every year, at least 4.7 million Canadians rely on chiropractors to help them manage the serious burden of musculoskeletal pain and disease. As one of Canada's largest primary contact health care professions, chiropractors provide evidence-based, non-invasive, drug-free manual therapies.

SOURCE Canadian Chiropractic Association

For further information: Arden Bagni-Fast, Manager, Marketing & Communications, Canadian Chiropractic Association, 416-585-7902 X 237, abagnifast@chiropractic.ca

Related Links

https://www.chiropractic.ca/

596

From: Jo-Ann Willson
Sent: Thursday, May 13, 2021 5:27 PM
To: Rose Bustria
Subject: Fwd: Notice of upcoming CCRF Member Meeting
Attachments: image001.jpg; NOTICE OF MEETING OF MEMBER - June 2021G.pdf

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

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Begin forwarded message:

> **From:** Lisa Denvir <ldenvir@chiroresearch.ca>
> **Date:** May 13, 2021 at 4:34:48 PM EDT
> **To:** Jo-Ann Willson <jpwillson@cco.on.ca>, drmizel@stcatharineschiropractic.com
> **Subject: Notice of upcoming CCRF Member Meeting**
>
> Dear Ms. Willson and Dr. Mizel
>
> As valued CCRF stakeholders, we're pleased to offer you guest invitations to our upcoming Annual Member Meeting on June 10th.
>
> CCRF's volunteer board and staff are proud of what has been accomplished over the past twelve months. We're looking forward to providing an update to our voting Member, the CCA, and well as our numerous supporters across Canada. As our guests, you will have an opportunity to ask questions after the formal business of the meeting has been concluded.
>
> **Please RSVP before May 31** so that the appropriate links can be provided.
>
> If you have any questions or comments, please feel free to contact me at the co-ordinates below.

Be well and we hope to see you in June.

598

Lisa

Lisa Denvir (She/her)

Marketing & Communications Specialist
Spécialiste du marketing et des communications

905-375-7632
184 Front St. East, Suite 200 Toronto, ON M5A 4N3
CANADIANCHIROPRACTICRESEARCHFOUNDATION.CA
FONDATIONCANADIENNEPOURLARECHERCHEENCHIROPRACTIQUE.CA

The CCRF acknowledges the enduring and vibrant presence, culture, history and inherent rights of First Nations people, Métis and Inuit across Canada on whose traditional territories the CCRF has its head office in Toronto.

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Fondation canadienne pour la recherche en chiropratique

Canadian Chiropractic Research Foundation

NOTICE OF MEETING OF MEMBER

TAKE NOTICE that an annual meeting for the member of the **CANADIAN CHIROPRACTIC RESEARCH FOUNDATION / LA FONDATION CANADIENNE POUR LA RECHERCHE EN CHIROPRATIQUE** (the "Corporation") will be held via Zoom Teleconference on the 10th day of June, 2021, at the hour of 2:30 pm EST for the following purposes:

(a) to receive the financial statements of the Corporation for the year ended December 31, 2020 together with the report of the auditors thereon;
(b) to appoint the auditor and authorize the directors to fix the remuneration of such auditor; and
(c) to transact such further and other business as may properly come before the meeting or any adjournment or adjournments thereof.

Please RSVP to Lisa Denvir, CCRF Project Manager (ldenvir@chiroresearch.ca or 905-375-7632) on or before May 31st, 2021, so links can be provided.

DATED the 14th day of May 2021.

CANADIAN CHIROPRACTIC RESEARCH FOUNDATION

Per:

Dr. C. Kulak
CCRF Chair

T (416) 585-7902 **TF** 1(877) 222-9303
184 Front St. East, Suite 200 Toronto, ON M5A 4N3
info@chiroresearch.ca
CanadianChiropracticResearchFoundation.ca

Report of the Executive Director

Welcome to the 2021 CCRF Annual Member Meeting. We appreciate your continued interest and engagement as we strive to increase the quantity, quality and impact of chiropractic research in Canada.

Since joining CCRF three years ago, it has been my pleasure to work with our board and supporters to augment foundation performance in many areas; from governance and operations, to granting and finances. In 2020 we made progress in each category, which we are pleased to share with you today.

Granting

In 2019 CCRF launched a volunteer-led national Research Committee and rapidly approved four (4) high-value projects. In 2020, we confirmed a further twelve (12) grants ($370,000 awarded) while instituting a twice-yearly pattern for RFP calls. Concurrently, standardized systems were set up to track grant allocations, monitor performance and provide researcher support during COVID-19.

Guidance: Granting processes and administration are now a modest strength of our organization. As a result, CCRF is ready to address continuous improvement items over the next two-year cycle; including advisory board development, partial/matching grant criteria and international project alignment.

Revenue

Total 2020 proceeds exceeded $800,000 thanks to a generous three-year CCA commitment and continued support from various provincial associations including Alberta, Saskatchewan, Ontario and New Brunswick. From the standpoint of granting capacity, the National Research Fund held total assets of over $1,300,000 at year end. While these results are encouraging in a year when the pandemic disrupted many balance sheets, it is equally important to note CCRF must work proactively with all associations to secure more consistent revenue inflows in the future.

Guidance: Financial performance was satisfactory this fiscal year. CCRF forecasts solid growth over the next two years driven by institutional engagement (within and outside the profession) and the launch of new individual donor giving campaigns.

Partnerships

It is a CCRF priority to increase collaboration with other respected organizations to maximize research reach while simultaneously improving net revenues. With the recent establishment of our Partnership Committee, we are pleased to report cooperative projects have been initiated with our colleagues at CMCC and UQTR. Outreach continues and we will announce additional agreements throughout 2021.

Guidance: Cooperative initiatives will increase our return on investment and build cross-organizational trust. With an effective structure now in place, CCRF is poised to make progress, which will include establishing key relationships with external funding bodies such as community foundations, private enterprises and complementary not-for-profits.

Governance
Consistent investments have helped support a multifaceted structure within our small foundation. For example, sound document and process management has positioned CCRF to take on more advanced aspirational governance goals in areas such as DEI, skills matrix administration, by-law updates, volunteer training and board/committee recruitment in new communities.

Guidance: From committee charters to volunteer postings, governance items have received appropriate time and attention. Combined with a reinvigorated leadership commitment, these actions will assist with capacity building. Such work will also include our valued associates at CCGI, as we mutually pursue enhancements to our fiduciary standards.

Planning
Refreshed templates and a clear annual planning process have upgraded CCRF administration. The outcome is an improved dashboard which has assisted with board and committee communications. In 2021, CCRF will maintain 16 core reporting objectives in four categories (Growth, Efficiency, Impact and Foresight) and use S.M.A.R.T. metrics to support both expansion and risk mitigation.

Guidance: An essential aspect of CCRF planning is the deployment of a yearly stakeholder "Choice Survey". The results are then used in our Q4 strategy meeting to assist with dashboard development. We would like to thank our Member and provincial associations for completing this work historically — and we look forward to hearing your views again this fall!

Operations
Our foundation continues to improve operational efficiency and effectiveness. Recent advancements include a comprehensive redesign of the CCRF website and the development of a biannual communications plan with a focus on new promotional channels and impact measurement. We have also made commitments in areas such as legacy giving, which will be introduced this September in coordination with outbound promotion from the *Canadian Association of Gift Planners*.

Guidance: It has been a year of encouraging developments vis-à-vis infrastructure, which will translate into improved project and program execution. These changes are also linked to sustainability, as sound systems are essential to support future change management and growth based on scale.

Volunteer Leadership
Thanks to the dedication of our board and committee members, CCRF has continued to provide high value to the professional chiropractic community, patients and policy makers. At this time, I would like to express my appreciation to Dr. Kate MacAdam and thank her for many years of exceptional service to our board. And to our current leadership, we hope your colleagues will join me in acknowledging your service and the personal time you have devoted to advance the mission of the CCRF.

Board: Dr. Chad Kulak (Chair), Mr. Philippe Garneau (Chair, Fundraising), Dr. Richard McIlmoyle (Chair, Research), Dr. Patrick Welsh, Dr. Sasha Hamid, Dr. Bryan Wolfe, Dr. Nadine Ellul, Dr. Vince Adams (CCA Liaison)

Committees: Dr. Shawn Thistle, Dr. Aaron Puhl, Dr. Kate Hood, Dr. Peter Shipka, Dr. Lisa McCabe, Dr. Julie Yaworski, Ms. Ronda Parkes

Risk

The impact of COVID-19 has made a substantial impact on the economic, emotional and physical health of many Canadians. As a result, foundations such as ours are under pressure as shifting stakeholder priorities and financial constraints are a factor. To address these challenges, CCRF's approach is to embrace reality-based optimism, centred around confidence that our community will successfully adapt to new conditions. Such a view also encourages us to think laterally, as shifts in our environment could create new research opportunities in areas ranging from utilization to multidisciplinary studies.

Summary

If you believe in the power of chiropractic research, we invite you to support the CCRF. It is only through your ideas, networking, information sharing and financial support that our foundation is able to elevate the quality-of-life of those burdened with NMSK pain and disability.

Sincerely,

Robert Harris

Robert Harris
Executive Director, CCRF

603

FCLB Virtual Meeting
May 1, 2021

ITEM 4.1.45

All times shown in Mountain Time

9:30 - 10:00 AM DISTRICT V CAUCUS 11:30

District V Delegates are invited to meet via Zoom to elect the District V Director and Alternate Director

10:15 - 10:45 AM DISTRICT II CAUCUS 12:15

District II Delegates are invited to meet via Zoom to elect the District II Director and Alternate Director

11:00 - 11:30 AM DISTRICT I CAUCUS 1pm

District I Delegates are invited to meet via Zoom to elect the District I Director and Alternate Director

11:45 AM CHECK - IN 1:45 pm

Delegate check in for the FCLB Annual Business Meeting

12:00 - 2:30 PM BUSINESS MEETING 2pm

Karlos Boghosian, D.C., FCLB President, Meeting Chairman

- Seating of Delegates
- Financial Report
- Resolutions & Bylaws Report
- Elections
- Announcements
- New Business
- Installation of New Board

ELECTIONS FOR:

PRESIDENT
VICE PRESIDENT
TREASURER
ADMINISTRATIVE FELLOW DIRECTOR
NOMINATING COMMITTEE

Made with **Visme**

604

5401 W. 10th Street, Suite 101 • Greeley, CO 80634 • 970.356.3500 • FAX: 970.356.3599

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FCLB's 94th Annual Business Meeting

2021 virtual event

with thanks to our partner: NBCE

SATURDAY, MAY 1, 2021

All times shown in Mountain Time

DISTRICTS I, II & V- MEMBER CAUCUS

9:30 - 10:00 AM	**District V Caucus** - District V Delegates and Alternates will meet via Zoom to elect the District V Director and Alternate Director.
10:15 - 10:45 AM	**District II Caucus** - District II Delegates and Alternates will meet via Zoom to elect the District II Director and Alternate Director.
11:00 - 11:30 AM	**District I Caucus** - District I Delegates and Alternates will meet via Zoom to elect the District I Director and Alternate Director.

VIRTUAL OFFERING

11:45 AM	**CHECK IN** for Delegates and Alternates
12:00 - 2:30 PM	**FCLB ANNUAL BUSINESS MEETING** Karlos Boghosian, D.C., (CT), FCLB President, Meeting Chairman • Seating of the Delegates • Financial Report • Resolutions & Bylaws Report • Elections: President, Vice President, Treasurer, Administrative Fellow Director and Nominating Committee • Announcements • New Business • Installation of the New FCLB Board of Directors

Plan for the 2022 Annual Conference in
Denver, Colorado - May 4th - 8th, 2022

606

94th Annual Congress

Agenda

Annual Meeting of the Delegate Assembly

Chair: Karlos Boghosian, D.C. – FCLB President

Saturday, May 1, 2021
12:00 PM Mountain Time

1. Call to Order
2. Credentials Committee Report / Seating of the Delegates
3. Roll Call: Establishment of Quorum
4. Adoption of Business Meeting Rules and Protocol
5. Approval of Agenda
6. Dedication to Service
7. Announcement of the Approval of the 2019 Minutes by Committee: Mission Bay, California
8. Introduction of Conference Supporters
9. President's Report
10. Business Reports
    - Financial Report
    - Executive Director's Report
    - Legal Report
11. Resolutions and Bylaws Committee Report

12. 2021 Nominating Committee Report: Elections
    - President, Vice President, Treasurer and Administrative Fellow Director
    - Nominating Committee Members
13. Announcement of District Elections
14. Passing of the Gavel
15. Installation Ceremony
16. Adjournment

RESOLUTION 1-21 Submitted for consideration by Dr. Mark Bronson (TX)

Draft as edited by Dr. Mark Bronson on 4/19/2021 at 5:00 PM Central, following a review of comments.

Chiropractic Includes the Nervous System

Whereas, the FCLB's mission is to promote excellence in chiropractic regulation with a vision of safe, ethical practice of chiropractic leading to enhanced public protection and that public protection is enhanced through enforcement of rules and regulations which are based on accurate information;

Whereas, the FCLB serves its member state regulatory boards not only as a resource for relevant news and accurate information but also as an educational platform for sharing practical knowledge of chiropractic science and philosophy, leading to better understanding of the unique nature of the profession and its established tenets;

Whereas, 48 member states provide statutory inclusion of nerves in their chiropractic scope of practice and rules;

Whereas, virtually every authoritative source for defining chiropractic includes reference to either the "nervous system" and/or the "neuromusculoskeletal system", and every authoritative definition of subluxation complex in the literature acknowledges a cause and effect relationship between joint structures and associated neural elements such that self-propulsion, active motion and proprioception are dependent upon interaction with the nervous system; and

Whereas, the study of neuroscience is integral to chiropractic education and research;

now, therefore, be it Resolved, that

The Federation of Chiropractic Licensing Boards hereby affirms that:

1. The nervous system is an essential element in chiropractic practice.

2. That the diagnosis, evaluation, and therapeutic management of patients in a chiropractic practice would be incomplete without including associated components of the nervous system.

3. That conceptual exclusion of nerves from biomechanics in a healthcare setting has limited practical application, and that no evidentiary exclusion of nerves from chiropractic practice exists.

4. That excluding the neural component in the application of chiropractic would be remiss and potentially misleading; and

5. That the nervous system is an integral and necessary component to the musculoskeletal system and subluxation complex, such that the practice of chiropractic necessarily includes and shall not exclude consideration of evaluation, diagnosis and treatment of the nervous system and its components insofar as they pertain to established chiropractic science and philosophy.

94th Annual Congress May 1, 2021 – Virtual Meeting

609

RESOLUTION 2-21

Submitted for consideration by Dr. Robert Frieman (MD)

Radiographic Imaging and Chiropractic Practice

Whereas, the chiropractic paradigm is based on the association between the physical structure and biomechanical function of the body and its influence on neurophysiologic integrity;

Whereas, radiographic imaging is well-established in health care for evaluating the structure of the skeletal system, its functional articulations and soft tissues;

Whereas, Doctors of Chiropractic are educated and trained in the use of radiographic imaging, its clinical indications and contraindications, and the inherent risks of ionizing radiation;

Whereas, radiographic imaging is a valuable diagnostic tool for identifying structural anomalies, abnormalities and pathologies of the spine, pelvis, intervertebral disc spaces and joint spacing, including extra spinal structures;

Whereas, most chiropractic therapeutic techniques apply mechanical forces into the body's structure and articulations;

Whereas, information obtained from radiographic imaging is clinically relevant (AND) could be pivotal for Doctors of Chiropractic to arrive at an accurate diagnosis and an appropriate treatment plan;

Whereas, visualizing structural and articular anomalies, abnormalities and pathologies are important for manipulative forces to be administered in an appropriate and efficient manner;

Now therefore be it –

Resolved, that the Federation of Chiropractic Licensing Boards recommends:

1. That the use of radiographic imaging in patient care is at the professional judgment of the treating Doctor of Chiropractic and determined (IN CONJUNCTION WITH THE PATIENT) on a case-by-case basis; and

2. That prior to obtaining radiographic imaging, a treating Doctor of Chiropractic will inform the patient of the benefits, options, and material risks of x-ray and will receive consent from the patient to be x-rayed; and

3. That chiropractic care policies and guidelines that impose practice standards based on parameters of time before a Doctor of Chiropractic may obtain radiographic imaging potentiates an unnecessary delay which can adversely affect the efficacy of patient care and their health as consumers of chiropractic services.

94th Annual Congress
May 1, 2021 – Virtual Meeting

RESOLUTION 3-21

Submitted for consideration by Dr. William Rademacher

Recognizing Subluxuation

Whereas, the sciences make use of an appropriate subject-related vocabulary, and,

Whereas, the term subluxation has been utilized since the time of Hippocrates and the first English definition of the term was in 1688, and,

Whereas, there are several hundred modifications and alternative expressions utilized by chiropractic, medical and other professions to describe subluxation, and,

Whereas, chiropractic definitions of subluxation include a neurological aberration and a mechanical disturbance, and,

Whereas, the Association of Chiropractic Colleges (ACC) definition of subluxation is representative of these inclusions: "A subluxation is a complex of functional and/or structural and/or pathological articular changes that compromise neural integrity and may influence organ system function and general health." And,

Whereas, research of subluxation correction had been conducted by Dr. B. J. Palmer from 1935 - 1961 with documented patient improvements in blood values, urological values, audiometric measures, electrocardiographic improvements, and basal metabolic improvements, and,

Whereas, subluxation research by Dr. Sharpless in 1975, revealed that 10 mm Hg pressure on spinal nerve roots reduced action potential from 100% down to 60% in 15 minutes, and,

Whereas, subluxation is recognized by the U. S. Government's Medicare program, by the World Health Organization (WHO) ICD-11 classification of vertebral subluxation complex – ME93.Y and by the National Board of Chiropractic Examiners (NBCE),

therefore, be it

Resolved, that the Federation of Chiropractic Licensing Boards, in concert with public protection, acknowledges and recognizes the Chiropractic Subluxation as a known entity and as a diagnosis germane to Chiropractic.

94th Annual Congress
May 1, 2021 – Virtual Meeting

From: Jo-Ann Willson
Sent: Monday, May 17, 2021 1:20 PM
To: Rose Bustria
Subject: FW: FCLB Annual Business Meeting Highlights

Council.

Jo-Ann Willson, B.Sc., M.S.W., LL.B.
Registrar & General Counsel
*Note Address Change
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59 Hayden St., Suite 800
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Fax: (416) 925-9610
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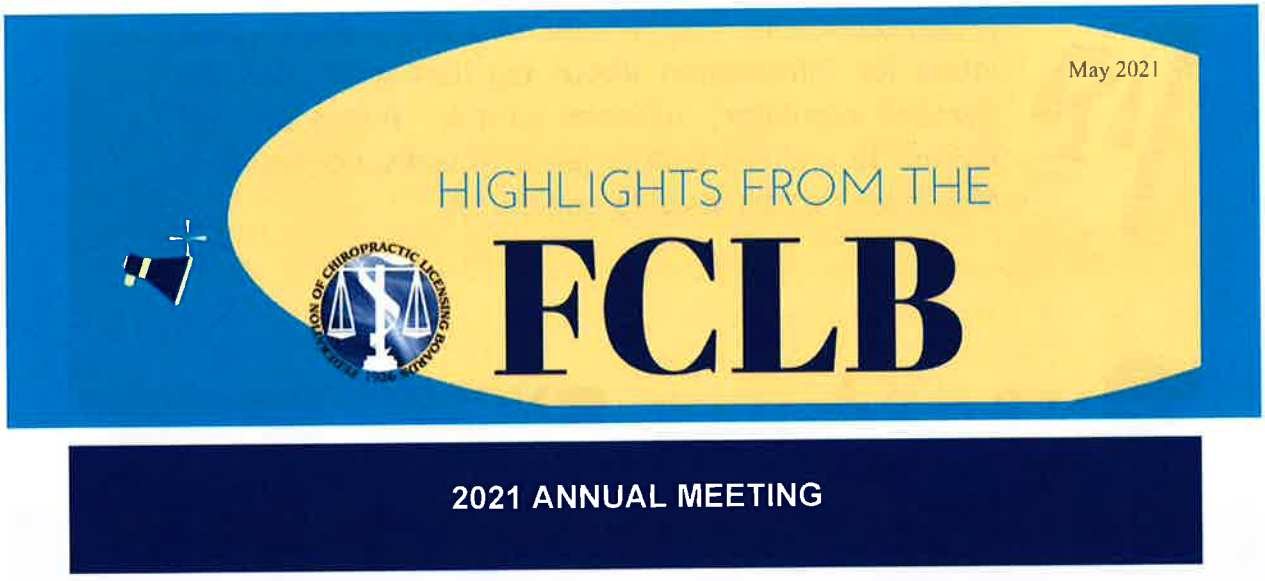
From: FCLB <kwebb@fclb.org>
Sent: Monday, May 17, 2021 1:12 PM
To: Jo-Ann Willson <jpwillson@cco.on.ca>
Subject: FCLB Annual Business Meeting Highlights



On May 1, the Federation of Chiropractic Licensing Boards hosted its 94th Annual Meeting via Zoom and Livestream.

The meeting focused on updating FCLB stakeholders on current projects and financial status as well as holding elections and voting on adoption of proposed resolutions.

Prior to the meeting, Dr. Karlos Boghosian (CT) presented awards to individuals and organizations whose leadership, commitment to public protection, and unwavering dedication to chiropractic regulation stood out in a year of challenges and rapid changes. Honorees were recognized for their willingness to go above and beyond to fulfill the mission of the FCLB.

FCLB Directors hosted caucuses read more

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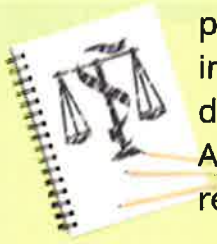
SIGN UP FOR SUMMER SCHOOL!

Get your enrichment on with FCLB's Summer School Series!



We're working hard to develop lectures and presentations to inspire and educate. Watch your inbox for information about registering for our on-demand regulatory summer school. Videos premier August 12 and will feature Janse lectures, hot topics in regulation, expert insights and more!

NBCE NATIONAL BOARD OF CHIROPRACTIC EXAMINERS
EBAS ETHICS FOR PUBLIC PROTECTION
NCMIC We Take Care of Our Own
Standard Process

From: Jo-Ann Willson
Sent: Monday, May 24, 2021 11:22 AM
To: Rose Bustria
Subject: Fwd: FCLB Annual Business Meeting Certificate
Attachments: Mr. MacKay.pdf

Council.

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

College of Chiropractors of Ontario
59 Hayden St., Suite 800
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Web Site: www.cco.on.ca

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Begin forwarded message:

> **From:** mackayrob@tbaytel.net
> **Date:** May 24, 2021 at 11:04:27 AM EDT
> **To:** Jo-Ann Willson <jpwillson@cco.on.ca>, Dennis Mizel <drmizel@stcatharineschiropractic.com>
> **Subject: FW: FCLB Annual Business Meeting Certificate**

> **From:** Janelle Grier <jgrier@fclb.org>
> **Sent:** May 24, 2021 10:50 AM
> **To:** mackayrob@tbaytel.net
> **Subject:** FCLB Annual Business Meeting Certificate
>
> Dear Mr. MacKay,
>
> The FCLB would like to take a moment to personally thank you for your participation in the 2021 Virtual Annual Business Meeting. We appreciate your flexibility and willingness to adapt to the format of this year's Annual

Business Meeting. Please accept the attached certificate as a token of our appreciation for you.

614

We look forward to the Fall District Meetings and hope to be able to meet in person to rekindle the camaraderie that our fall meetings are known for.

Thanks!

Janelle Grier
Federation of Chiropractic Licensing Boards
Program / CIN-BAD Administrator
5401 W. 10th Street, Suite #101
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2021 VIRTUAL ANNUAL BUSINESS MEETING!

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Karlos Boghosian D.C.

May 1, 2021

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Federation of Chiropractic Licensing Boards

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Beth Ehlich, D.C.
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Beth Kidd

May 13, 2021

Hello Everyone!

Thank you to those who were able to join us for our first ever virtual annual business meeting and elections. As a board, we are thankful for the technology that makes this connection possible. As individuals who are gregarious by nature, we certainly missed connecting in person and networking, reestablishing relationships, establishing new ones and collaborating as a body of regulators committed to public protection. In essence, we miss YOU! I look forward to our district meetings in a few short months that will allow, fingers crossed, an in-person conference. Personally, I am excited to be in attendance for at least two of our three meetings and have the opportunity to thank you for your service, encourage your participation and expound upon our upgrades and initiatives.

Our election process occurred seamlessly thanks to the behind the scenes work of Dr. Schwartzbauer and our staff, the production company and generous assistance from NBCE both in offering physical space as well as technological and financial assistance. I applaud everyone involved for their attention to detail, planning and preparation that made this meeting a success. Bravo!! I am certainly proud, humbled and honored to serve as your next president, and look forward to the things that we will accomplish together.

Commitment to our member boards and stakeholders is my first priority. Upgrading our websites to produce a more user-friendly website, user-friendly information sharing and user-friendly dissemination of information is underway. Our PACE website has recently been upgraded and we continue to approve additional CE providers and add jurisdictions that accept PACE. We are at 42 now, and I need to take a moment to thank those that have come before me that have poured their intellect, influence and communication skills into creating, adapting and marketing PACE. Certified Chiropractic Clinical Assistants are present in 33 jurisdictions and counting. Our Recognized Chiropractic Specialties Program is developing to assist member boards with a framework in determining universal minimum standards in education and oversight in determining specialty certification. The Telehealth committee is in the process of canvassing current and emerging language and designations throughout our jurisdictions to produce language for the model practice act which may be of assistance as our member boards tackle this new mode of practice while safeguarding public protection. Lastly, our Diversity and Inclusion committee is at work to ensure diversity and inclusion at all levels of those involved in chiropractic regulation.

In addition to this excitement, we are going to welcome you all to school this summer! Please watch your email and register for summer school this August to increase your knowledge as we all strive towards achieving regulatory excellence.

Lastly, I would like to personally thank the 2021 delegates that were so kind and patient with the campaigning phone calls, emails, voicemails and in some cases snail mail. Virtual elections mean virtual campaigning. This equates to time. Time on the phone, reading emails and many phone tag encounters. Thank you for your time spent in this process and time spent in service.

Congratulations to all newly elected board members, alternates and our new administrative fellow.

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Have a wonderful spring!

God Bless!

Dr. Carol J. Winkler
FCLB President

IN THE SUPREME COURT OF TEXAS

No. 18-1223

TEXAS BOARD OF CHIROPRACTIC EXAMINERS;
PATRICK FORTNER, IN HIS OFFICIAL CAPACITY AS THE BOARD'S EXECUTIVE DIRECTOR;
AND TEXAS CHIROPRACTIC ASSOCIATION, PETITIONERS,

v.

TEXAS MEDICAL ASSOCIATION, RESPONDENT

ON PETITION FOR REVIEW FROM THE
COURT OF APPEALS FOR THE THIRD DISTRICT OF TEXAS

Argued September 16, 2020

CHIEF JUSTICE HECHT delivered the opinion of the Court, in which JUSTICE GUZMAN, JUSTICE LEHRMANN, JUSTICE DEVINE, JUSTICE BLACKLOCK, and JUSTICE BUSBY joined in full, and in which JUSTICE BOYD and JUSTICE BLAND joined except with respect to Part III(D).

JUSTICE BLAND delivered an opinion dissenting in part, in which JUSTICE BOYD joined.

JUSTICE HUDDLE did not participate in the Court's decision.

This ten-year-old case is part of "a long history of professional, scientific, or economic antagonism between chiropractors and the medical community, and resultant disputes, spanning all three branches of government, regarding where any legal line between chiropractic and the

practice of medicine is or should be."[1] The Texas Chiropractic Act (the Act)[2] draws that line by defining the practice of chiropractic to include evaluating the *musculoskeletal system* and improving the *subluxation complex*.[3] The Texas Board of Chiropractic Examiners (the Board) has issued rules defining both terms as involving nerves in addition to muscles and bones.[4] Another Board rule authorizes chiropractors to perform an eye-movement test for neurological problems that is known by the acronym VONT.[5] The Texas Medical Association (TMA) asserts that only physicians may perform VONT. But as we recently stated, "every act that a physician may do is not automatically the unlawful practice of medicine when done by a non-physician, and terminology in one field may overlap with that of another."[6] We conclude that the challenged rules, read in context, do not exceed the statutory scope of chiropractic practice. We reverse that part of the court of appeals' judgment declaring the rules invalid[7] and render judgment that they are valid.

---

[1] *Tex. Bd. of Chiropractic Exam'rs v. Tex. Med. Ass'n*, 375 S.W.3d 464, 467 (Tex. App.—Austin 2012, pet. denied). That case was a precursor to this one. The parties have appealed the underlying case three times to the court of appeals and twice to this Court. Each appeal to the court of appeals is styled *Texas Board of Chiropractic Examiners v. Texas Medical Board*. In order they are No. 03-12-00151-CV, 2012 WL 5974063 (Tex. App.—Austin Nov. 21, 2012, no pet.) (mem. op.); No. 03-14-00396-CV, 2014 WL 7014530 (Tex. App.—Austin Dec. 8, 2014, pet. denied) (mem. op.); and 566 S.W.3d 776 (Tex. App.—Austin 2018) (the decision below).

[2] TEX. OCC. CODE §§ 201.001–201.606.

[3] *Id.* § 201.002(b)(1)–(2).

[4] *See* 22 TEX. ADMIN. CODE § 78.1(a)(5), (9).

[5] *See id.* § 78.1(c)(3)(B) (providing that certain chiropractors may perform "Technological Instrumented Vestibular-Ocular-Nystagmus Testing" on patients).

[6] *Tex. State Bd. of Exam'rs of Marriage & Family Therapists v. Tex. Med. Ass'n*, 511 S.W.3d 28, 41 (Tex. 2017).

[7] 566 S.W.3d 776 (Tex. App.—Austin 2018).

I

A

Chiropractic traces its roots to an encounter in the late 1800s between an alternative-medicine practitioner, D.D. Palmer, and his hearing-impaired office janitor. The details of the encounter have been disputed, but Palmer later claimed that he performed a manual manipulation of the janitor's spine, after which his hearing rapidly improved.[8] What is not in dispute is that Palmer came to theorize that disease and ill health are caused by vertebral misalignment, a condition he called *subluxation*.[9]

Like medical practice, chiropractic practice has evolved over the last century, though spinal alignment remains at its core. Today chiropractors are portal-of-entry healthcare providers in all 50 states, meaning that a referral is not required to visit one. Medicare and Medicaid cover chiropractic services. Texas' workers' compensation regulations authorize the more than 6,000 chiropractors in this state to treat injured workers.[10]

B

Article XVI, Section 31 of the Texas Constitution authorizes the Legislature to "pass laws prescribing the qualifications of practitioners of medicine in this State, and to punish persons for mal-practice". Exercising that authority, the Legislature has passed the Medical Practice Act (the

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[8] A brief summary of the history of chiropractic may be found on the American Chiropractic Association's website. *Origins and History of Chiropractic Care*, AM. CHIROPRACTIC ASS'N, https://www.acatoday.org/About/History-of-Chiropractic (last visited Jan. 24, 2021).

[9] The word *subluxation*, built on the Latin *luxatio*, dislocation, means a partial dislocation. *Subluxation*, WEBSTER'S THIRD NEW INT'L DICTIONARY (1969).

[10] 28 TEX. ADMIN. CODE § 42.20(a).

MPA).[11] *Practicing medicine* is broadly defined as "the diagnosis, treatment, or offer to treat a mental or physical disease or disorder or a physical deformity or injury by any system or method".[12] The MPA empowers the Texas Medical Board "to regulate the practice of medicine" in Texas[13] and provides that "[a] person may not practice medicine in this state unless the person holds a license issued" by the Board.[14] The MPA carves out certain nonphysician healthcare providers whose practices would otherwise fall within the definition of practicing medicine, including dentists, optometrists, nurses, podiatrists, psychologists, physical therapists,[15] and "licensed chiropractor[s] engaged strictly in the practice of chiropractic as defined by law".[16]

The Act defines chiropractic practice. As passed in 1949, the Act provided that a chiropractic practitioner is one "who shall employ objective or subjective means . . . for the purpose of ascertaining the alignment of the vertebrae of the human spine[] and . . . adjusting the vertebrae to correct any subluxation or misalignment thereof."[17] Forty years later, the Legislature amended this provision to define a chiropractic practitioner as one who "(1) uses objective or subjective means to analyze, examine, or evaluate the biomechanical condition of the spine and musculoskeletal system of the human body [or] (2) uses adjustment, manipulation, or other procedures in order to

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[11] TEX OCC. CODE §§ 151.001–170.003.

[12] *Id.* § 151.002(13).

[13] *Id.* § 152.001(a).

[14] *Id.* § 155.001.

[15] *Id.* § 151.052(1)–(2), (4)–(7).

[16] *Id.* § 151.052(3).

[17] Act of Apr. 21, 1949, 51st Leg., R.S., ch. 94, § 1, 1949 Tex. Gen. Laws 160, 160–161 (current version at TEX. OCC. CODE §§ 201.001–201.606). The Court of Criminal Appeals had invalidated prior legislation regulating chiropractic practice. *See Ex parte Halsted*, 182 S.W.2d 479, 488 (Tex. Crim. App. 1944).

improve subluxation or the biomechanics of the musculoskeletal system".[18] We refer to these two provisions as *evaluation* and *treatment*, respectively. In 1995, the Legislature further clarified the evaluation provision.[19] Today, following further amendments, the scope of chiropractic practice, now codified in § 201.002(b) of the Act, is as follows:

> (b) A person practices chiropractic . . . if the person:
>
> (1) uses objective or subjective means to diagnose, analyze, examine, or evaluate the biomechanical condition of the spine and musculoskeletal system of the human body; [or]
>
> (2) performs nonsurgical, nonincisive procedures, including adjustment and manipulation, to improve the subluxation complex or the biomechanics of the musculoskeletal system[.][20]

The Act does not define the terms in these provisions. It excludes "incisive or surgical procedures" from the practice,[21] but that exclusion does not apply to "the use of a needle for the purpose of drawing blood for diagnostic testing."[22] The Act also excludes from chiropractic practice prescribing drugs and using x-rays or other therapies that expose the body to radiation.[23] But the Act otherwise leaves to the Board the adoption of "rules clarifying what activities are included within the scope of the practice of chiropractic and what activities are outside of that scope."[24]

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[18] Act of May 12, 1989, 71st Leg., R.S., ch. 227, § 1, 1989 Tex. Gen. Laws 1005, 1005 (current version at TEX. OCC. CODE §§ 201.002(b)(1)–(2)).

[19] *See* Act of May 29, 1995, 74th Leg., R.S., ch. 965, § 13, 1995 Tex. Gen. Laws 4789, 4802 (current version at TEX. OCC. CODE §§ 201.002(b)(1)–(2)).

[20] TEX. OCC. CODE § 201.002(b)(1)–(2).

[21] *Id.* § 201.002(c)(1).

[22] *Id.* § 201.002(a)(3).

[23] *Id.* § 201.002(c)(2)–(3).

[24] *Id.* § 201.1525.

The Board had no such rulemaking authority under the 1949 Act; its function was to license and train chiropractors.[25] In 1981, the Legislature directed the Board to "adopt guidelines for . . . acceptable practices for all aspects of the practice of chiropractic."[26] But the Legislature drew back in 1993, forbidding the Board from

> adopt[ing] a rule relating to the meaning of the practice of chiropractic under this Act except for:
>
> (1) a rule relating to an adjustment, manipulation, or other procedure directly related to improving the subluxation of the spine or of the musculoskeletal system as it directly relates to improving the subluxation of the spine; or
>
> (2) a rule that defines an unacceptable practice of chiropractic and provides for a penalty or sanction under this Act.[27]

In the very next session, the Legislature about-faced, replacing this very restrictive provision with a 12-word carte blanche: "The Board shall adopt rules for regulation and enforcement of this Act."[28] Finally, in 2005 the Legislature amended the Act to clarify that "[t]he board may adopt rules . . . necessary to . . . regulate the practice of chiropractic" and "shall adopt rules for the enforcement" of the Act.[29] More specifically, the Act states:

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[25] *See* Act of Apr. 21, 1949, 51st Leg., R.S., ch. 94, § 4, 1949 Tex. Gen. Laws 160, 161–162 ("The Board may prescribe rules, regulations and bylaws in harmony with the provisions of this Act for its own proceedings and government for the examination of applicants for license to practice chiropractic.") (current version at TEX. OCC. CODE § 201.1525).

[26] Act of May 26, 1981, 67th Leg., R.S., ch. 781, § 4(d), 1981 Tex. Gen. Laws 2955, 2957 (current version at TEX. OCC. CODE § 201.1525).

[27] Act of May 30, 1993, 73rd Leg., R.S., ch. 910, § 6, sec. 4(c), 1993 Tex. Gen. Laws 3834, 3837 (current version at TEX. OCC. CODE § 201.1525).

[28] Act of May 29, 1995, 74th Leg., R.S., ch. 965, § 15, sec. 4(c), 1995 Tex. Gen. Laws 4789, 4802 (current version at TEX. OCC. CODE § 201.1525).

[29] TEX. OCC. CODE § 201.152 (a)–(b).

> The board shall adopt rules clarifying what activities are included within the scope of the practice of chiropractic and what activities are outside of that scope. The rules:
>
> (1) must clearly specify the procedures that chiropractors may perform;
>
> (2) must clearly specify any equipment and the use of that equipment that is prohibited; and
>
> (3) may require a license holder to obtain additional training or certification to perform certain procedures or use certain equipment.[30]

Thus, over time the Legislature has chosen to prescribe chiropractic practice in broad terms undefined by statute and to require the Board to clarify by rules what activities are included and excluded. The Board consists of nine members, six chiropractors and three public members, all appointed by the Governor with Senate approval.[31] The chiropractor appointees must be "reputable" and currently "practicing".[32] Eligibility disqualifiers in the Act help protect against conflicts of interest.[33] As a state administrative agency, the Board is required to comply with the notice-and-comment procedures of the Administrative Procedure Act (the APA) when promulgating rules.[34] But the Act also imposes on the Board the additional obligation—"early in the rule development process" and "before [it] complies with the rulemaking requirements of" the APA—to "identify[] [the] persons who will be most affected" by the proposed rules and to solicit their "advice and

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[30] *Id.* § 201.1525.

[31] *Id.* § 201.051.

[32] *Id.* § 201.051(a)(1).

[33] *See id.* §§ 201.052–201.053.

[34] *Id.* § 201.1526(a); *see also* TEX. GOV'T CODE § 2001.023(a) (requiring an agency to give notice of a proposed rule by publishing it in the Texas Register at least 30 days before its effective date); *id.* § 2001.024 (imposing detailed requirements for the content of the notice); *id.* § 2001.029 (requiring an agency to give "all interested persons a reasonable opportunity" to submit comments and, under certain circumstances, to hold a public hearing before adopting a substantive rule).

opinions".[35] The APA, supplemented by the Act's requirements, assures that the Board's rulemaking process is informed by input from interested parties and the public and provides the protection of judicial review.

C

In 2006, the Board adopted what is now Rule 78.1, titled "Scope of Practice", defining two critical terms in the Act's definition of chiropractic practice.[36] With respect to the evaluation provision (§ 201.002(b)(1)), Rule 78.1(a)(5) defines *musculoskeletal system* as "[t]he system of muscles and tendons and ligaments and bones and joints and associated tissues and nerves that move the body and maintain its form."[37] With respect to the treatment provision (§ 201.002(b)(2)), Rule 78.1(a)(9) defines *subluxation complex* as

> [a] neuromusculoskeletal condition that involves an aberrant relationship between two adjacent articular structures that may have functional or pathological sequelae, causing an alteration in the biomechanical and/or neuro-physiological reflections of these articular structures, their proximal structures, and/or other body systems that may be directly or indirectly affected by them.[38]

In comments to the Board, TMA opposed the definition of musculoskeletal system as "so broad as to include the nervous system and brain, and requested that the definition be limited to the spine."[39] The Board rejected the request, noting that its definition was based on medical

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[35] TEX. OCC. CODE § 201.1526(a)–(b).

[36] 31 TEX. REG. 8363–8364 (2006) (codified as an amendment to TEX. ADMIN. CODE § 75.16) (proposed Oct. 6, 2006).

[37] 22 TEX. ADMIN. CODE § 78.1(a)(5).

[38] *Id.* § 78.1(a)(9).

[39] 31 TEX. REG. at 8363.

dictionaries and was limited to structures "that move the body and maintain its form."[40] TMA also criticized the definition of subluxation complex as "expansive" and again requested that it be "revised to narrowly focus on the spine."[41] The Board also rejected this request, stating that its definition was consistent with the statute. "[A]s commonly used by health care providers," the Board explained, "and as commonly described in medical dictionaries, the musculoskeletal system includes more than the spine."[42]

The Board also adopted in the 2006 scope-of-practice rule a provision, now in Rule 78.1(d), stating that "[i]n the practice of chiropractic, licensees may render an analysis, diagnosis, or other opinion regarding the findings of examinations and evaluations."[43] At that time, the Act's evaluation provision used only the words "analyze, examine, or evaluate" and did not include the word *diagnose*. Shortly after the rule was adopted, TMA sued for a declaration that diagnosis is the practice of medicine and beyond the Act's authorization of chiropractors to "analyze, examine, or evaluate" certain conditions. The court of appeals rejected TMA's contention, concluding that the diagnosis authorized by the rule was confined to the statutory practice of chiropractic.[44]

While that litigation was pending, the Board in 2010 adopted what is now Rule 78.1(c)(3)(B), authorizing chiropractors who complete specialized training and pass an

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[40] *Id.*

[41] *Id.* at 8363–8364.

[42] *Id.* at 8364.

[43] 22 TEX. ADMIN. CODE § 78.1(d)(1).

[44] *Tex. Bd. of Chiropractic Exam'rs v. Tex. Med. Ass'n*, 375 S.W.3d 464, 495–496 (Tex. App.—Austin 2012, pet. denied).

examination to perform vestibular-ocular-nystagmus testing, or VONT.[45] VONT is generally an eye-movement test performed with cameras or electrodes to detect nystagmus, a type of involuntary, side-to-side eye movement that may indicate a problem in the brain, inner ears, or eyes. Authorized chiropractors use the test to help diagnose the cause of a patient's balance problem by ruling out a neurological condition that would require referral of the patient to a physician.

A few months later, TMA sued to invalidate the VONT rule as exceeding the scope of chiropractic practice prescribed by the Act. After the court of appeals reversed summary judgment for TMA,[46] TMA amended its pleadings on remand to challenge Rule 78.1(a)'s definitions of the musculoskeletal system and the subluxation complex, asserting that their references to "nerves", "neuromusculoskeletal condition", and "neuro-physiological reflections" exceed the Act's restriction of chiropractic practice to "biomechanical condition[s]".[47] TMA added that the definitions authorized diagnosis, which it continued to insist, as it had in its earlier suit, is solely a medical

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[45] 35 TEX. REG. 9508, 9508 (2010) (to be codified as an amendment to 22 TEX. ADMIN. CODE § 75.17) (proposed Oct. 22, 2010) (adopting "an amendment to § 75.17 without changes to the proposed text as published" in the *Texas Register* on June 25, 2010). Rule 78.1(c)(3)(B) provides in full that

> Technological Instrumented Vestibular-Ocular-Nystagmus Testing may be performed by a licensee with a diplomate in chiropractic neurology and that has successfully completed 150 hours of clinical and didactic training in the technical and professional components of the procedures as part of coursework in vestibular rehabilitation including the successful completion of a written and performance examination for vestibular specialty or certification. The professional component of these procedures may not be delegated to a technician and must be directly performed by a qualified licensee.

22 TEX. ADMIN. CODE § 781.(c)(3)(B).

[46] *Tex. Bd. of Chiropractic Exam'rs v. Tex. Med. Ass'n*, No. 03-12-00151-CV, 2012 WL 5974063, at *1 (Tex. App.—Austin Nov. 21, 2012, no pet.) (mem. op.).

[47] *Compare* 22 TEX. ADMIN. CODE § 78.1(a)(5), (a)(9), *with* TEX. OCC. CODE § 201.002(b)(1).

practice.[48] After a bench trial, the court issued findings of fact and conclusions of law, holding that the challenged rules are invalid because they exceed the statutory scope of chiropractic practice. It rendered judgment accordingly. The Board appealed, along with the Texas Chiropractic Association (TCA), which had joined the suit.

The court of appeals affirmed in part. Relying on the trial court's findings of fact and the evidence adduced at trial, the court of appeals held that Rule 78.1(a)(5) and (9), defining musculoskeletal system and subluxation complex as involving the nervous system, exceed the scope of practice prescribed by § 201.002(b)(1)–(2) of the Act. The court concluded:

> Although consideration of other bodily systems may be necessary to evaluate the biomechanical condition of the spine and the musculoskeletal system, that does not mean that the definition of "musculoskeletal system" should be expanded to include associated nerves or that "subluxation complex" should be defined as a condition extending beyond the musculoskeletal system. Based on our review of the evidence put forth before the trial court, we hold that sufficient evidence supports the court's findings related to the Rule's reference to nerves and the "neuromusculoskeletal system" in its definition of "musculoskeletal system" or "subluxation complex."

The court reached the same conclusion regarding Rule 78.1(c)(3)(B), allowing certain chiropractors to use VONT testing:

> Although [the Board] produced evidence indicating that VONT may be a useful tool to chiropractors, the evidence establishes that VONT helps in the diagnosis of vestibular issues. The evidence further establishes that, although vestibular diseases might have an impact on the musculoskeletal system, disorders falling within the ambit of chiropractic do not cause vestibular pathologies. Simply because the test might under some circumstances be useful does not require that chiropractors be able to perform the test—the fact remains that the scope of chiropractic practice is limited under Texas law. On this record, we cannot conclude that the trial court erred in its findings of fact or in concluding that the Rule's provision related to VONT exceeded the scope of chiropractic.[49]

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[48] On interlocutory appeal, the court of appeals rejected the Board's argument that TMA's *diagnosis* complaint was a collateral attack on the final judgment in the prior case. *Tex. Bd. of Chiropractic Exam'rs v. Tex. Med. Ass'n*, No. 03-14-00396-CV, 2014 WL 7014530, at *1 (Tex. App.—Austin Dec. 8, 2014, pet. denied) (mem. op.).

[49] 566 S.W.3d 776, 785–787 (Tex. App.—Austin 2018) (citation omitted).

While the appeal was pending, the Legislature amended the evaluation provision of the Act to add the word *diagnose*, so that the Act now authorizes chiropractors to "diagnose, analyze, examine, or evaluate the biomechanical condition of the spine and musculoskeletal system".[50] The court of appeals reversed the trial court's judgment invalidating the rules as authorizing diagnosis outside the statutory scope of chiropractic practice.[51]

We granted the Board's and TCA's petitions for review. As their positions are aligned, we refer to their arguments simply as the Board's.

II

As a threshold matter, the Board argues that the APA affords TMA no basis for challenging Rule 78.1. Section 2001.038(a) allows a challenge to an administrative rule "if it is alleged that the rule or its threatened application interferes with or impairs, or threatens to interfere with or impair, a legal right or privilege of the plaintiff."[52] The Board argues that TMA's assertions do not meet this standard because there is no evidence that chiropractors are practicing medical neurology or failing to refer patients with medical problems to physicians. TMA, the Board contends, has done no more than assert policy differences with the Legislature over the scope of chiropractic practice. TMA responds that it has alleged that Rule 78.1 diminishes the privilege of practicing medicine and the value of physicians' medical licenses by authorizing the unlicensed practice of medicine.

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[50] Act of May 22, 2017, 85th Leg., R.S., ch. 294, § 1, 2017 Tex. Gen. Laws 545, 545 (codified at TEX. OCC. CODE § 201.002(b)(1)).

[51] 566 S.W.3d at 787–788; *see Tex. State Bd. of Exam'rs of Marriage & Family Therapists v. Tex. Med. Ass'n*, 511 S.W.3d 28, 41 (Tex. 2017) (rejecting TMA's challenge to an agency rule permitting therapists to provide diagnostic assessments as invading the practice of medicine).

[52] TEX. GOV'T CODE § 2001.038(a).

We agree with TMA that its allegation satisfies § 2001.038(a). The MPA recognizes that "the practice of medicine is a privilege" reserved to physicians subject to "licensing, regulating, and disciplining" under that statute.[53] Obtaining and maintaining the privilege of practicing medicine imposes economic costs on physicians, and allowing nonphysicians to practice medicine outside the MPA's control would impair—or at least threaten to impair—that privilege.

The Board characterizes § 2001.038(a) as a "statutory standing" provision. Constitutional standing is a prerequisite for subject matter jurisdiction.[54] In *Finance Commission of Texas v. Norwood*, we treated § 2001.038(a) "as but another expression of the general[,] [constitutional] doctrine of standing."[55] But last Term in *Pike v. EMC Management, LLC*, we discouraged the use of the term *standing* to describe extra-constitutional restrictions on the right of a particular plaintiff to bring a particular lawsuit.[56] "[T]he question whether a plaintiff has . . . satisfied the requisites of a particular statute", we said, "pertains in reality to the right of the plaintiff to relief rather than to the subject-matter jurisdiction of the court to afford it."[57]

Although the Board does not argue that TMA lacks constitutional standing, "we have an obligation to examine our jurisdiction any time it is in doubt".[58] Constitutional standing requires a

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[53] TEX. OCC. CODE § 151.003.

[54] *Heckman v. Williamson Cty.*, 369 S.W.3d 137, 150 (Tex. 2012); *DaimlerChrysler Corp. v. Inman*, 252 S.W.3d 299, 304–305 (Tex. 2008). In Texas, the constitutional prerequisite of standing is grounded in the Open Courts and Separation of Powers provisions of the Texas Constitution. *See* TEX. CONST. art. I, § 13 ("All courts shall be open, and every person for an injury done him, in his lands, goods, person or reputation, shall have remedy by due course of law."); *id.* art. II, § 1 ("The powers of the Government of the State of Texas shall be divided into three distinct departments, each of which shall be confided to a separate body of magistracy . . . and no person, or collection of persons, being of one of these departments, shall exercise any power properly attached to either of the others . . . .").

[55] 418 S.W.3d 566, 582 n.83 (Tex. 2013).

[56] 610 S.W.3d 763, 774 (Tex. 2020).

[57] *Id.* (citing *Dubai Petrol. Co. v. Kazi*, 12 S.W.3d 71, 76–77 (Tex. 2000) (cleaned up)).

[58] *Pike*, 610 S.W.3d at 774.

concrete injury that is both traceable to the defendant's conduct and redressable by court order.[59] When constitutional standing is raised for the first time on appeal, the test must be lenient because "there is no opportunity [for the plaintiff] to cure [a pleading] defect."[60] Construing the record "liberally . . . as [we] must" at this stage[61] and "resolving any doubt in [TMA's] favor",[62] we conclude that TMA has constitutional standing to bring this lawsuit. Keeping in mind that no party contests TMA's constitutional standing, we conclude that TMA's assertion that some physicians will suffer economic harm due to increased competition from chiropractors sufficiently alleges the concrete injury required for standing.[63] That alleged injury is directly traceable to the Board's rule-making and would be redressed here by judicial invalidation of the challenged rules. Likewise, no party contests TMA's associational standing to file suit on behalf of its members, and we conclude that TMA's unchallenged allegations satisfy the requirements under our caselaw for associational standing.[64]

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[59] *See Heckman v. Williamson Cty.*, 369 S.W.3d 137, 154–155 (Tex. 2012) (citing *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560–561 (1992)). Texas has adopted the constitutional standing test employed by the federal courts.

[60] *Tex. Ass'n of Bus. v. Tex. Air Control Bd.*, 852 S.W.2d 440, 446 (Tex. 1993).

[61] *Fin. Comm'n of Tex. v. Norwood*, 418 S.W.3d 555, 582 (Tex. 2013).

[62] *Tex. Ass'n of Bus.*, 852 S.W.2d at 447.

[63] *See Ass'n of Data Processing Serv. Orgs., Inc. v. Camp*, 397 U.S. 150, 152 (1970) (holding that organizations could demonstrate constitutional standing to challenge government action based on "alleg[ations] that [increased] competition" resulting from such official action "might entail some future loss of profits" for the firms represented by the plaintiff organization).

[64] In *Texas Association of Business v. Texas Air Control Board*, we adopted the three-part test for associational standing articulated by the Supreme Court of the United States: "(a) [the association's] members would otherwise have standing to sue in their own right; (b) the interests [the association] seeks to protect are germane to the organization's purpose; and (c) neither the claim asserted nor the relief requested requires participation of individual members in the lawsuit." 852 S.W.2d at 447 (quoting *Hunt v. Wash. State Apple Advert. Comm'n*, 432 U.S. 333, 343 (1977)).

Having concluded that TMA is entitled to bring this action, we will now consider the merits of its claims.

III

The issue before us is whether Rules 78.1(a)(5) and (9), which define *musculoskeletal system* and *subluxation complex*, and Rule 78.1(c)(3)(B), which allows certain chiropractors to perform VONT, exceed the scope of practice prescribed by § 201.002(b)(1)–(2) of the Act. We first set out our standard of review, then consider its application to Board rulemaking, and finally determine the validity of the challenged rules.

A

Our standard of review in this case is well settled. The parties agree, as they must, that interpreting the Act and the rules involves only questions of law, which we determine de novo.[65] Although the court of appeals never expressly agreed or disagreed with this standard, it repeatedly stated that its holdings were based on the evidence and the trial court's findings. While it was not improper for the trial court to allow evidence to be offered as background describing medical and chiropractic practice and placing the case in context, the question whether the Board exceeded its authority by adopting rules that conflict with the Act is a legal one.

The parties also agree, again as they must, that agency rules are presumed valid and that the challenger has the burden of showing that a "rule's provisions are not 'in harmony with the general objectives of the act involved.'"[66] The court of appeals acknowledged this principle in

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[65] *See Tex. State Bd. of Exam'rs of Marriage & Family Therapists v. Tex. Med. Ass'n*, 511 S.W.3d 28, 33 (Tex. 2017).

[66] *Id.* at 33 (quoting *Edgewood Indep. Sch. Dist. v. Meno*, 917 S.W.2d 717, 750 (Tex. 1995)).

setting out the standard of review[67] but never in its analysis, which gave no deference to the Board's expertise regarding chiropractic practice.

When statutes use terms they do not define, as the Act does, "we must apply their common, ordinary meaning unless a contrary meaning is apparent from the statute's language."[68] Of course, the Act's terms must be understood in the context of healthcare in general and chiropractic practice in particular, which are the subject of the Act.[69] The issue is whether the definitions that the Board adopted in the rules are consistent with the meaning of the terms in the Act.

We recently applied these principles in another case involving a challenge by TMA to the validity of an administrative rule. In *Texas State Board of Examiners of Marriage and Family Therapists v. Texas Medical Association*, TMA objected to an agency rule authorizing marriage and family therapists to provide diagnostic assessments using the Diagnostic and Statistical Manual of Mental Disorders, commonly referred to as the DSM.[70] TMA argued there, as it also has in this case, that diagnosis is the practice of medicine and that the rule violated both the Licensed Marriage and Family Therapists Act and the MPA by empowering therapists to diagnose any mental disease or disorder. The Therapists Board countered that the rule only authorized therapists to diagnose disorders within their sphere of expertise and training.

We treated the question of the rule's validity as a purely legal one and explained that we were obliged to decide it "based on the relevant Texas statutes" and "not on whether [therapists]

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[67] *See* 566 S.W.3d 776, 781 (Tex. App.—Austin 2018).

[68] *Marriage & Family Therapists*, 511 S.W.3d at 34.

[69] *Cf. Murphy Expl. & Prod. Co.-USA v. Adams*, 560 S.W.3d 105, 109 (Tex. 2018) (explaining that when interpreting an oil-and-gas lease, "we may consider 'objectively determinable facts and circumstances that contextualize the parties' transaction' and 'inform' the meaning of the language used" (quoting *URI, Inc. v. Kleberg Cty.*, 543 S.W.3d 755, 758 (Tex. 2018))).

[70] 511 S.W.3d at 30.

are qualified to make DSM diagnoses or whether other states' laws allow them to."[71] We began our analysis with the general principle that state administrative agencies like the Therapists Board have "only those powers that the Texas Legislature has expressly conferred upon [them] and those implied powers that are reasonably necessary to carry out [their] statutory duties."[72] Agency rules must therefore be "authorized by and consistent with [their] statutory authority."[73] "Courts generally presume", we said, "that agency rules are valid, so parties who challenge a rule have the burden of proving its invalidity."[74] The challenger's ultimate burden is to demonstrate "that the rule's provisions are not 'in harmony with the general objectives of the act involved'", which we discern from the statute's plain text.[75] The challenger can meet his burden by showing that the challenged rule: "(1) contravenes specific statutory language; (2) runs counter to the general objectives of the statute; or (3) imposes additional burdens, conditions, or restrictions in excess of or inconsistent with the relevant statutory provisions."[76] Where the plaintiff argues that an agency rule is too permissive, only the first two showings are relevant.

In *Marriage and Family Therapists*, we explained that when the governing statute does "not define . . . key terms, we . . . apply their common, ordinary meaning unless a contrary meaning is apparent from the statute's language."[77] We cited for this proposition *University of Texas at*

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[71] *Id.* at 33.

[72] *Id.*

[73] *Id.* (quoting *R.R. Comm'n of Tex. v. Lone Star Gas Co.*, 844 S.W.2d 679, 685 (Tex. 1992)).

[74] *Id.*

[75] *Id.* (quoting *Edgewood Indep. Sch. Dist. v. Meno*, 917 S.W.2d 717, 750 (Tex. 1995)).

[76] *Id.*

[77] *Id.* at 34.

Arlington v. Williams, where we had reiterated that "context is fundamental to understanding the use of language" and cautioned against drawing "meaning . . . from isolated words or phrases".[78] If a definition that is "different, more limited, or [more] precise" than the dictionary definition "is apparent from the term's use in the context of the statute, [then] we apply that meaning."[79]

The starting point of our analysis in *Marriage and Family Therapists* was the language of the Licensed Marriage and Family Therapists Act authorizing therapists to engage in "the evaluation and remediation of cognitive, affective, behavioral, or relational dysfunction in the context of marriage or family systems."[80] Against that standard we compared the Therapists Board rule authorizing therapists to provide a diagnostic assessment using the DSM "as part of their therapeutic role to help individuals identify their emotional, mental, and behavioral problems when necessary."[81] TMA conceded that the statutory authorization of evaluations included authorization for assessments, but it argued that the inclusion in the rule of the adjective *diagnostic* was a bridge too far. After looking to both traditional and medical dictionary definitions of the relevant terms to discern their "common, ordinary meanings . . . within their statutory context",[82] we concluded that TMA was "mak[ing] too much of the rule's use of the word 'diagnostic.'"[83]

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[78] 459 S.W.3d 48, 52 (Tex. 2015) (citing *TGS–NOPEC Geophysical Co. v. Combs*, 340 S.W.3d 432, 439 (Tex. 2011) ("Undefined terms in a statute are typically given their ordinary meaning, but if a different or more precise definition is apparent from the term's use in the context of the statute, we apply that meaning.")).

[79] *In re Hall*, 286 S.W.3d 925, 929 (Tex. 2009) (orig. proceeding) (citing *Tex. Dep't of Transp. v. Needham*, 82 S.W.3d 314, 318 (Tex. 2002)).

[80] 511 S.W.3d at 34 (quoting TEX. OCC. CODE § 502.002(6)).

[81] *Id.* (quoting 22 TEX. ADMIN. CODE § 801.42(13)).

[82] *Id.* at 38.

[83] *Id.* at 37.

Critically, we looked to other Therapists Board rules to provide context for the rule that TMA was challenging. Our conclusion that TMA had not met its burden of demonstrating that the rule authorizing diagnostic assessments exceeded the statutory scope of practice was based in part on other rules limiting therapists to providing "services within [their] professional competency" and requiring referral of a client to another care provider when appropriate.[84]

An undercurrent of TMA's argument in *Marriage and Family Therapists* was that any act within the statutory scope of medical practice must necessarily be excluded from the statutory scope of other healthcare professions. We rejected that line of thinking, explaining that "every act that a physician may do is not automatically the unlawful practice of medicine when done by a non-physician, and terminology in one field may overlap with that of another."[85] This principle is clear from the text of the MPA, which defines medical practice in the broadest terms possible—"the diagnosis[] [or] treatment" of any "mental or physical disease or disorder", "physical deformity", "or injury"[86]—and then exempts from the prohibition against unlawfully practicing medicine certain nonphysician healthcare providers "engaged strictly in the practice of" their professions as they are "defined by law".[87] Thus, the question in a § 2001.038(a) suit for judicial review of an agency rule regulating nonphysician healthcare providers is not whether any part of the rule authorizes a provider to engage in an activity that also constitutes the practice of medicine. Rather, the question is whether the plaintiff has overcome the presumption that the rule is valid by showing

[84] *Id.* at 39 (quoting 22 TEX. ADMIN. CODE § 801.44(r)).

[85] *Id.* at 41.

[86] TEX. OCC. CODE § 151.002(13).

[87] *Id.* § 151.052.

that any part of the rule either "contravenes specific . . . language" of the regulated profession's enabling statute or "runs counter to the general objectives of" that statute.[88]

B

The lower courts failed to apply this analysis, even though the court of appeals had the benefit of our decision in *Marriage and Family Therapists* and even though the legal principles we applied there broke no new ground. The trial court weighed evidence—specifically, witness testimony presenting each side's view of the appropriate line between chiropractic and medical neurology—as if it were doing the Board's work anew. The court's findings of fact and conclusions of law make it clear that it failed to afford Rule 78.1 a presumption of validity. For example, the court found that "[t]here is no commonly accepted definition of musculoskeletal system that includes nerves"—implicitly crediting TMA's evidence over the Board's. TMA witnesses testified that strict anatomical lines delineate one system of the human body from another.[89] Board witnesses testified that chiropractic takes a functional view of the body that does not permit the biomechanical condition of the muscles and bones that comprise the musculoskeletal system to be evaluated apart from the nerves that animate them. The court of appeals gave a nod to our analysis in *Marriage and Family Therapists* but then held that in light of the witness testimony presented by TMA, "sufficient evidence" supported the trial court's judgment that Rule 78.1 exceeds the

[88] *Marriage & Family Therapists*, 511 S.W.3d at 33. The third prong of the test—whether the challenged rule "imposes additional burdens, conditions, or restrictions in excess of or inconsistent with" the Act, *id.*—does not apply here because TMA argues that Rule 78.1 is too broad, not too narrow.

[89] The trial court's findings of fact adopt the view of TMA's witnesses that the distinct systems of the human body are skeletal, muscular, nervous, cardiovascular, digestive, reproductive, urinary, endocrine, and integumentary (skin).

statutory scope of chiropractic.[90] In so doing, the court applied an incorrect standard of review. The proper question for the court was whether, despite Rule 78.1's presumption of validity, the rule contravenes the Act's specific text or runs counter to its purpose as a matter of law.

With the Board, the Legislature has delegated to a regulated group of practitioners and public members the responsibility of "clarifying what activities are included within the scope of the practice of chiropractic and what activities are outside of that scope",[91] and it has required the Board in doing so to take measures beyond what is required by the APA to "seek input early in the rule development process" from the "persons who will be most affected" by it.[92] Judges are experts in statutory analysis, not in healthcare. To prevent expensive and time-consuming usurpations of administrative agencies' policymaking work, the court's inquiry in a § 2001.038(a) suit challenging the validity of an agency rule must be limited. The textual analysis we set out in *Marriage and Family Therapists* ensures that courts will stay in their lane. To that analysis we now turn.

C

TMA contends that Rule 78.1(a)'s references to nerves exceed the Act's scope of chiropractic practice. Specifically, the rule's definition of the statutory phrase *musculoskeletal system* includes not only bones, joints, muscles, tendons, and ligaments but also the "associated . . . nerves that move the body and maintain its form."[93] And the rule defines the statutory phrase *subluxation complex* as a "neuromusculoskeletal condition" that can alter certain "neuro-physiological

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[90] 566 S.W.3d 776, 781 (Tex. App.—Austin 2018) (restating the legal analysis set forth in *Marriage & Family Therapists*); *id.* at 785–786 (reviewing the testimony and concluding that "sufficient evidence supports the [trial] court's findings related to the [Scope of Practice] Rule's reference to nerves . . . in its definition of 'musculoskeletal system' [and] 'subluxation complex'"); *id.* at 787 (affirming the trial court's judgment that the VONT rule is invalid).

[91] TEX. OCC. CODE § 201.1525.

[92] *Id.* § 201.1526(b).

[93] 22 TEX. ADMIN. CODE § 78.1(a)(5).

reflections".[94] TMA argues that these references to nerves authorize chiropractors to diagnose any neurological condition, which is the practice of medicine.

TMA's argument echoes its position in *Marriage and Family Therapists* that a rule permitting therapists to make diagnostic assessments allows them to diagnose any mental disorder. But here, as was the case there, the rule's words cannot be read beyond their context. Nothing in Rule 78.1 suggests that chiropractic practice extends beyond the evaluation and treatment of the musculoskeletal system. The rule merely acknowledges the reality that chiropractors cannot ignore the presence and effect of associated nerves that help shape the musculoskeletal system and allow it to move. The Board's definition of musculoskeletal system only includes those nerves "associated" with the muscles, tendons, ligaments, bones, joints, and tissues "that move the body and maintain its form." For Rule 78.1 to exceed its proper scope, the rule must contravene the Act's specific words or purpose. It does neither. Nothing in the text of either definition gives chiropractors carte blanche to practice medical neurology, and the Board has rejected the notion that chiropractic is so broad.

Though the Act contains some specific exclusions from chiropractic—"incisive or surgical procedures", prescribing drugs, and using x-rays or other therapies that expose the body to radiation[95]—it certainly cannot be read to include all healthcare that it does not specifically exclude, and the Board makes no argument to the contrary. Because chiropractic is carved out of the comprehensive regulation of the practice of medicine under the MPA, its scope under the Act must be limited. Rule 78.1 acknowledges and respects the Act's boundaries.

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[94] *Id.* § 78.1(a)(9).

[95] TEX. OCC. CODE § 201.002(c).

The limited nature of Rule 78.1(a)'s definitions is clear when they are considered alongside other Board rules. Directly below the definitions of musculoskeletal system and subluxation complex, another section of Rule 78.1 defines chiropractic practice exactly as the Act does, word for word.[96] The Rule also explains that Board licensees are expected to "provide necessary examination and evaluation services" to "[d]ifferentiate a patient or condition for which chiropractic treatment is appropriate from a patient or condition that is in need of care from a medical or other class of provider."[97] Rule 79, governing "Unprofessional Conduct", states that "[a] licensee shall . . . timely refer a patient to another appropriate health care provider for a condition outside the scope of practice"[98] and that "[a] licensee *may not* . . . perform or attempt to perform procedures for which the licensee is untrained".[99] Licensees who engage in unprofessional conduct are "subject to disciplinary action."[100] Far from authorizing chiropractors to stray beyond the Act's boundaries, the Board's rules, taken together, seek to ensure that chiropractors remain inside them.

TMA argues that no commonly accepted definition of the musculoskeletal system includes nerves. But TMA over reads Rule 78.1. The rule merely recognizes the reality that musculoskeletal dysfunctions cannot be diagnosed or treated without considering associated nerves. Medical neurology is a far broader field. The Board argues that chiropractors must consider the nerves involved in a musculoskeletal system in order to determine whether referral to a neurologist is required. TMA characterizes this view as functional and argues that it ignores the fact that body systems are

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[96] 22 TEX. ADMIN. CODE § 78.1(b)(1).

[97] *Id.* § 78.1(c)(1).

[98] *Id.* § 79.2(a) (emphasis added).

[99] *Id.* § 79.2(b) (emphasis added).

[100] *Id.* § 79.2(c).

separate. But it is not for the judiciary to decide between these competing views. That decision was the Board's, and it could reasonably consider neural involvement in the musculoskeletal system in defining the scope of chiropractic. TMA argues that the danger is that a chiropractor will not make a referral to a neurologist when one is required. But the answer to TMA's concern is in Rule 79, which provides for professional discipline if that were to occur.

For all of these reasons, we conclude that TMA "makes too much" of the references to nerves in the Board's definitions of musculoskeletal system and subluxation complex.[101] TMA has not overcome the definitions' presumption of validity by demonstrating that they contravene specific language in the Act or run counter to the Act's objectives.[102]

D

TMA also challenges Rule 78.1(c)(3)(B)'s authorization for chiropractors who have completed specialized training to perform VONT. The technical language of the rule does not aid our statutory analysis. The parties describe VONT as a test that measures a patient's eye movements with a camera or through electrodes, and they agree that it does not fall within any category of procedure that the Legislature has expressly excluded from the scope of chiropractic—VONT is not "incisive or surgical"; it does not require "the prescription of controlled substances"; and it does not "use . . . x-ray therapy" or otherwise "expose[] the body to radioactive materials."[103] TMA presented evidence in the trial court that VONT is a neurological test that a medical doctor may use to diagnose a problem of the brain, inner ear, or eyes, none of which is a part of the spine or

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[101] *Marriage & Family Therapists*, 511 S.W.3d at 37.

[102] *See id.* at 34.

[103] TEX. OCC. CODE § 201.002(c).

musculoskeletal system. Therefore, TMA argues, it exceeds the statutory scope of chiropractic for a chiropractor to perform VONT.

But the Board also presented evidence that VONT can be used to facilitate chiropractic treatment. One chiropractor witness, Frederick Carrick, D.O., testified by deposition that because spinal joints move reflexively opposite the direction of eye movements, VONT can "tell[] you the integrity of spinal musculature in reaction reflexogenically to an environmental perturbation" and "can be indispensable in [demonstrating] what side of the spine to treat".[104] The Board explains that a chiropractor can also use VONT to rule out nonchiropractic causes of certain disorders, which can help the chiropractor to determine whether chiropractic treatment is appropriate or whether the patient should be referred to another healthcare provider. The Board gives the example of a patient who comes to a chiropractor with dizziness, a common occurrence. Dizziness has numerous possible causes, many of which are outside the scope of chiropractic. But one possible cause is cervical vertigo—dizziness arising from head-and-neck misalignment, often the result of a sports injury or car accident—which can be treated with manual manipulation. The Board presented evidence that a negative VONT test can help to confirm a diagnosis of cervical vertigo by ruling out a problem in the brain, inner ear, or eyes, a process known as making a differential diagnosis.

Though the dissent agrees that Rule 78.1's references to nerves in defining the musculoskeletal system and the subluxation complex properly "clarify the Legislature's scope-of-practice

[104] Dr. Carrick is licensed in New Hampshire and has never practiced in Texas. In fact, it appears that VONT is not widely used by Texas chiropractors. TCA maintains that since the Board's adoption in 2010 of the rule approving VONT's use, only two chiropractors in Texas have jumped through the regulatory hoops to receive Board authorization to use it.

limitations",[105] it argues that the rule's authorization of specially trained chiropractors to perform VONT exceeds these limitations. However, a reading of all the Board's rules together makes it clear that a chiropractor's proper use of VONT is not for treating a neurological condition, which is certainly outside the scope of chiropractic, but rather for the limited purpose of determining whether and how to treat a patient's musculoskeletal system. The Legislature has authorized chiropractors "to diagnose . . . the biomechanical condition of the spine and musculoskeletal system".[106] In Rule 78.1, which is presumptively valid, the Board has set out how a VONT test can be used to perform that diagnosis without exceeding the statutory scope of chiropractic. The dissent dramatically concludes that with the Rule's limited authorization of VONT, "limitations on chiropractic practice lose all meaning" and "[a] chiropractor's practice becomes coextensive with a medical doctor's practice".[107] But far from equating chiropractors and physicians, the Board's rules in fact carefully observe the statutory boundary between the two professions.

The dissent also echoes TMA's argument that the Act does not permit chiropractors to make differential diagnoses by ruling out possible neurological causes of a patient's dysfunction. The dissent says that "[t]o 'rule out' a neurological condition based on a neurological examination is to say, affirmatively, that it is not a cause of the patient's symptoms."[108] The accuracy of this characterization is questionable. A more realistic explanation of differential diagnosis is that it is the process every healthcare provider goes through when assessing a patient's symptoms to determine whether it is appropriate to treat the patient or refer the patient elsewhere. An unchallenged

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[105] *Post* at 6.

[106] TEX. OCC. CODE § 201.002(b)(1).

[107] *Post* at 8.

[108] *Id.* at 9.

Board rule expressly addresses this process by requiring chiropractors to refer patients to other healthcare providers when appropriate.[109] Yet the dissent would not allow this routine process to ever take place. The way the dissent sees it, any time a patient goes to a chiropractor with a generalized problem like dizziness that could potentially have a cause outside the scope of chiropractic, the chiropractor must immediately stop treatment and refer the patient to a medical doctor. There is no textual support for this argument in the Act.

Simply put, a healthcare provider cannot diagnose a problem without ruling out other potential causes of the problem. In other words, making a differential diagnosis is an unavoidable part of making a diagnosis. Virtually any problem that a chiropractor treats could potentially have a nonchiropractic source. Accepting the dissent's position would effectively read into the Act a requirement that patients obtain a referral for chiropractic treatment when the Legislature has not imposed one.

In sum, the VONT-authorization rule is presumptively valid,[110] no specific language in the Act forbids chiropractors from performing VONT, and the Board has articulated how a chiropractor might use the test "to diagnose, analyze, examine, or evaluate the biomechanical condition of the spine and musculoskeletal system".[111] Because a § 2001.038(a) suit challenges the facial validity of an agency rule, that must be the end of the inquiry. The court of appeals reasoned that "[s]imply because [VONT] might under some circumstances be useful does not require that chiropractors be able to perform the test".[112] Whether VONT *should* be used by chiropractors is a

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[109] 22 TEX. ADMIN. CODE § 79.2(a)(5).

[110] *Tex. State Bd. of Exam'rs of Marriage & Family Therapists v. Tex. Med. Ass'n*, 511 S.W.3d 28, 33 (Tex. 2017).

[111] TEX. OCC. CODE § 201.002(b)(1).

[112] 566 S.W.3d 776, 787 (Tex. App.—Austin 2018).

policy judgment for the Legislature and the Board, not for the courts.[113] The sole question for courts is whether the text or objectives of the Act forbid chiropractors from using VONT.[114] We hold that they do not.

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Applying the proper standard of review, we conclude that TMA has not carried its burden of demonstrating that the challenged provisions of Rule 78.1 contravene the specific text or the objectives of the Act. Accordingly, we reverse the judgment of the court of appeals in part and render judgment declaring that the challenged provisions are valid.

Nathan L. Hecht
Chief Justice

Opinion delivered: January 29, 2021

[113] *Marriage & Family Therapists*, 511 S.W.3d at 33 ("[W]e must decide this case based on the relevant Texas statutes, not on whether MFTs are qualified to make DSM diagnoses or whether the DSM or other states' laws allow them to.").

[114] *See id.*