



Chiropody and Podiatry: Regulation of the Profession and the Model of Foot Care in Ontario

Volume 1



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Health Professions Regulatory
Advisory Council

August 31, 2015

The Honourable Dr. Eric Hoskins
Minister of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4

Dear Minister,

The Health Professions Regulatory Advisory Council (HPRAC) is pleased to present this report, which provides an analysis of the current model of foot care in Ontario, considers whether there should be changes to existing legislation governing chiropodists and podiatrists, and examines issues of restricted titles and whether the existing legislation which prohibits the registration of new podiatrists should continue.

As part of our assessment process, we completed a jurisprudence review and two literature reviews, which included information on foot care in other jurisdictions. We also conducted two extensive consultation programs with a broad group of stakeholders.

In developing our advice, HPRAC follows a process that is thorough, timely and efficient, and reflects the principles of independence, fairness, transparency and evidence-based decision-making. HPRAC's recommendations related to the regulation of chiropody and podiatry are based on its assessment of the profession's ability to meet the criteria for a change in scope of practice, and the need for such a change.

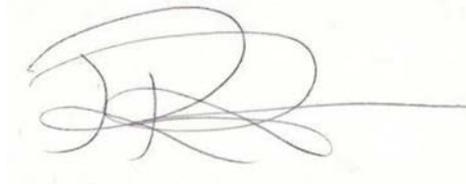
Using these criteria, HPRAC found that the applicant did not satisfy HPRAC's criteria for a scope of practice change and that no changes should be made at this time to the current legislation that prohibits the registration of new podiatrists in Ontario. HPRAC did find that changes should be made to titles within the profession and that the list of drugs available to the profession should be reviewed.

We look forward to meeting with you to discuss the findings and recommendations in this report.

Sincerely,



Thomas Corcoran, Chair

A stylized, cursive handwritten signature consisting of several overlapping loops and a long horizontal tail stroke.

Rex Roman, Vice Chair

A cursive handwritten signature that reads "Robert Carman" in a fluid, connected script.

Bob Carman, Member

A cursive handwritten signature that reads "Jeanette Dias D'Souza" in a fluid, connected script.

Jeanette Dias D'Souza, Member

A cursive handwritten signature that reads "Said Tsouli" in a fluid, connected script.

Said Tsouli, Member

Chiropody and Podiatry: Regulation of the Profession and the Model of Foot Care in Ontario

Report by the Health Professions Regulatory Advisory Council

August 2015

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Executive Summary

Overview

In June 2007, the Minister of Health and Long-Term Care, the Honourable George Smitherman, asked the Health Professions Regulatory Advisory Council (HPRAC) to “review issues relating to the regulation of chiropody and podiatry and provide advice as to whether and how there should be changes to existing legislation.” The Minister also asked that HPRAC include in its review “an analysis of the current model of foot care in Ontario, issues regarding restricted titles, and whether the existing limitation on the podiatrist class of members should continue.”¹

In March 2010, the Minister wrote to HPRAC, noting that “regulation is currently in place which is effective,” and asked that work not commence on this referral until advice on the regulation of diagnostic sonographers, dental assistants and paramedics was submitted.² No date was given as to when HPRAC was to provide its advice to the Minister.

In May 2013, the Minister directed that HPRAC start its work on the referral no later than January 1, 2014.³

Chiropodists are regulated health professionals who assess, treat and prevent diseases and disorders of the foot by orthotic, therapeutic and palliative means. Chiropodists assist in the reduction or elimination of foot pain, and improve the mobility and function of the foot. They treat a variety of injuries and conditions related to the foot, including corns, warts, ingrown toenails and fungal or bacterial infections. Patient care from a chiropodist may include routine nail care, but can also extend to nail and soft tissue surgery. Chiropodists are regulated under the *Chiropody Act, 1991*.

Podiatrists are also regulated health professionals, similar to chiropodists, in terms of their scope of practice and practice location; however, important distinctions exist between the two professions. Much like chiropodists, podiatrists examine, treat and prevent foot disorders. However, unlike chiropodists, podiatrists in Ontario are permitted to communicate a diagnosis that identifies a disease or disorder of the foot, and may also cut into the bony tissue of the forefoot (i.e., perform bone surgery). Since 1991, Ontario legislation has prohibited the registration of new podiatrists in the province. Podiatrists are also regulated under the *Chiropody Act, 1991* as a separate class within the College of Chiropodists of Ontario (COCOO, or “the college”).

¹ Letter from George Smitherman, Minister of Health and Long-Term Care, to Barbara Sullivan, HPRAC Chair, June 28, 2007.

² Letter from Deb Matthews, Minister of Health and Long-Term Care, to Barbara Sullivan, HPRAC Chair, March 26, 2010.

³ Letter from Deb Matthews, Minister of Health and Long-Term Care, to Tom Corcoran, HPRAC Chair, May 7, 2013.

HPRAC's Process

For the referral, HPRAC undertook a multi-staged process that began with preliminary research and analysis, as well as a consultation on the model of foot care. After completing this work, HPRAC identified COCOO as the applicant for potential changes to existing legislation. The college subsequently submitted a proposal to HPRAC for an expanded scope of practice. HPRAC then carried out a second consultation on the regulation of the profession. This was followed up by further research, analysis and recommendation development.

HPRAC's Analysis of Ontario's Model of Foot Care

Having completed its analysis of the model of foot care, HPRAC learned that proper foot function can have an important impact on an individual's health and quality of life. Foot care services are particularly important for the elderly, individuals with diabetes, Aboriginal people and marginalized populations, who were identified as those most likely to require foot care services. HPRAC also learned that there are a variety of health care professionals and practitioners (e.g., chiropodists, podiatrists, physicians, nurses, orthotists, personal support workers and others) providing foot care in a number of settings (private practices, hospitals, family health teams, in the home and community, etc.) in Ontario. Although HPRAC heard about many challenges with the model of foot care in Ontario, particularly around access, it also learned about many centres of excellence in the province that excel at maintaining the foot health of Ontarians.

Coming out of its analysis of the model of foot care, HPRAC suggests that the Minister consider enhancing access to foot care services and devices by examining whether the health care system can avoid costly foot surgeries (especially amputations) through a focus on prevention.

HPRAC's Recommendations on the Regulation of Chiropody and Podiatry

Having concluded its review of the model of foot care in Ontario and the applicant's request for an expanded scope of practice, HPRAC members were united in their understanding that a number of issues raised by the applicant and stakeholders are of great importance to Ontarians.⁴

It should be noted that HPRAC's review of the application for an expanded scope of practice did not include an assessment of the merits of the profession. HPRAC used its criteria from a *Review of a Professional Scope of Practice under the Regulated Health Professions Act, 1991*,⁵ to evaluate the application for an expanded scope of practice. Applications from professions

⁴ HPRAC identified COCOO as the applicant for potential changes to existing legislation. Please see Chapter IIIIV for further details on the applicant.

⁵ For further information, see

http://www.hprac.org/en/projects/resources/Scope_of_Practice_Review_Application_Guide.pdf.

seeking a scope of practice increase under the *Regulated Health Professions Act, 1991*, are viewed as “subject matter experts”. As such, they must satisfy the criteria for a change in their scope of practice and must demonstrate, with evidence, the need for such a change.

Having conducted its review of the regulation of chiropody and podiatry in Ontario, HPRAC has recommended:

- transitioning those practitioners currently registered as “chiropodists” to the title “podiatrist”;
- transitioning those currently registered as “podiatrists” to the title “podiatric surgeon”;
- transitioning the title of the college from the College of Chiropodists of Ontario to the College of Podiatrists of Ontario (the college may choose another title in so far as it responds to the changes to the title of registrants);
- amending the title of the *Chiropody Act, 1991* to reflect the changes to title; and
- the Ministry consider re-evaluating the current list of medications available to the profession as new and more effective drugs not previously approved under governing regulations may be available.

However, based on the application of HPRAC’s criteria to the submission received by the applicant, and on additional information available at the time of writing, HPRAC has recommended:

- no scope of practice increase;
- no expansion of controlled and authorized acts; and
- no changes should be made at this time to the current limitation on the registration of podiatrists in Ontario.

HPRAC’s decision was based on a number of factors, including the following recurring observations:

- The applicant failed to acknowledge the risk of harm associated with the controlled acts requested, particularly as it related to communicating a diagnosis, performing ankle and foot surgery or ordering and applying x-rays. As a result, the applicant did not demonstrate how it would mitigate that risk and ensure that practitioners have the requisite knowledge, skill, training and judgment to provide care according to evidence-based best practices.
- The applicant did not provide a well-reasoned, evidence-based rationale supporting the proposed expanded scope of practice.
- There were few, if any, limitations imposed on the requested controlled and authorized acts. The applicant did not provide clear anatomical boundaries for the surgeries it would perform nor did it provide clear limitations on the diseases that practitioners would diagnose.
- The proposed scope of practice increase focused on a model of care centred on advanced foot and ankle surgery; these procedures do not, as noted by stakeholders, address the most significant need for Ontarians — routine, publicly accessible, preventative foot care.
- The applicant did not adequately demonstrate how it would ensure that practitioners have the requisite knowledge, skill, training and judgment to perform the requested acts and authorities. Few details were provided about the content of a bridging program for

practitioners, what would satisfy residency requirements, if any, and whether or not accreditation would be required and, if so, what would constitute this requirement.

In addition to the considerations and recommendations noted above, HPRAC would like to bring a number of matters to the attention of the Minister that came out of its analysis of the model of foot care generally and its recommendations related to the regulation of chiropody and podiatry specifically:

- The Minister may wish to consider establishing foot and ankle surgery as a quality-based procedure to reduce wait times and improve efficiencies.
- The Minister may wish to consider how chiropodists and podiatrists can be further integrated into interprofessional care (IPC) teams where foot care services are publicly accessible.
- The Minister may wish to consider asking COCOO to develop an inspection program for podiatrists who are currently performing surgery in an out-of-hospital setting.
- The Minister may wish to consider the following policy questions that were raised but were beyond the scope of the referral, which include: a) whether foot care services and devices should be publicly funded and b) whether the foot care needs of Ontarians require a greater role for chiropodists and podiatrists in foot surgery or if the needs of Ontarians can be met through the existing supply of health care providers.

Chapter I: Background on the Referral

Referral Question

In June 2007, the Minister of Health and Long-Term Care asked HPRAC to “review issues relating to the regulation of chiropody and podiatry and provide advice as to whether and how there should be changes to existing legislation.” The Minister also asked that HPRAC include in its review “an analysis of the current model of foot care in Ontario, issues regarding restricted titles, and whether the existing limitation on the podiatrist class of members should continue.”⁶

In March 2010, the Minister wrote to HPRAC, noting that “regulation is currently in place which is effective,” and asked that work not commence on this referral until advice on the regulation of diagnostic sonographers, dental assistants and paramedics was submitted.⁷ No date was given on when HPRAC was to provide its advice to the Minister.

In May 2013, the Minister directed that HPRAC start its work on the referral no later than January 1, 2014.⁸

HPRAC’s Process

When a referral is received from the Minister of Health and Long-Term Care, HPRAC determines relevant public interest concerns and questions. HPRAC attempts to understand all perspectives on an issue, including those of regulated and unregulated health care providers, other affected health care professionals, clients and patients, advocates and regulators. Each issue proceeds through a multi-stage process in which information and responses are requested from and shared with stakeholders.⁹

HPRAC’s process for this referral was comprised of two stages and consisted of the following major milestones:

- preliminary research and analysis by HPRAC;
- an initial consultation on the model of foot care in Ontario, including key informant interviews;
- completion of the proposal by the applicant;
- a second consultation on the regulation of chiropody and podiatry, including key informant interviews and site visits; and
- data analysis/validation, recommendation development and submission of the final report to the Minister.

⁶ Letter from George Smitherman to Barbara Sullivan, June 28, 2007.

⁷ Letter from Deb Matthews to Barbara Sullivan, March 26, 2010.

⁸ Letter from Deb Matthews, Minister of Health and Long-Term Care, to Tom Corcoran, HPRAC Chair, May 7, 2013.

⁹ HPRAC, Current Ministerial Referrals, http://www.hprac.org/en/projects/Chiropody_Podiatry.asp.

Part I: The Model of Foot Care

Chapter II: The Foot and Foot Care Delivery

As part of the chiropody and podiatry referral from the Minister of Health and Long-Term Care, HPRAC was asked to carry out “an analysis of the current model of foot care in Ontario.”¹⁰ Subsequently, HPRAC conducted significant research on the practice of foot care in the province and beyond.

The model of foot care in Ontario, as assessed by HPRAC, exists as an ill-defined model made up of a series of often independent parts. As noted by the Ontario Podiatric Medical Association (OPMA) in the first of HPRAC’s consultations, “there is no current, organized or easily identifiable model for foot care in Ontario.”¹¹ HPRAC observed that, while linkages exist between the various parts of the foot care sector, these linkages often function autonomously of one another, with multiple practitioners and providers working separately or, sometimes, in teams, to provide care. This was consistent with available evidence from other jurisdictions, which suggests a lack of clearly defined models of foot care.

One assessment of the model of foot care provided by a stakeholder noted that “Ontario’s ‘current foot care model’ is multidisciplinary and multifaceted along a continuum of care. This foot care ‘model’ is not defined by legislation or policy, cannot be said to be integrated or comprehensive and has evolved over time and continues to evolve in response to health care system demands and the needs and choices of patients.”¹²

To better understand Ontario’s current model of foot care, HPRAC engaged with a variety of stakeholders during multiple consultations, and spoke with a diverse group of key informants. One universal characteristic HPRAC noted was the sincerity with which respondents spoke about the importance of foot health.

What is the Foot?

Before conducting an analysis of the model of foot care, it is important to first have a basic understanding of foot anatomy. The foot is made up of more than 100 muscles, tendons and ligaments, 33 joints, 26 bones, and a network of nerves, blood vessels and other soft tissues.¹³ HPRAC learned that the foot is typically understood as divided into three parts: the forefoot, midfoot and hindfoot. The forefoot includes an individual’s toes and the bones attached to these

¹⁰ Letter from George Smitherman to Tom Corcoran, June 28, 2007.

¹¹ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part I: Surveys Submitted Online*, 75, http://www.hprac.org/en/reports/resources/Chiropody_Consultation_1_PART_1_2014-07-24.pdf.

¹² Ibid.

¹³ Health Communities, Foot Anatomy, accessed April 14, 2015, <http://www.healthcommunities.com/foot-anatomy/foot-anatomy-overview.shtml>.

toes (metatarsals). The midfoot is the collection of bones that form the arches of an individual's feet. The hindfoot comprises the heel and ankle.¹⁴

It should be noted that the applicant's submission for an expanded scope of practice, which will be discussed in detail later in this report, requested a scope that includes the ankle. HPRAC learned that the ankle joint proper is a separate entity, while the foot is considered to be everything distal to it.¹⁵ A scope of practice that includes structures that cross the ankle — part of the hindfoot — would include muscles of the lower leg, those below the knee and one muscle that inserts above the knee.¹⁶

What is Foot Care?

Foot care in Ontario ranges from services that are delivered by unregulated individuals, such as estheticians providing cosmetic services and nail care, to regulated health care professionals, such as orthopaedic surgeons, who perform surgery in a hospital operating room.

Services provided to treat the foot may include routine, less invasive treatments, but may also consist of more complex care; these may or may not involve the application of controlled acts. Under s. 27(2) of the *Regulated Health Professions Act, 1991* (RHPA)¹⁷, 13 procedures are listed that, if not performed by a qualified practitioner, may pose a risk of harm to the public. These procedures are known as “controlled acts.” In Ontario, controlled acts may only be performed by authorized health care professionals or those who have been delegated the act by an authorized professional or as otherwise authorized under the Act.¹⁸

Procedures performed during the delivery of foot care include: routine nail care of high risk patients, nail care for various pathological nail conditions and infections, the treatment of corns, calluses, warts and other skin conditions like athlete's foot (tinea pedis), the assessment and treatment of various biomechanical conditions including flat feet, heel pain, plantar fasciitis¹⁹, wound debridement²⁰, applying topical medicines and bandages, wrapping the foot²¹, applying electrical modalities, massage and stretching²², and the casting and dispensing of orthotics and prosthetics.²³ HPRAC considers these services and procedures to be “routine foot care.” While HPRAC considers these services and procedures to be “routine foot care”, this should not diminish the complexity of these procedures, nor their importance to an individual's health. The majority of the procedures performed during the delivery of routine foot care are not controlled acts.

¹⁴ WebMD, image collection, Human Anatomy, accessed March 16, 2015, <http://www.webmd.com/pain-management/picture-of-the-feet>.

¹⁵ Email from Dr. Mark MacLeod, orthopaedic surgeon, Victoria Hospital, to HPRAC Secretariat, March 5, 2015.

¹⁶ Email from Dr. Timothy Daniels, orthopaedic surgeon, St. Michael's Hospital, to HPRAC Secretariat. March 13, 2015.

¹⁷ S.O. 1991, c.18. <http://www.ontario.ca/laws/statute/91r18>

¹⁸ RHPA, s. 27 and s. 29.

¹⁹ Key informant interview, chiropodist, Danforth Chiropody.

²⁰ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part I: Surveys Submitted Online*, 85.

²¹ COCOO submission, additional questions, 7.

²² *Ibid.*, 8.

²³ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part I: Surveys Submitted Online*, 85.

Foot care services also include the performance of more complex procedures, such as: surgical procedures on the nail, surgical procedures on soft tissue to treat warts and neuromas²⁴, and surgery on the bone, such as an intervention to repair a hammertoe, amputation of a toe, repairing of an Achilles tendon, fixing a fracture and other surgical procedures.²⁵ These procedures are controlled acts. Care may also include rehabilitation once a procedure has been performed.²⁶

These services and procedures may be carried out during the treatment of a variety of conditions and illnesses, such as arthritic deformities, blisters, bunions, foot and ankle injuries, ingrown toenails, ulcers and other skin and nail problems related to the foot.²⁷

Whether it is routine or complex, a patient's foot care may begin with an assessment of the foot,²⁸ which may or may not result in the development of an individualized care plan that could include specific treatments²⁹ and/or the provision of health education about how to properly care for the foot or manage a disease or condition that affects the health of the patient's feet.³⁰

Where is Foot Care Delivered and How is It Paid For?

During HPRAC's consultations, a number of settings for foot care delivery were identified. The list below provides a brief description of some of the practice settings where foot care is delivered in Ontario:

- **Private practices:** Foot care is provided in individual practice settings, often with a sole practitioner working in a private practice.³¹ A sole practitioner may be a podiatrist, chiropodist, physician or other regulated or unregulated health care provider. Services offered in private practice locations typically require private payment; this payment may or may not include coverage by a third-party insurance provider.³² Certain services provided by a physician related to foot care, such as an assessment, consultation and treatment of certain conditions³³ can be billed to OHIP.³⁴ Podiatric services, to a

²⁴ Key informant interview, chiropodist, Danforth Chiropody.

²⁵ COCOO, submission, additional questions, 6

²⁶ COCOO submission, additional questions, 5.

²⁷ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part II(b): Other Submissions*, 164, http://www.hprac.org/en/reports/resources/Chiropody_Consultation_1_Part_2b_2014-07-30.pdf.

²⁸ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part I: Surveys Submitted Online*, 12.

²⁹ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part II(b): Other Submissions*, 163.

³⁰ Note that this should not be considered an exhaustive list of all the various forms of foot care that may be delivered within this complex sector.

³¹ COCOO submission, 22.

³² North York General Hospital, Central LHIN Centre for Complex Diabetes Care, accessed March 17, 2015, <http://www.nygh.on.ca/Default.aspx?cid=1981>.

³³ Quarry Foot Clinic, About Your Doctor, accessed August 10, 2015, <http://www.mydoctor.ca/user/ASP/about.asp?id=1627>.

maximum of \$135 annually, can be billed to OHIP.³⁵

- **Patients' homes:** Many individuals receive foot care within their own home, through home care services.³⁶ Home care in Ontario may be privately purchased,³⁷ organized by a Community Care Access Centre (CCAC)³⁸ or coordinated through a hospital clinic.³⁹ CCACs coordinate services for Ontarians who require health care services in order to live independently. Services provided by CCACs are publicly funded.⁴⁰
- **Primary Health Care Organizations:** Primary health care organizations, such as Family Health Teams (FHT) are “organizations that include a team of family physicians, nurse practitioners, registered nurses, social workers, dietitians, and other professionals who work together to provide primary health care for their community.”⁴¹ While the makeup of FHTs varies considerably in Ontario, FHTs may employ a chiroprapist or podiatrist to provide foot care to patients within its community.⁴² While the services provided by FHTs are publicly funded, FHTs are not set up to collect payment for devices. As a result, chiroprapists are not able to dispense devices in this setting due to the fact that these devices typically require private payment.⁴³
- **Hospitals:** As noted by the applicant and by stakeholders during consultations, chiroprapists and podiatrists are working less frequently in hospitals and other institutional settings.⁴⁴ HPRAC did visit two hospital-based clinics that were devoted to foot care. These clinics treat patients with complex needs, and focus on interprofessional care (IPC). For example, at one clinic visited by HPRAC, care is delivered by a team composed of a chiroprapist, a registered nurse, two to three cast technicians, clerical assistants, a resident and one to two fellows. Services provided by hospitals are publicly funded; however, certain devices require private payment by patients.⁴⁵
- **Long-Term Care Homes:** An individual will often become a resident of a long-term care home when there is no longer sufficient support for the person to live at home. Residents typically require significant physical care and may or may not be suffering from a disease such as Alzheimer's or some form of dementia.⁴⁶ As noted by the

³⁴ Health First, Physician Info, accessed August, 6, 2015, <http://www.healthfirstwellnesscentre.ca/physician-info.htm>.

³⁵ Ontario Podiatric Medical Association, Patient Information Sheet, accessed July 14, 2015, <http://www.opma.ca/Resources/Documents/OPMA%20OHIP%20%20Priv%20Ins%20-%20Patient%20fact%20sheet%20-%20V1%208%20-%20July%202014.pdf>.

³⁶ COCOO submission, additional questions, 7.

³⁷ HPRAC, *Stakeholder Feedback on the Chiroprapody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part I: Surveys Submitted Online*, 17.

³⁸ COCOO submission, 38.

³⁹ Key informant interview, St. Michael's Hospital Foot/Fracture Clinic.

⁴⁰ MOHLTC, Community Care Access Centres, accessed March 17, 2015, <http://www.health.gov.on.ca/en/public/contact/ccac>.

⁴¹ MOHLTC, Family Health Teams, accessed January 19, 2015, <http://www.health.gov.on.ca/en/pro/programs/fht>.

⁴² Key informant interview, executive director, Queen Square Family Health Team.

⁴³ Ibid.

⁴⁴ COCOO submission, additional questions, 22.

⁴⁵ Email from Joan Mothersill, administrative/clerical coordinator, St. Michael's Foot/Fracture Clinic, to HPRAC Secretariat, Friday March 6, 2015.

⁴⁶ Ontario Association of Non-Profit Homes and Services for Seniors, Tell Me More About Long Term Care Homes, accessed August 12, 2015,

applicant, “Subsection 35. (1) of Ontario Regulation 79/10 under the *Long-Term Care Homes Act* requires every home to ensure that each resident receives preventive and basic footcare services, including the cutting of toenails, to ensure comfort and to prevent infection.”⁴⁷ Services provided by chiropodists and podiatrist in long-term care homes are funded in a variety of ways, including: by the long-term care home, by the resident or by some form of private insurance. In the case of a podiatrist, part of his or her services may be billed to OHIP.⁴⁸ As noted by the applicant, in Ontario there are currently 630 long-term care homes, in which approximately 77,000 residents reside.⁴⁹

- **Centres for Complex Diabetes Care (CCDC):** CCDCs offer time-limited treatment and management for individuals whose diabetes and related conditions require a more intensive and comprehensive team-based approach.⁵⁰ The programs offer “specialized diabetes education, management and treatment.”⁵¹ An individual may access a CCDC based on a referral from a physician.⁵² A typical CCDC team consists of a physician, nurse practitioner, registered nurse, registered dietitian, social worker, pharmacist and chiropodist. CCDCs may also include a physiotherapist, kinesiologist, psychologist or psychiatrist. There are currently six CCDCs operating across Ontario.⁵³ Services provided at CCDCs are publicly funded; however, certain devices require private.⁵⁴
- **Diabetes Education Program (DEP):** DEPs assist individuals in managing diabetes through education, nutrition counselling, outreach and monitoring behaviour and patient outcomes. A DEP team consists of a registered dietitian and a registered nurse. Certain communities may also have a DEP that has access to a nurse practitioner, chiropodist and social worker. There are 152 DEPs in Ontario.⁵⁵ Services provided at DEPs are publicly funded and are available in hospitals, community health centres and other settings.⁵⁶
- **Aboriginal Diabetes Initiatives:** These programs focus on the development and enhancement of services and programs that educate, prevent and manage people with diabetes in Aboriginal communities on and off reserve. Practitioners visit Aboriginal, Métis and Inuit communities, upon request, to establish temporary foot clinics.⁵⁷ Individuals access the programs through a variety of partners, including Aboriginal friendship centres, Native women’s groups, etc. Services by one such program, the

http://www.oanhss.org/OANHSS/Consumers/About_Long_Term_Care/OANHSS/Navigation/Consumers/AboutLongTermCare/About_LTC.aspx.

⁴⁷ COCOO submission, additional questions, 39.

⁴⁸ Ibid., 24-25.

⁴⁹ Ibid., 39.

⁵⁰ Email from Rose Dumsha, Clinical Team Manager, Diabetes Centre, to HPRAC Secretariat, March 13, 2015.

⁵¹ MOHLTC, Stand Up to Diabetes, accessed January 19, 2015.

<http://www.health.gov.on.ca/en/pro/programs/diabetes/ccdc.aspx>.

⁵² Ibid.

⁵³ Ibid.

⁵⁴ North York General, Central LHIN Centre for Complex Diabetes Care.

⁵⁵ Email from Rena Menaker, Manager, Health System Accountability and Performance Division, to HPRAC Secretariat, October 6, 2014.

⁵⁶ MOHLTC, Diabetes Education Program, accessed April 10, 2015, <https://www.ontario.ca/health-and-wellness/diabetes-education-program>.

⁵⁷ Southern Ontario Diabetes Initiative, SOADI’s Foot Care Program, accessed March 7, 2015, <http://www.soadi.ca/footcarecarljones/documents/FootCareSnapshot.pdf>.

Southern Ontario Aboriginal Diabetes Initiative, are typically publicly funded.⁵⁸

⁵⁸ Ibid.

Chapter III: Who is the Patient?

Although foot care services may be required by many kinds of Ontarians, it became evident during HPRAC’s consultations that there are specific individuals/groups that are most likely to require foot care services.

The Elderly

Those over the age of 65 are approximately two-and-a-half times more likely to suffer from foot pain than individuals who are 35 years old or younger.⁵⁹ The elderly are often subject to a number of acute foot problems, such as skin and nail issues, ulcers and other types of foot wounds.⁶⁰ While an elderly individual may be otherwise healthy, many have foot problems, which increases the risk of falls.⁶¹ Moreover, elderly Ontarians are often affected by conditions such as vascular disease or diabetes, which can cause issues in the extremities, including the feet. A major symptom of diabetes, for example, is peripheral neuropathy, which can result in a loss of sensation in the feet. This can affect the ability to walk normally, to balance or to sense an injury or infection.⁶²

Individuals with Diabetes

Diabetes is of particular importance to foot health and is not restricted to elderly populations. Complications from diabetes can cause significant foot problems, including ulceration, infection and even the need for amputation.⁶³ The Canadian Association of Wound Care notes that there are currently “nearly 2.3 million Canadians living with diabetes of whom approximately 345,000 will develop a foot ulcer.”⁶⁴ Approximately 14-24% of patients with leg and foot ulcers require amputation.⁶⁵ Amputation is associated with an increased risk of mortality; 69% of these patients will not survive beyond five years after amputation, and 30% will die within one year of amputation.⁶⁶

Regular foot assessment is recommended for people with diabetes for the prevention and early detection of foot problems. HPRAC heard, however, that foot assessment is not occurring with the frequency that it should to maintain a healthy foot.⁶⁷ A diabetic foot, if not properly

⁵⁹ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part I: Surveys Submitted Online*, 103.

⁶⁰ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part II(b): Other Submissions*, 164.

⁶¹ *Ibid.*

⁶² Canadian Federation of Podiatric Medicine, *Seniors Needs Regulatory Podiatric Check-Ups*, accessed October 24, 2014, <http://www.podiatryinfocanada.ca/Public/Seniors-Need-Regular-Podiatric-CheckUps>.

⁶³ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part II(b): Other Submissions*, 164.

⁶⁴ COCOO submission, 41.

⁶⁵ Ontario Wound Care, *Diabetes Mellitus*, accessed August, 6, 2015, <http://www.ontariowoundcare.com/diabetes.htm>.

⁶⁶ COCOO submission, 41.

⁶⁷ “Action 2014 – Skin Health Canada Conference,” October 31, 2014.

maintained, can result in a small blister, which can turn into a wound that is at risk of infection if it does not heal. Those with diabetes suffer from an increased likelihood of infection spreading.⁶⁸

Aboriginal Populations

Foot care issues are of particular concern for Aboriginal populations because of the high incidence of diabetes. In one study reviewed by HPRAC, diabetes prevalence rates for First Nations and Inuit peoples, when age-adjusted to the Canadian population, were almost four times higher for men and more than five times higher for women than amongst non-Aboriginal Canadian men and women.⁶⁹

Foot care issues for Aboriginal populations are also compounded by the challenges accessing services because of the remote geographical location of many Aboriginal communities. For example, northern communities often face shortages of health care professionals. As noted by one stakeholder, “There are 26 Chiropodists/Podiatrists in Northeastern Ontario covering 500,000 square km of land and the highest incidence of soft tissue foot infections and leg ulcers across the Province. The 26 professionals are located in only 7 of the communities in the region, requiring patients to travel significant distances to access foot care and management.”⁷⁰

Marginalized Populations

Homeless and other marginalized populations also face an increased likelihood of developing foot problems as a result of a number of factors, including: exposure to moisture and trauma, prolonged standing and walking, improper footwear and poor living conditions. These populations often face difficulty accessing foot care services because of their precarious living circumstances, lack of ability to pay for private foot care and a lack of proper identification, such as an OHIP card.⁷¹

⁶⁸ Canadian Federation of Podiatric Medicine, Common Conditions and Treatments, accessed October 24, 2014, <http://www.podiatryinfoCanada.ca/Public/Foot-and-Heel-Conditions>.

⁶⁹ Singh, N., Armstrong, D.G. & Lipsky, B.A, “Preventing Foot Ulcers in Patients with Diabetes,” *Journal of the American Medical Association*, (2005): 293(2), 217.

⁷⁰ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part II(b): Other Submissions*, 74.

⁷¹ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part II(b): Other Submissions*, 163-4.

Chapter IV: Who Provides Foot Care in Ontario

A number of providers and professionals deliver foot care in Ontario. These individuals may be unregulated professionals who provide routine foot care, or regulated health care professionals who offer a range of services, from routine foot care to more complex care requiring the use of controlled acts. The descriptions below detail the range of foot care services these individuals deliver.

Regulated Providers

Chiropodists and Podiatrists

Chiropodists are regulated health professionals⁷² who assess, treat and prevent diseases and disorders of the foot by orthotic, therapeutic and palliative means.⁷³ Chiropodists assist in the reduction or elimination of foot pain and improve the mobility and function of the foot. They treat a variety of injuries and conditions related to the foot, including corns, warts, ingrown toenails and fungal or bacterial infections.⁷⁴ Patient care from a chiropodist may include routine nail care, but can also extend to nail and soft tissue surgery.⁷⁵

Currently, under the *Chiropody Act, 1991*, chiropodists are authorized to perform a number of controlled acts, including cutting into tissue on the foot, administering prescribed substances by injections into the foot, prescribing drugs specified in the regulations and administering a substance specified in the regulation by inhalation (chiropodists cannot currently perform this latter act, however, because a regulation has not yet been made under the Act identifying what substance they may administer in this manner).⁷⁶ In 2013, 568 chiropodists were registered to practise with COCOO.⁷⁷

Chiropodist services and devices are primarily paid for privately⁷⁸; however, as noted in the “Where is Foot Care Delivered and How is It Paid For?” section in Chapter II, chiropodists and podiatrists may also practise in settings that are publicly funded.

Podiatrists are regulated health professionals⁷⁹ and are similar to chiropodists in terms of their scope of practice and practice location. However, important distinctions exist between the two

⁷² Chiropodists are regulated under the *Chiropody Act, 1991* (S.O. 1991, c. 20, accessed January 22, 2015, <http://www.ontario.ca/laws/statute/91c20>) and the *Regulated Health Professions Act, 1991*, (RHPA) as well as other relevant legislation.

⁷³ Health Force Ontario, *Health Human Resources Toolkit*, accessed January 22, 2015,

<https://www.healthforceontario.ca/UserFiles/file/PolymakersResearchers/hhr-toolkit-april-2007-en.pdf>.

⁷⁴ Ibid.

⁷⁵ Ibid.

⁷⁶ *Chiropody Act, 1991*.

⁷⁷ COCOO submission, 15.

⁷⁸ COCOO submission, additional questions, 24.

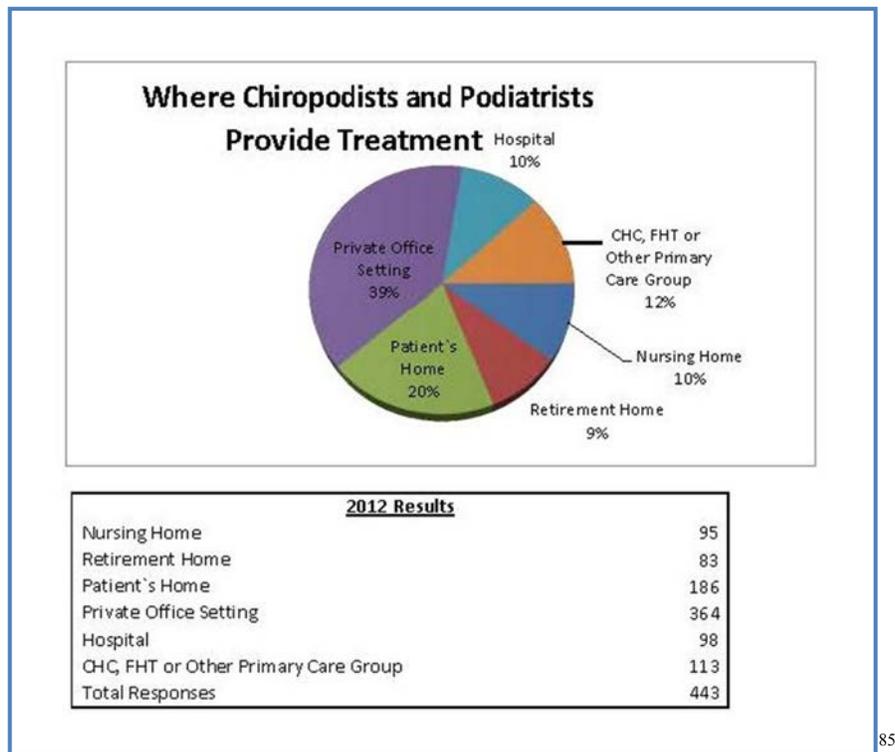
⁷⁹ Podiatrists are regulated under the *Chiropody Act, 1991*, and the RHPA, as well as other relevant legislation.

professions. Much like chiropodists, podiatrists examine, treat and prevent foot disorders. However, unlike chiropodists, podiatrists in Ontario are permitted to communicate a diagnosis that identifies a disease or disorder of the foot; they may also cut into the bony tissue of the forefoot (i.e., perform bone surgery).^{80,81} Only a portion of the cost of podiatric services can be billed to OHIP (a maximum of \$135 annually) with the remainder typically paid for privately.⁸²

In 2013, 69 podiatrists were practising in Ontario.⁸³ Since 1991, Ontario legislation has prohibited the registration of new podiatrists in the province.⁸⁴

Chiropodists and podiatrists work in a number of different settings (see Figure 1).

Figure 1: Practice Settings for Chiropodists and Podiatrists in Ontario (2012)



Although chiropodists and podiatrists currently work primarily in private practice settings, until the early 1990s, chiropodists often worked as salaried employees in hospitals, community health centres and other institutions, as part of multidisciplinary teams. It was noted by OPMA in the first consultation that, by the early 1990s, the “deinstitutionalization” of chiropody from hospitals was “well underway,” resulting in the closure of chiropody clinics at these sites. As explained to HPRAC, as a result of this change, chiropody services that were never covered by

⁸⁰ Health Force Ontario, Health Human Resources Toolkit.

⁸¹ *Chiropody Act, 1991*.

⁸² COCOO submission, additional questions, 25.

⁸³ COCOO submission, 15.

⁸⁴ *Chiropody Act, 1991*.

⁸⁵ *Ibid.*, 41.

OHIP ended up moving from publicly funded hospitals to privately funded, private practice settings.⁸⁶

Chiropractors

Chiropractors are regulated health professionals⁸⁷ who provide a number of different foot care services, including the application of electrical modalities, massage, stretching, prescription of exercise and the prescription of orthotics.⁸⁸ Chiropractors can also take and order radiographs for diagnostic purposes.⁸⁹ They are “educated in the management of patients with foot pain, including the use of orthotic devices.”⁹⁰ For the year 2013-2014, 4,517 members of the College of Chiropractors of Ontario (CCO) were registered to practise in the province.⁹¹ Chiropractic services are predominantly privately paid for in Ontario.⁹²

Nurses

Registered nurses (RNs), registered practical nurses (RPNs) and nurse practitioners (NPs) (collectively referred to as “nurses”) are regulated health care professionals⁹³ who provide foot care in a variety of care settings, including long-term care homes, hospitals, CCDCs, FHTs, physician offices, in the community, such as in a client’s home or through outreach clinics.^{94,95} Nurses assess patients, provide preventative care and educate and refer patients to other practitioners where necessary. They also provide non-invasive foot care services, such as clipping nails, paring calluses and corns, debriding morbid tissue, treating ulcers, providing wound care, monitoring conditions of the foot, prescribing and dispensing orthotics, and wrapping and bandaging the feet.⁹⁶

According to the College of Nurses of Ontario, in 2014 there were approximately 148,678 nurses (RNs, RPNs and NPs) registered to practise in Ontario.⁹⁷ Approximately 1,000 of these nurses

⁸⁶ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part II(b): Other Submissions*, 54.

⁸⁷ Chiropractors are regulated under the *Chiropractic Act, 1991*, S.O. 1991, c.21, the RHPA and other relevant legislation.

⁸⁸ COCOO submission, additional questions, 8.

⁸⁹ Ibid. 9.

⁹⁰ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part I: Surveys Submitted Online*, 108.

⁹¹ College of Chiropractors of Ontario (CCO), *Annual Report 2013*, accessed January 21, 2015, http://www.cco.on.ca/site_documents/CCO_Annual_Report13_web.pdf.

⁹² Ontario Chiropractic Association (OCA), *Chiropractic Coverage*, accessed March 5, 2015, <http://www.chiropractic.on.ca/chiropractic-coverage#.VO-EXZTXIdU>.

⁹³ Nurses in Ontario are regulated under the *Nursing Act, 1991*, the RHPA and other relevant legislation.

⁹⁴ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part I: Surveys Submitted Online*, 85.

⁹⁵ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part II(b): Other Submissions*, 163.

⁹⁶ COCOO submission, additional questions, 7.

⁹⁷ Key informant interview, MOHLTC, Health Workforce Evidence & Innovation Unit.

self-reported that they were working for at least one employer in the practice activity entitled “Foot Care.”⁹⁸ Care by nurses may be paid for privately or be publicly funded.⁹⁹

Physicians

A number of different physician classes provide foot care to Ontarians, including: family physicians, family physicians specializing in foot care, orthopaedic surgeons, dermatologists, and vascular surgeons. Physicians often work in a private practice location, hospital or other setting.

Family physicians are regulated health professionals¹⁰⁰ who provide varying levels of foot care depending upon their area of practice. As primary care providers to patients, family physicians are often the patient’s first contact within the health care system when dealing with health care issues related to the foot. Family physicians conduct foot screenings, which assist with the management of potential health care concerns related to the foot. According to the College of Physicians and Surgeons (CPSO), for the year 2013-2014 there were almost 40,000 family physicians practising in Ontario.¹⁰¹

Certain family physicians may specialize in foot care. These specialists may concentrate in the prevention and treatment of ulcerations of the foot and also treat abnormal toenails, calluses and other problems causing pain in the feet.¹⁰²

Dermatologists are regulated health professionals¹⁰³ whose primary role is to treat conditions related to the skin, hair and nails. As many foot issues are related to the skin on the foot, dermatologists will either treat the condition themselves or refer the patient to another health care professional.¹⁰⁴ According to CPSO’s website, at the time the report was written there were more than 260 dermatologists currently practising in Ontario.¹⁰⁵

Vascular surgeons are regulated health professionals¹⁰⁶ who provide medical (e.g., non-surgical treatment such as medication), interventional (e.g., balloons, angioplasties, etc.) and surgical management of blood vessels outside of the heart and brain. Vascular surgeons will often see patients with diabetes or a history of smoking that have narrowings secondary to atherosclerosis, the patients require wound care management or who would benefit from improved circulation in

⁹⁸ Ibid.

⁹⁹ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part II(b): Other Submissions*, 163.

¹⁰⁰ Physicians are regulated under the *Medicine Act, 1991*, S.O. 1991, c.30, the RHPA and other relevant legislation.

¹⁰¹ College of Physicians and Surgeons of Ontario (CPSO), *Annual Report*, accessed March 16, 2015, <http://www.joomag.com/magazine/annual-report-2013/0843094001406570079?short>.

¹⁰² Quarry Foot Clinic, About Your Doctor, accessed January 23, 2015, <http://www.mydoctor.ca/user/ASP/about.asp?id=1627>.

¹⁰³ As physicians, dermatologists are regulated under the *Medicine Act, 1991*, S.O. 1991, c.30, the RHPA and other relevant legislation.

¹⁰⁴ Canadian Dermatology Association (CDA), What is a dermatologist, accessed August 6, 2015, <http://www.dermatology.ca/about/about-dermatology/what-is-a-dermatologist/>.

¹⁰⁵ CPSO, Doctor Search, accessed January 28, 2015, [http://www.cpso.on.ca/Public-Register-Info-\(1\)/Doctor-Search-Results](http://www.cpso.on.ca/Public-Register-Info-(1)/Doctor-Search-Results).

¹⁰⁶ As physicians, vascular surgeons are regulated under the *Medicine Act, 1991*, S.O. 1991, c.30, the RHPA and other relevant legislation.

their feet.¹⁰⁷ According to CPSO’s website, at the time the report was written there were approximately 100 vascular surgeons currently practising in Ontario.¹⁰⁸

Orthopaedic surgeons are regulated health care professionals¹⁰⁹ who diagnose, treat and manage the rehabilitation of patients on matters related to the musculoskeletal system. This includes foot surgery. They also provide preventative protocols for patients suffering from injuries and diseases related to the musculoskeletal system.¹¹⁰

Many orthopaedic surgeons specialize in certain areas, such as the foot and ankle, spine, hip or knee.¹¹¹ These physicians perform a number of different types of surgeries, including arthroscopy (using special cameras to diagnose and treat problems inside a joint), fusion (“welding” bones together with bone grafts) and osteotomy (correction of bone deformity).¹¹²

In 2012, there were 490 orthopaedic surgeons practising in Ontario.¹¹³ According to the applicant, there are currently “25 registered orthopaedic surgeons in Ontario specializing in the foot and ankle.”¹¹⁴ However, the Canadian Orthopaedic Foot and Ankle Society (COFAS), the Ontario Orthopaedic Association (OOA) and the Canadian Orthopaedic Association (COA) noted in their submissions that there are 37 subspecialist orthopaedic foot and ankle surgeons and over 100 general orthopaedic surgeons who perform some foot and ankle surgeries in Ontario.¹¹⁵

Between 2008 and 2012, there was a 13% increase in the number of orthopaedic surgeons in training in Ontario; 166 were in training in 2012, with 30 of these in their last year of training.¹¹⁶

The services provided by physicians are predominantly paid for by OHIP.¹¹⁷

Physiotherapists

Physiotherapists are regulated health professionals¹¹⁸ who provide a number of foot care services in a variety of settings (hospitals, long-term care homes, clinics, etc.).¹¹⁹ Physiotherapists assess and diagnose diseases and disorders and impairments resulting in the loss of function or pain of

¹⁰⁷ Key Informant Interview, vascular surgeon.

¹⁰⁸ CPSO, Doctor Search.

¹⁰⁹ As physicians, orthopaedic surgeons are regulated under RHPA, the *Medicine Act, 1991*, and other relevant legislation.

¹¹⁰ Canadian Orthopaedic Foundation, Glossary, accessed January 20, 2015,

<http://www.canorth.org/en/resources/glossary.asp#O>.

¹¹¹ OrthoInfo, Orthopaedics, accessed October 23, 2014, <http://orthoinfo.aaos.org/topic.cfm?topic=a00099>.

¹¹² Ibid.

¹¹³ Key informant interview, MOHLTC, Health Workforce Evidence & Innovation Unit.

¹¹⁴ COCOO submission, additional questions, 5.

¹¹⁵ HPRAC, *Stakeholder Feedback on the Chiroprody/Podiatry Referral: The Regulation of Chiroprody & Podiatry, Part II: Other Submissions*, 38.

¹¹⁶ Key informant interview, MOHLTC, Health Workforce Evidence & Innovation Unit.

¹¹⁷ MOHLTC, Schedule of Benefits for Physician Services under the Health Insurance Act, accessed April 10, 2015, http://www.health.gov.on.ca/english/providers/program/ohip/sob/physserv/physserv_mn.html.

¹¹⁸ Physiotherapists are regulated under the *Physiotherapy Act, 1991*, S.O. 1991, c. 37 the RHPA, and other relevant legislation.

¹¹⁹ Ontario Physiotherapy Association, Access and Payment, accessed March 5, 2015,

http://www.opa.on.ca/about_phys_acc.shtml.

the foot and ankle.¹²⁰ When delivering care, physiotherapists conduct debridement and wound care, mobilizations and other techniques to increase mobility, prescribe exercises, use therapeutic heat and cold and apply acupuncture and acupressure. Physiotherapists also refer patients who require more complex care, such a procedure below the dermis, to a physician or other appropriate specialist.¹²¹ For the year 2013–2014, 7,792 physiotherapists were registered to practise in the province of Ontario.¹²² Physiotherapy services in Ontario are paid for publicly and privately.¹²³

Unregulated Providers

Estheticians

Estheticians, pedicurists and cosmetologists are unregulated providers whose primary focus is on maintaining nails in a healthy and visually appealing state.¹²⁴ As providers who are unregulated and largely uncertified practising in the private sector, HPRAC was unable to determine how many estheticians provide foot-related care in Ontario. These services are paid for privately.

Orthotists and Prosthetists

Orthotists and prosthetists are unregulated providers who assess, prescribe, design, cast, modify, fabricate, fit, adjust, maintain and review orthotics for the entire body.¹²⁵ Orthotists and prosthetists work in a number of settings, including hospitals, rehabilitation centres, specialty clinics, long-term care facilities, etc.¹²⁶ The devices prepared by orthotists and prosthetists were characterized by the applicant as “significantly more complicated and complex than the orthotics usually prescribed and dispensed by chiropodists or podiatrists and by other professions.”¹²⁷ The foot prosthetics and orthotics that are created by orthotists and prosthetists are typically used after amputation or because of a patient’s congenital and chronic condition.

Under Ontario’s Assistive Devices Program (ADP), orthotists and prosthetists manage foot and ankle conditions under the oversight of a physician or nurse practitioner.¹²⁸ The ADP was established to “provide consumer centered support and funding to Ontario residents who have long-term physical disabilities and to provide access to personalized assistive devices appropriate

¹²⁰ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part I: Surveys Submitted Online*, 76.

¹²¹ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part I: Surveys Submitted Online*, 77.

¹²² College of Physiotherapists, *Perspectives*, accessed February 28, 2015, http://www.collegept.org/Assets/website/annual_reports/Perspectives_Summer2014_AnnualReport_140612.pdf.

¹²³ Ontario Physiotherapy Association (OPA), Access and Payment, accessed March 5, 2015, http://www.opa.on.ca/about_phys_acc.shtml.

¹²⁴ COCOO submission, additional questions, 13.

¹²⁵ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part II(b): Other Submissions*, 85.

¹²⁶ OPCareers, Frequently Asked Questions, accessed August 5, 2015, <http://www.opcareers.org/faq/>.

¹²⁷ COCOO submission, additional questions, 10.

¹²⁸ Ibid..

for the individual's basic needs.”¹²⁹ There are approximately 200 orthotists and prosthetists certified by the Canadian Board for Certification of Prosthetists and Orthotists currently practising in Ontario.¹³⁰

The costs for prosthesis in Ontario are partially paid for by ADP. The remaining cost must be covered by the patient or could be covered by a third-party payer.¹³¹

Pedorthists

Pedorthists are unregulated orthopaedic footwear providers trained in “postural analysis, movement patterns, and musculoskeletal examination.”¹³² In the course of their duties, pedorthists cast, manufacture, adjust and dispense foot orthotics and shoes.¹³³ Pedorthists work in a number of different settings, including hospitals and clinics.¹³⁴ There are approximately 250 pedorthists currently practising in Ontario.¹³⁵ The services and devices provided by pedorthists are predominantly privately funded.¹³⁶

Personal Support Workers

Personal support workers (PSWs) are unregulated health care providers who provide routine foot care as a part of the activities of daily living. PSWs work in a number of different care settings, including hospitals, long-term care homes, community-based care settings and in patients' homes.¹³⁷ There are currently more than 100,000 individuals providing PSW services in Ontario.¹³⁸ Services provided by PSWs are both publicly and privately paid for.¹³⁹

¹²⁹ MOHLTC, Assistive Devices Program, accessed January 28, 2015,

<http://www.health.gov.on.ca/en/public/programs/adp/default.aspx>.

¹³⁰ COCOO submission, additional questions, 10.

¹³¹ Sunnybrook Health Sciences Centre, Amputee care and prosthetic services, accessed August 6, 2015,

<http://sunnybrook.ca/content/?page=amputee-prosthetics-artificial-limbs-toronto>.

¹³² COCOO submission, additional questions, 11.

¹³³ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part II(b): Other Submissions*, 85.

¹³⁴¹³⁴ Pedorthic Footcare Association, What is a credentialed Pedorthist? accessed, August, 5, 2015,

<http://www.pedorthics.org/?page=WHATISACREDPED>.

¹³⁵ COCOO submission, additional questions, 12-13.

¹³⁶ Ibid., 27

¹³⁷ Ontario Personal Support Worker Association, Scope of Practice, accessed April 10, 2015,

<http://opswa.webs.com/scope-of-practice>.

¹³⁸ COCOO submission additional questions, 6.

¹³⁹ Ibid., 26.

Chapter V: What HPRAC Heard

For all referrals, HPRAC engages in broad-based consultation that seeks stakeholder input to help in its analysis and recommendation development for the Minister of Health and Long-Term Care. Upon commencing this referral, HPRAC began determining relevant public interest, concerns and questions, and attempting to understand all perspectives on the model of foot care in Ontario, including those of patients/clients, regulated and unregulated health care professionals, advocates and regulators.

The First Consultation Program

As noted, HPRAC conducted two separate consultation programs for this referral. The first consultation program examined the model of foot care in the province (see below); the second consultation program examined the regulation of the professions of chiropody and podiatry in Ontario (see Chapter IX).

As part of the first consultation program, HPRAC conducted public consultations from April 4, 2014, to July 4, 2014. The submissions received were posted on HPRAC's website for a two-week review period, which ended on July 25, 2014. To ensure that the broader community of interest had the opportunity to participate in this referral, HPRAC asked a number of groups/organizations and individuals to comment on the issue, including:

- the public, including patients;
- regulatory health colleges;
- regulated health professions' associations;
- regulated health care professionals;
- academics and subject matter experts with an interest and/or expertise in the model of foot care and other relevant issues;
- organizations/groups with an interest in the model of foot care;
- educational institutions; and
- health facilities.

HPRAC's goal for the consultation process was to both confirm broad themes and uncover unanticipated issues — not to create a quantitative summary of stakeholder interests or concerns.

HPRAC's website was the main communications vehicle for the consultation process. A chiropody and podiatry web page was established as a repository for relevant background material. The page included a link to an online survey, through which members of the public were invited to express their views.

Survey Responses

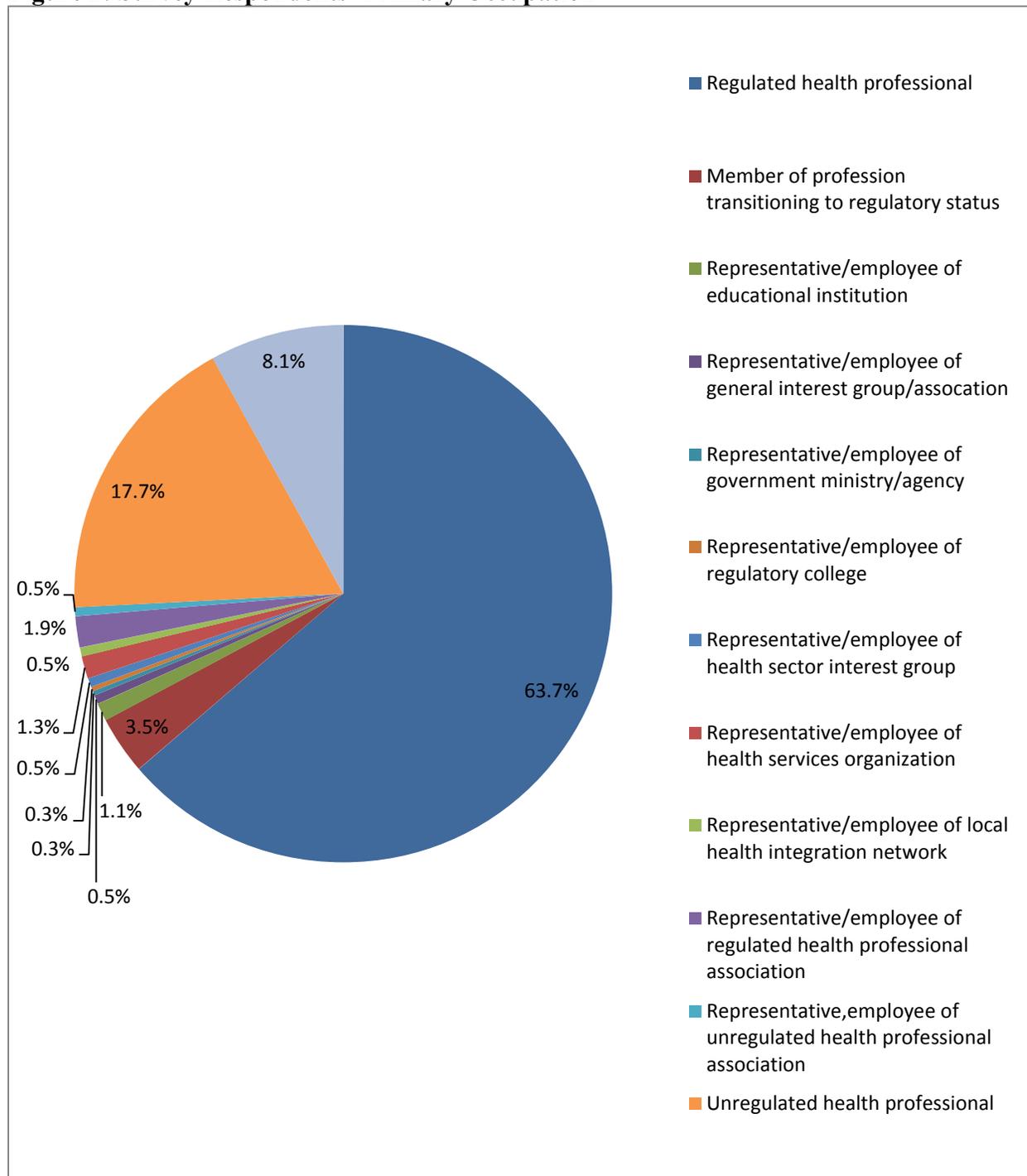
Participants were asked their view, or the view of their organization, on the current model of foot care in Ontario. Participants were also asked to share their views on the major issues facing patients, practitioners and others.

The majority of responses received were completed as online surveys. Stakeholders also sent completed copies of the survey to HPRAC's office or provided their views in the form of a letter. By the close of the consultation period, 198 stakeholders had made submissions to HPRAC.¹⁴⁰ One hundred and seventy-eight submissions were submitted in survey form online. Twenty-one submissions were mailed, faxed or emailed to HPRAC's office, in survey form or in another format. Roughly 80% of the submissions were provided by individuals, and more than 90% of comments were submitted by Ontarians.

Of the participants who identified themselves as members of COCOO, almost all were practising chiropodists; less than 5% were podiatrists.

¹⁴⁰ One organization provided both a survey and a written response; two separate organizations provided more than one survey response.

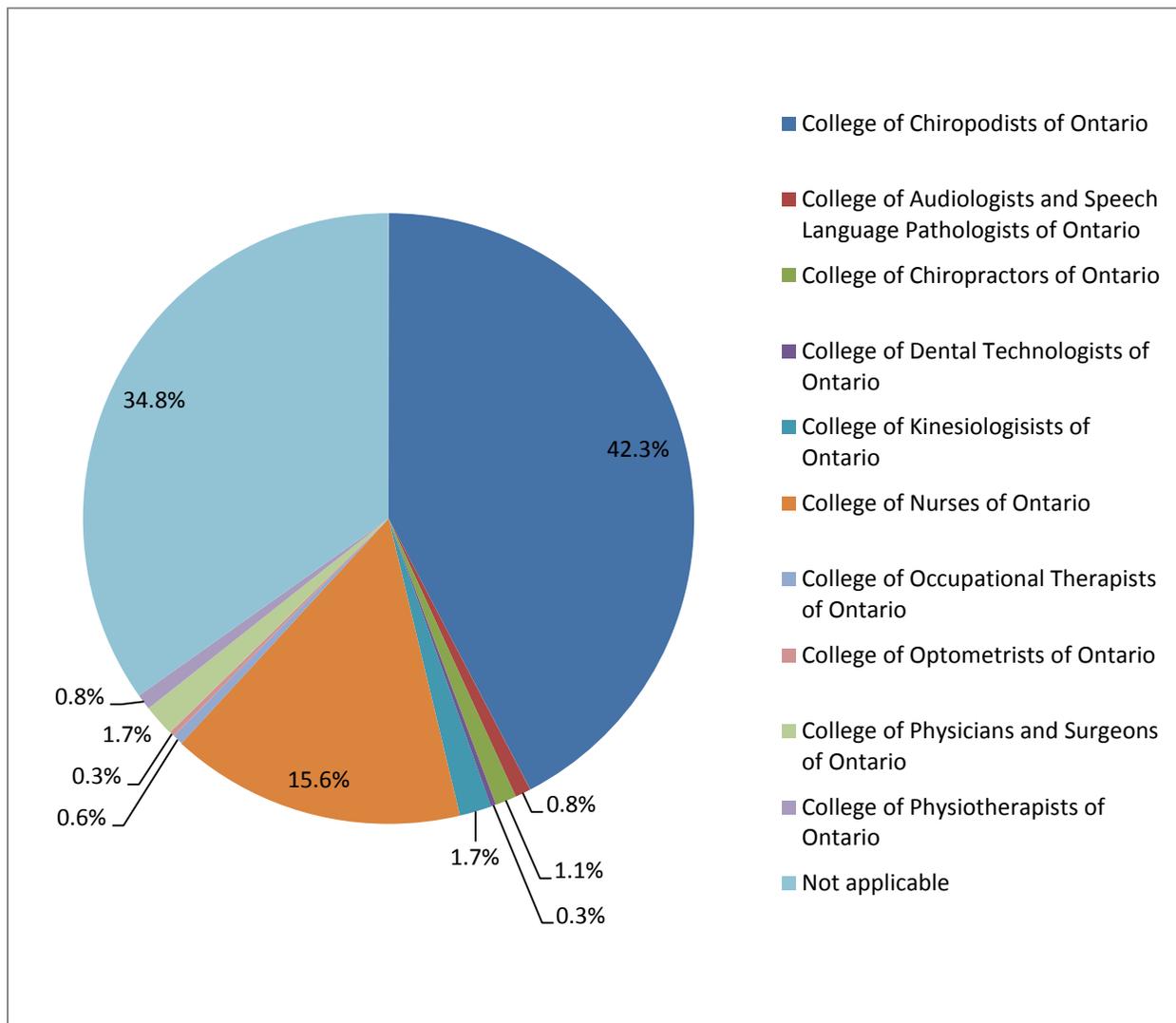
Figure 2: Survey Respondents' Primary Occupation¹⁴¹



More than 40% of consultation participants identified themselves as members of COCOO. Roughly two-thirds of consultation participants were regulated health professionals (see Figure 3); less than one-third were unregulated.

¹⁴¹ HPRAC, Question Pro Survey Response, Chiropractic/Podiatry Survey, accessed May 11, 2015.

Figure 3: Respondents by Membership in Ontario Health Regulatory College¹⁴²



Written Comments

Although comments from stakeholders were both extensive and broad in focus, certain comments and issues were more frequently raised in survey responses and written comments. These comments are discussed below.

Confusion About the Terms “Chiroprapist” and “Podiatrist”

More than any other issue, consultation participants noted their concerns about the titles of “chiroprapist” and “podiatrist.” Participants expressed an interest in maintaining consistency with foot care practitioners in other jurisdictions, who are typically called podiatrists, for all members

¹⁴² Ibid.

of the regulatory college dedicated to foot care.^{143,144,145} Many stakeholder comments supported an elimination of the title “chiropodist” based on the similarities in the scope of practice for chiropodists and podiatrists¹⁴⁶; some stakeholders, in fact, concurred with the maxim, “one title, one profession.”¹⁴⁷

Stakeholders also noted that the titles presently used are not well understood by patients, other health care providers or insurance companies, that the distinction between the two professions is not clear, and that, as a result, there are barriers to patients receiving foot care in an expeditious and straightforward way.¹⁴⁸ Submissions reflected the notion that, because patients, health care providers and insurers are unclear about the title and roles of both podiatrists and chiropodists, patients who need their services often do not know that they are available, and family physicians do not refer patients to them, which directly affects patient care. According to stakeholders, this confusion has also affected the ability of chiropodists and podiatrists to be full members of IPC teams. Some stakeholders submitted that the confusion about the title and role of COCOO members has, in effect, held back the profession and led to a lack of respect for podiatrists and chiropodists.¹⁴⁹ Using one title — “podiatrist” — would, according to certain stakeholders, encourage public awareness and understanding of the profession, lower costs and wait times, and ensure greater access.¹⁵⁰

Other stakeholders supported the adoption of the term “podiatrist,” along with various subspecialty titles to reflect the fact that COCOO members have different levels of training. For example, it was suggested that the title “podiatrist” should be used for practitioners operating at a baseline level of training, and the title “podiatric surgeon” would be reserved for practitioners who work to an expanded scope (i.e., performing surgery).¹⁵¹

The Ability to Access Care

The second-most common issue HPRAC heard about was the accessibility of foot care services, especially as it relates to the funding of these services. Many stakeholders expressed the view that foot care should be funded for vulnerable and/or high-needs patients, such as people with diabetes, the elderly, people with obesity, those with vascular problems, Ontario Disability Support Program recipients, children and homeless/marginalized populations.¹⁵²

¹⁴³ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part I: Surveys Submitted Online*, 5.

¹⁴⁴ *Ibid.*, 7.

¹⁴⁵ *Ibid.*, 9.

¹⁴⁶ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part II(a): Other Submissions*, 60.

http://www.hprac.org/en/reports/resources/Chiropody_Consultation_1_Part_2a_2014-07-24.pdf

¹⁴⁷ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part I: Surveys Submitted Online*, 8.

¹⁴⁸ *Ibid.*, 12.

¹⁴⁹ *Ibid.*, 49.

¹⁵⁰ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part II(a): Other Submissions*, 53.

¹⁵¹ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part I: Surveys Submitted Online*, 3.

¹⁵² *Ibid.*, 44.

Central to the issue of access was what stakeholders identified as the challenge of affording privately paid-for foot care services.¹⁵³ As noted previously, the majority of chiropodists and podiatrists in Ontario practise in private settings, and many foot care services are not paid for publicly¹⁵⁴ (podiatrists may bill OHIP up to an annual total of \$135 per patient).¹⁵⁵ Participants described an inadequate number of publicly funded foot care clinics to address the demand for services.^{156,157,158,159,160,161,162} The result, according to stakeholders, is that a significant percentage of the population is unable to afford critical foot care services.¹⁶³ Where publicly funded foot care clinics do exist, stakeholders described a number of barriers to access, including practitioners not accepting new patients, long wait times^{164,165,166} and/or limitations on the services provided.^{167,168} As well, some chiropodists described another kind of perceived inequity, in which only podiatrists can bill for publicly funded OHIP services, making their services more accessible than chiropodists'.¹⁶⁹

The cost of foot care delivered in the home was also identified as a deterrent to accessible care for patients lacking mobility. One RPN, for example, described the issue as follows: "Wound care is very expensive and patients need wounds attended/treated on a weekly/daily or 3x week, etc. The supplies and visits, travel, time, companion and parking at times are very expensive, time consuming, etc. So, cost is the issue for many of my patients."¹⁷⁰ Patients in northern Ontario and in rural communities face additional barriers to accessing care because they often are required to drive long distances to reach an urban centre where foot care is available.^{171,172} Other problems with accessing foot care, according to stakeholders, included challenges in patients getting to foot care clinics because of advancing age, disability, an inability to drive, etc.^{173,174}

¹⁵³ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part II(b): Other Submissions*, 117.

¹⁵⁴ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part I: Surveys Submitted Online*, 60.

¹⁵⁵ Ontario Podiatric Medical Association, Patient Information Sheet, accessed July 14, 2015, <http://www.opma.ca/Resources/Documents/OPMA%20OHIP%20%20Priv%20Ins%20-%20Patient%20fact%20sheet%20-%20V1%208%20-%20July%202014.pdf>.

¹⁵⁶ *Ibid.*, 15.

¹⁵⁷ *Ibid.*, 17.

¹⁵⁸ *Ibid.*, 26.

¹⁵⁹ *Ibid.*, 40.

¹⁶⁰ *Ibid.*, 44.

¹⁶¹ *Ibid.*, 68.

¹⁶² *Ibid.*, 71.

¹⁶³ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part II(b): Other Submissions*, 32.

¹⁶⁴ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part I: Surveys Submitted Online*, 67.

¹⁶⁵ *Ibid.*, 74.

¹⁶⁶ *Ibid.*, 7.

¹⁶⁷ *Ibid.*, 13.

¹⁶⁸ *Ibid.*, 54.

¹⁶⁹ *Ibid.*, 50.

¹⁷⁰ *Ibid.*, 34.

¹⁷¹ *Ibid.*, 18.

¹⁷² *Ibid.*, 74.

¹⁷³ *Ibid.*, 14.

¹⁷⁴ *Ibid.*, 35.

Impediments to the Efficient Delivery of Care

A separate yet significant issue identified by stakeholders during the first consultation was the variety of expensive and time-consuming administrative and logistical impediments to the delivery of efficient foot care under the current model.^{175,176,177} For example, because chiropodists and podiatrists are unable to order a number diagnostic tests (e.g., laboratory tests, ultrasounds), patients need to be referred from a chiropodist or podiatrist back to their family physician in order to get a requisition when these tests are required.¹⁷⁸ The test results are then provided to the physician, who then reports them back to the chiropodist or podiatrist. This process was often referred to as a “circular referral,”¹⁷⁹ and it was noted to HPRAC that it can be a strain on busy physicians¹⁸⁰ and the health care system, while potentially compromising patient care and safety by increasing wait times.¹⁸¹

Other examples of inefficiencies in chiropodists’ and podiatrists’ practice were also reported during the consultation. For example, a chiropodist can prescribe oral antibiotics to treat infections, but is unable to order lab tests to ascertain whether an infection exists.¹⁸² Similarly, chiropodists and podiatrists are not authorized to prescribe certain newer medications and, as a result, the patient is required to see his or her family physician in order to obtain the appropriate prescription.^{183,184} Some consultation participants noted that these additional delays and other barriers to care are exacerbated when a patient does not have a family doctor.¹⁸⁵

Consumer Protection

Two other interrelated issues raised by stakeholders were the need for more consistency and standardization in the training of individuals who provide foot care, and the potential for behaviour by foot care providers that may give rise to a conflict of interest or possible allegations of unethical or possibly fraudulent behaviour.

Orthotists, pedorthists and other consultation participants commented on the need for consumer protection measures because of the difficulty experienced by patients in navigating the current foot care system¹⁸⁶ and the confusion patients sometimes experience when trying to understand the credentials of the professionals providing foot care services and devices.¹⁸⁷ As noted by one stakeholder, there are currently no restrictions on who can provide prosthetic and orthotic treatment in Ontario; this respondent submitted that the quality of care “can vary considerably

¹⁷⁵ Ibid., 46.

¹⁷⁶ Ibid., 50.

¹⁷⁷ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part II(b): Other Submissions*, 9.

¹⁷⁸ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part I: Surveys Submitted Online*, 70.

¹⁷⁹ Ibid., 20.

¹⁸⁰ Ibid., 35.

¹⁸¹ Ibid., 66.

¹⁸² Ibid., 40.

¹⁸³ Ibid., 54.

¹⁸⁴ Ibid., 36.

¹⁸⁵ Ibid., 54.

¹⁸⁶ Ibid., 76.

¹⁸⁷ Ibid., 25.

among professionals who have little to no formal training in prosthetic or orthotic treatments.”¹⁸⁸ The result, according to some stakeholder comments, is a foot care model in which certain untrained individuals can “pass off insole and other basic aids as foot orthoses.”¹⁸⁹

Other participants identified the incidence of both regulated and unregulated health professionals providing care without specific education related to foot care or foot biomechanics, or providing care outside of their professional scope of practice. The result, it was asserted, is that the practitioner does not have the proper knowledge needed to provide follow-up care to the patient.¹⁹⁰ Similarly, OPMA described the increasing trend of unregulated and unqualified practitioners providing foot care, noting cases in which there are “aestheticians and cosmetologists performing foot care procedures below the dermis, without adequate training or supervision and without following proper procedures such as the appropriate sterilization of instruments.”¹⁹¹

Stakeholder comments about the standardization of best practices were also linked to the concerns HPRAC heard as it related to assertions about questionable behaviour and billing practices in the foot care sector. Some consultation comments described how foot specialists sometimes refer patients to themselves¹⁹² or both prescribe and dispense orthotics, noting that this is a clear conflict of interest.^{193,194} One stakeholder noted a tendency toward the increased dispensing of orthotics among a group of practitioners who both prescribe and dispense these items.¹⁹⁵ The stakeholder, an orthotist, questioned why this practice is permitted, as it is not in the interests of the patient. He described the manner in which he fabricates orthoses:

I require a doctor’s prescription in order to treat a patient and provide my services of custom bracing and orthotics. Orthotists are not able to self prescribe or prescribe medical intervention. I feel that this is key in providing unbiased treatment to a patient population. I am not able to decide whether or not a person requires my services, a doctor justifies me treating a patient.¹⁹⁶

Questionable and possibly fraudulent behaviour by practitioners was described in a number of consultation comments. Some participants provided anecdotal evidence that foot care businesses sometimes forward claims to insurance companies for custom orthotics or compression socks when these devices were, in fact, never dispensed by the practitioner. In these instances, it was submitted that the patient receives a non-custom product and/or shoes or gift cards in lieu of a proper orthotic.¹⁹⁷ The Canadian Life and Health Insurance Association Inc. noted that “insurers

¹⁸⁸ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part II(a): Other Submissions*, 42.

¹⁸⁹ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part II(b): Other Submissions*, 46.

¹⁹⁰ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part I: Surveys Submitted Online*, 42.

¹⁹¹ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part II(b): Other Submissions*, 8.

¹⁹² HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part I: Surveys Submitted Online*, 11.

¹⁹³ *Ibid.*, 30.

¹⁹⁴ *Ibid.*, 34.

¹⁹⁵ *Ibid.*, 44.

¹⁹⁶ *Ibid.*, 16.

¹⁹⁷ *Ibid.*, 3.

have seen an increase in misrepresentation and abuse on claims for footwear which has created a need to develop additional controls.”¹⁹⁸

To combat this kind of behaviour, stakeholders recommendations included a recommendation that a “standardized model of foot care be developed that includes accepted definitions, guidelines and criteria on what is considered a custom orthotic and orthopaedic shoe, and clearly outlines the education and training of professionals that is required in order to prescribe and dispense them.”¹⁹⁹

Education and Preventative Care

To alleviate financial costs, human suffering and poor patient outcomes, many stakeholders described the importance of proper preventative foot care and education.²⁰⁰ The current foot care model, according to one stakeholder, is more likely to amputate than to be proactive and preventative.²⁰¹

A number of respondents noted that, at a high level, a shift in public perception is needed before foot care can be seen as a critical part of staying healthy and active.²⁰² This shift will become increasingly important, noted one participant, as the population ages and the incidence of chronic diseases such as diabetes increases, and patients become unable to bend and take care of their feet.

Many consultation participants, particularly RPNs who provide foot care, described the emphasis that they place, as foot health care practitioners, on preventative care by educating their patients/clients.²⁰³ Some nursing stakeholders also emphasized the low cost of delivering preventative foot care by nurses, comparing the low cost of regular treatments over a patient’s lifetime to that of the high cost of amputation.²⁰⁴

Other stakeholders pointed out the important role that orthotics play in preventing the deterioration of foot health. A podiatrist in Alberta, for example, described how non-invasive attention to footwear choices and insoles/orthotics is a good starting point in foot-related health care. The podiatrist also described basic physical therapy and exercise prescription as an effective treatment. According to this podiatrist, footwear choices, insole/orthotic considerations and physical therapy are inexpensive treatment options that are well supported in the literature to maintain good foot health.²⁰⁵

Stakeholders also articulated the importance of preventative care as it relates to savings for the public health care system. One stakeholder explained, “I do know from personal experience that a proper full contact orthotic has saved many a foot each year. This has saved the Ontario

¹⁹⁸ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part II(a): Other Submissions*, 63.

¹⁹⁹ *Ibid.*, 63.

²⁰⁰ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part II(b): Other Submissions*, 32.

²⁰¹ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part I: Surveys Submitted Online*, 15.

²⁰² *Ibid.*, 18.

²⁰³ *Ibid.*, 15.

²⁰⁴ *Ibid.*

²⁰⁵ *Ibid.*, 29.

Government hundreds of thousands of dollars over the years...²⁰⁶ Some stakeholders pointed out that these savings within the public health system have been achieved because many patients privately pay for their orthotics. An orthotist with a practice that exclusively supplies orthotic devices suggested that government funding, such as ADP, be extended to cover foot orthotics and orthopaedic and/or custom footwear in some situations, because “unfortunately some people do without for financial reasons, and later end up as amputees, likely costing the healthcare system a lot more than they would have, had they been treated preventatively earlier on in their disease progression.”²⁰⁷ HPRAC heard, during key information interviews, that up to 80% of amputations can be prevented,²⁰⁸ and that Health Quality Ontario identifies the cost for foot ulcer admissions requiring amputation at \$67,123 per patient, whereas the estimated cost in Ontario for the year 2012–2013 for foot amputations as a result of an ulcer was \$118,606,341.²⁰⁹ These numbers suggest that there are approximately 2,000 amputations occurring every year in Ontario because of foot ulcers.

By drawing on evidence available, one stakeholder described the cost savings of preventative care:

In 2014 a study titled “Direct medical costs of complications of diabetes in the United States: estimates for event-year and annual state costs (USD 2012)” was released detailing costs of individual procedures that happened as a result of diabetes. The cost of each amputation was on average \$9048 and the cost of each diabetic foot ulcer was \$2147. The cost of foot orthotics currently generally ranges from \$450-\$550 and the cost of diabetic footwear costs approximately \$150-\$250. Once an amputation occurs the Ontario government through the Assistive Devices Program will contribute 75% of a maximum towards a prosthesis. These costs are also in the multiple thousands. Ironically, the Assistive Devices Program will cover 75% of the cost of a foot orthotic if a portion of the smallest toe has been amputated as it is now considered a prosthetic device but will not fund the orthotic that could have prevented it or other more intensive consequences. In a report titled “Reducing foot complications for people with Diabetes” again published by the Registered Nurses Association of Ontario in 2004 (revised in 2011) a recommendation was made that “Organizations should advocate for strategies and funding to assist clients to obtain appropriate footwear and specialized diabetes education. For example, the inclusion of funding support through the Assistive Devices Program (ADP) for appropriate footwear and orthotics.”²¹⁰

Stakeholder-Proposed Foot Care Models

Many stakeholders provided thoughtful suggestions and comments on potential improvements to the delivery of foot care in Ontario. Certain stakeholders recommended an emphasis on

²⁰⁶ Ibid., 26.

²⁰⁷ Ibid., 19.

²⁰⁸ World Health Organization (WHO), World Diabetes Day: too many people are losing lower limbs unnecessarily to diabetes, accessed April 16, 2015, <http://www.who.int/mediacentre/news/releases/2005/pr61/en>.

²⁰⁹ Key informant interview, Jennifer Michaud, February 13, 2015.

²¹⁰ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part I: Surveys Submitted Online*, 21.

evidence-based decision-making. Consistent with this perspective, some respondents advocated for the development of guidance material such as algorithms,²¹¹ practice guidelines^{212,213} or decision charts to clarify practice roles and identify the most appropriate health care providers for various foot care procedures. As noted by one respondent:

Foot care includes many different aspects, some that are better managed from different health care professions. For example, cutting nails, prescribing topical lotions/dressings etc., for infections and assessing for providing biomechanical assessments and foot orthoses; all of which have very different requirements for education, assessment and treatment.²¹⁴

This sentiment was echoed by other comments HPRAC received. One foot care worker, for example, noted that “the chiropodist should be picking up the workload of where an RN practice stops...”²¹⁵ Other stakeholders identified the need to develop common care protocols to ensure that all patients with the same pathology are treated in the same way: “Clients getting all types of devices from custom shoes to short walking casts to full air casts for the same pathology; many are not effective.”²¹⁶ Consistent with these comments, it was recommended by the Registered Nurses’ Association of Ontario (RNAO) that “standardizing the education of foot care for all health professionals who practice foot care would serve to improve access to foot care and improve outcomes for clients.”²¹⁷

In addition to improving patient care and greatly reducing costs to the health care system, stakeholders identified the development of standardized guidelines as a way to address current issues with payment from insurance companies, such as chiropodists not receiving payment due to title confusion.

The importance of IPC as a way to ensure patient safety and efficient delivery of care was also noted in a number of consultation comments about potential changes to the delivery of health care. Specifically, stakeholders described the need for all health care professionals to work together with the client and his/her family to develop, contribute to and deliver the patient’s care plan.²¹⁸

IPC care is especially important for foot care patients, according to stakeholders, because follow-up care sometimes takes place over years and involves multiple health care practitioners in both the private and public health care spheres and in various practice settings. As one stakeholder noted, “the pathway between professionals should be seamless.”²¹⁹

As well, based on the prevalence of diabetes among foot care patients, a number of stakeholders identified the need to incorporate dietitians and other allied health care practitioners into IPC teams. Stakeholders who identified themselves as pedorthists also noted the difficulties inherent

²¹¹ Ibid., 19.

²¹² Ibid., 21.

²¹³ Ibid., 35.

²¹⁴ Ibid., 11.

²¹⁵ Ibid.

²¹⁶ Ibid., 19.

²¹⁷ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part II(b): Other Submissions*, 166.

²¹⁸ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Current Model of Foot Care in Ontario, Part I: Surveys Submitted Online*, 76.

²¹⁹ Ibid., 11.

in becoming part of IPC teams, and advocated for recognition as valued health care providers on those teams.²²⁰ Because there is overlap among various health care practitioners (both regulated and unregulated) in providing foot care to patients, some stakeholders linked confusion among patients and others (about who should provide which services) to concerns about accountability.²²¹ The Podiatric Association of Canada, for example, suggested that for unregulated professionals, “There needs to be some form of safeguard or title protection under some type of legislation or registry, to ensure greater public safety and protection.”²²²

Several new practice models were proposed, many with a different focus. Some consultation participants expressed a need for province-wide foot care clinics, for example. The Sport and Exercise Medicine section of the Ontario Medical Association (OMA) described the wait time for foot and ankle surgery in the Ottawa area as a “major problem,” ranging from three to five years, while “many of the surgeons have agreed to only see hind foot pathology.”²²³ To address this situation, it was proposed that a foot and ankle intake clinic be fashioned after existing joint assessment clinics, with a mandate to help patients receive quicker access to care and reasonable referrals to surgery. The intake clinics would be made up of IPC teams, including a sport medicine physician, a physiotherapist and a chiropractor or podiatrist working alongside an orthopaedic surgeon.²²⁴

In addition, some consultation participants, especially RPNs who practise foot care in home settings, described foot care models that focused on the elderly. With an aging population and with the health care system transitioning to more community care, some stakeholders emphasized the need to create foot care delivery models that can be implemented at home or in long-term care.²²⁵

Other consultation participants expressed the need to focus the delivery of foot care on high-need, high-cost patient groups, specifically those with diabetes. One participant noted that “Diabetic foot disease is the most prevalent complication in diabetes but gets very little attention.”²²⁶ The stakeholder, a family physician with a practice focused exclusively on diabetic foot and wound care, advocated for a diabetic foot care strategy as a means of reducing the costs associated with diabetic foot disease.²²⁷ According to this stakeholder, the FHT structure could accommodate the proposed diabetic model of care.²²⁸ Additionally, FHTs have the infrastructure available to support program tracking to assess the success of the program and measure outcomes such as ulceration, amputation rates and successful wound healing.²²⁹

²²⁰ Ibid., 23-4.

²²¹ Ibid., 25.

²²² HPRAC, *Stakeholder Feedback on the Chiropractor/Podiatry Referral: The Current Model of Foot Care in Ontario*, Part II(b): Other Submissions, 95.

²²³ Ibid., 75.

²²⁴ Ibid.

²²⁵ Ibid., 17-8.

²²⁶ HPRAC, *Stakeholder Feedback on the Chiropractor/Podiatry Referral: The Current Model of Foot Care in Ontario, Part I: Surveys Submitted Online*, 22.

²²⁷ Ibid., 22.

²²⁸ Ibid., 23.

²²⁹ Ibid., 22-3.

Two-Week Review Period

Following the close of the initial consultation, stakeholder comments were publicly posted on HPRAC's website. HPRAC allowed for a two-week period in which stakeholders could make comments on any of the submissions that it received during the initial consultation.

During this review period, HPRAC received a total of 57 submissions (46 submissions from individuals and 11 submissions from organizations).

Responses from Individuals

The most frequently identified issue by stakeholders was related to the titles of chiropodist and podiatrist. A number of submissions were received which advocated for: 'One title, one scope of practice.'

A number of submissions were received which appeared to be either a reproduction of a template letter, or were variations on that same letter. Recurring issues which appeared in many of the submissions included: scope of practice, grand-parenting and the notion that the referral had been side tracked by other unregulated professions.

Responses from Organizations

HPRAC received submissions from organizations which presented divergent perspectives on certain aspects of a proposed model of foot care in Ontario. The most commonly heard issue related to title. While certain organizations highlighted the need for a single protected title, podiatrist, other organizations noted that such a title could lead to confusion, misunderstanding and safety issues.

Chapter VI: Conclusions and Other Considerations

HPRAC met with and heard from stakeholders who consistently emphasized the importance of the foot and the impact that healthy feet can have on an individual's quality of life. As explained by one chiropodist, the “feet are the foundation for the body.”²³⁰

Through its consultations, HPRAC learned about the importance of a healthy foot. Without proper foot function, individuals can very easily lose mobility, which, in turn, can greatly affect an individual's quality of life. Impaired foot function can cause an individual to struggle with basic life functions, face challenges with maintaining paid employment and face significant difficulties when attempting to maintain a healthy lifestyle.

While the absence of proper foot function can result in reduced mobility or the inability to use the feet for weight-bearing activities, more drastic consequences may exist for a patient who has severe foot care issues. If, for example, an individual is required to amputate a toe or an entire foot because of a bone infection, this will put the patient at an increased risk of mortality.

Participants consistently emphasized to HPRAC that the negative implications associated with poor foot health (loss of mobility, amputation, threat to life, etc.) could be avoided with preventative foot care. According to a number of patients and practitioners, however, this care can often be out of reach for patients for financial reasons. In Ontario, the provision of foot care often requires the individual to pay for these services. Yet many patients — the elderly with arthritis, middle-aged individuals with diabetes or young people in need of an offloading device to limit further foot injury — may find these services unaffordable.

Beyond financial barriers, Ontarians in rural and remote communities also face challenges accessing qualified foot care practitioners who are able to provide appropriate foot care.

Challenges to access may, as HPRAC heard, be leading to unnecessary losses in patients' quality of life. They could also be contributing to increased costs to the health care system, through the increased and unnecessary use of publicly funded amputations. In one study, the Canadian Institute for Health Information (CIHI) found that the cost of amputations is between 10 and 40 times greater than that of effective initiatives that prevent the need for amputation.²³¹

While HPRAC heard of many challenges with the model of foot care in Ontario, it also learned about many centres of excellence in the province that excel at maintaining the foot health of Ontarians. These institutions are built on a foundation of IPC, which provides patients access to multiple care providers, such as chiropodists, nurses, orthopaedic surgeons or physicians, dieticians, etc. This multi-practitioner approach helps patients effectively manage and maintain good foot health. These IPC settings provide ongoing care and maintenance (often required for those with a diabetic foot), manage multiple diseases or comorbidities and provide education to assist with preventative care.

²³⁰ Site visit, Danforth Foot Clinic, March 11, 2015.

²³¹ Canadian Institute for Health Information (CIHI), *Compromised Wounds in Canada*, accessed April 15, 2015, https://secure.cihi.ca/free_products/AiB_Compromised_Wounds_EN.pdf.

Preventative Care

The Minister may wish to consider examining enhancements to access to foot care services and devices in the province through expanding or increasing the number of centres of excellence, and by examining whether the health care system can avoid costly foot surgeries (especially amputations) through a focus on prevention.

Part II: Regulation of Chiroprody and Podiatry

Chapter VII: Background on a Scope of Practice Review

What is a Scope of Practice?

The term “scope of practice” is used in the context of the regulation of health professionals to define the procedures, actions, and processes that a registered individual is authorized to perform. A regulated health professional is usually limited to practising the areas of the profession’s scope of practice in which individuals have received education and clinical experience, and in which she or he had demonstrated competency. Each jurisdiction has its own legislative framework governing entry-to-practice education requirements as well as required additional training and practice.

The scope of practice model under Ontario’s health professions’ regulatory framework, has four key elements:

- a scope-of-practice statement;
- controlled and authorized acts;
- the harm clause; and
- title protections.²³²

The scope of practice statement in the *Chiropody Act, 1991*, states: “The practice of chiropody is the assessment of the foot and the treatment and prevention of diseases, disorders or dysfunctions of the foot by therapeutic, orthotic or palliative means.”²³³ This scope of practice statement applies not only to chiropodists, but to podiatrists as well.

What are Controlled Acts and Authorized Acts?

In Ontario, each regulated health profession-specific statute establishes the scope of practice for the profession and which of the controlled acts listed in the RHPA members of the College are authorized to perform (if any). As explained in Part I of this report, s. 27(2) of the RHPA, lists 13 procedures²³⁴ that, if not performed by a qualified practitioner, may pose a risk of harm to the public. These procedures are known as “controlled acts.” In Ontario, controlled acts may only be

²³² HPRAC, *Review of a Professional Scope of Practice under the Regulated Health Professions Act, 1991: Application Guide, August 2014*, http://www.hprac.org/en/projects/resources/Scope_of_Practice_Review_Application_Guide.pdf, accessed June 17, 2015.

²³³ *Chiropody Act, 1991*, s. 4., <http://www.ontario.ca/laws/statute/91c20>, accessed June 17, 2015.

²³⁴ Please see the Appendix B for a full list of controlled acts.

performed by authorized health care professionals, persons who have been delegated the act by an authorized professional or persons in circumstances otherwise identified.²³⁵

Chiropodists are currently authorized to perform the following controlled acts:

- cutting into subcutaneous tissues of the foot;
- administering, by injection into the feet, a substance designated in the regulations under the *Chiropody Act, 1991*;
- prescribing drugs designated in the regulations; and
- administering, by inhalation, a substance designated in the regulations under the *Chiropody Act, 1991*.²³⁶

Podiatrists are authorized to perform a similar, but **expanded**,²³⁷ list of controlled acts:

- **communicating a diagnosis identifying a disease or disorder of the foot as the cause of a person's symptoms;**
- **cutting into subcutaneous tissues of the foot and bony tissues of the forefoot;**
- administering, by injection into feet, a substance designated in the regulations;
- prescribing drugs designated in the regulations; and
- administering, by inhalation, a substance designated in the regulations.²³⁸

For the purposes of this report, references to authorized acts include acts authorized under other legislations, such as the *Healing Arts and Radiation Protection Act* and the *Laboratory and Specimen Collection Centre Licensing Act*.

What is the Difference between an Individual and a Professional Scope of Practice?

In addition to the scope of practice for a profession, the term “scope of practice” is employed by regulatory authorities to identify the procedures, actions and processes that a specific registered individual may perform. This individual scope of practice is based on, among other things, the registrant’s education, clinical experience and demonstrated competency. While a profession’s scope of practice describes the full scope of activity open to the profession as a whole, an individual scope of practice describes the scope of activity within which individual practitioners may conduct their practice. The individual scope of practice therefore generally represents a subset of the larger scope of practice for the profession.

²³⁵ RHPA, s. 27 and s. 29.

²³⁶ *Chiropody Act, 1991*, s.5.

²³⁷ Emphasis added to highlight differences in controlled acts available to podiatrists.

²³⁸ *Ibid.*

How Does HPRAC Review a Scope of Practice Increase Request?

In developing its advice to the Minister, HPRAC attempts to ensure that its processes are thorough, timely and efficient, and that they reflect principles of independence, fairness, transparency and evidence-based decision-making. As noted in Chapter I, HPRAC undertakes research to secure evidence for its conclusions, drawing on organizations and individuals with expertise in the matters under consideration, both in Ontario and elsewhere. As well, HPRAC tailors its consultation process to the individual matters under consideration. Given the wide interest in the request for a scope of practice increase for chiropractors and podiatrists, HPRAC conducted an extensive program of research and consultation.

HPRAC's recommendations for a scope of practice change are based on its assessment of the profession's ability to meet the criteria for a change in its scope of practice, as well as the need for such a change.²³⁹ HPRAC's criteria for a change in scope of practice are:

- **Relevance to the profession:** The profession should demonstrate that the requested change in scope of practice is rationally related to the practice of the profession and to the qualifications and competencies of members of the profession. It should describe whether the proposed change to the scope of practice provides recognition and authority for existing competencies, or seeks to expand the scope of the practice of the profession.
- **Risk of harm:** If the proposed change in scope of practice presents an increased risk of harm to the public, the profession should demonstrate how it intends to mitigate that risk, and how the training and competencies of members of the profession provide assurance that patients or clients will be cared for within evidence-based best practices.
- **Relevance to the health care system and relationship to other professions:** The profession should demonstrate that a change in the scope of practice is consistent with the evolution of the health care delivery system, and particularly with changing dynamics between health professionals who work in integrated, team-based and collaborative care models.
- **Sufficiency of supervision and need for autonomy:** The profession should demonstrate that a change in the scope of practice is the most appropriate, effective and efficient means to provide clinical and patient care services, that delegation or supervisory structures currently available are inadequate and that the authority for independent or autonomous professional activity is required in the provision of patient care.
- **Body of knowledge:** The profession should show that there is a systematic body of knowledge within the profession to perform the activities being requested and that this change in role is broadly accepted within the profession.

²³⁹ For a scope of HPRAC's *Application Guide* for a Review of a Professional Scope of Practice under the *Regulated Health Professions Act, 1991* please visit: http://www.hprac.org/en/projects/resources/Scope_of_Practice_Review_Application_Guide.pdf

- **Education and accreditation:** Members of the profession should demonstrate that they have, or will have, the knowledge, training, skills and experience necessary to carry out the duties and responsibilities involved in the proposed change in scope of practice. In addition, the profession should demonstrate that its education programs are appropriately accredited by an approved accreditation body.
- **Leadership's ability to favour the public interest:** The profession's leadership should show that it will distinguish between the public interest and the profession's self-interest and will favour the public interest at all times.
- **Profession's support and willingness to comply with regulation:** The profession should demonstrate that it supports the proposed change in scope of practice and that compliance with regulatory requirements is likely among its membership.
- **Economic impact:** The profession should demonstrate an understanding and appreciation of the economic impact of the proposed change in scope of practice for the profession, the public and the health care system.
- **Public need:** The profession should demonstrate that a significant public need would be met through the proposed change in scope of practice.²⁴⁰

The application for a scope of practice increase served as a starting point for HPRAC's work in assessing the request for a change in scope of practice. In addition to the responses to the standard questions included in the application, the applicant was asked to address additional questions that were relevant to the issues raised by the Minister. Beyond the application and responses to additional question HPRAC was informed by literature reviews that included an analysis of how other jurisdictions regulate the professions of chiropody and podiatry, a review of jurisprudence and what HPRAC heard through extensive consultations, key informant interviews and site visits.

All evidence and information reviewed by HPRAC were measured against the applicant's ability to satisfy each criteria described above.

²⁴⁰ HPRAC, *Review of a Professional Scope of Practice under the Regulated Health Professions Act, 1991: Application Guide, August 2014.*

Chapter VIII: Background on the Referral

Referral Question

As noted in Chapter I, in June 2007, the Minister of Health and Long-Term Care asked HPRAC to “review issues relating to the regulation of chiropody and podiatry and provide advice as to whether and how there should be changes to existing legislation.” The Minister also asked that HPRAC include in its review “an analysis of the current model of foot care in Ontario, issues regarding restricted titles, and whether the existing limitation on the podiatrist class of members should continue.”²⁴¹

Who is the Applicant?

The applicant for this referral is COCOO. As with all referrals, the applicant is considered the subject matter expert and, as such, the onus is on the applicant to provide sufficient evidence to HPRAC that it can use to effectively assess the application against HPRAC’s criteria for an expanded scope of practice under the RHPA.

COCOO, pursuant to the RHPA and the *Chiropody Act, 1991*, and reflected in its mission statement, is responsible for the regulation of chiropodists and podiatrists in the public interest. The college notes that it helps to ensure that the public receives competent care from chiropodists and podiatrists by regulating the profession in accordance with the RHPA, the *Chiropody Act, 1991*, and its respective regulations, establishing standards of practice, entry-to-practice and continuing competency requirements, responding to concerns and complaints from the public; and educating the public about chiropody and podiatry.²⁴²

COCOO’s Proposal

As explained by the applicant, “The College is proposing the creation of a unitary podiatry profession in Ontario with a scope of practice and authorized acts that reflect the podiatry scope of practice in British Columbia, Alberta and in other comparable jurisdictions; and that are adapted to Ontario’s healthcare policy, regulatory and healthcare delivery frameworks.”²⁴³

To meet the requirement of a unitary podiatric profession, the applicant is proposing a newly expanded scope of practice, which would include a number of new or expanded controlled and authorized acts; changes to the title of practitioners; and modifications to the list of drugs available to chiropodists and podiatrists.

²⁴¹ Letter from George Smitherman to Barbara Sullivan, June 28, 2007.

²⁴² COCOCO, *Professional Regulation in the Public Interest*, annual report, accessed June 17, 2015, http://www.cocoo.on.ca/pdfs/annual_report_2013.pdf.

²⁴³ COCOCO submission, 27.

Why Does Ontario Use the Chiropody Model of Foot Care?

For this referral, significant consideration is given to the distinction between a chiropodist and a podiatrist. The following section provides a brief look at how Ontario came to adopt a chiropody model of foot care.

As described by the applicant, in 1966, the Committee on the Healing Arts and, in 1972 and 1973, the Ontario Council of Health, recommended that the chiropody model of foot care be adopted in Ontario. This model was to be based on the scope of practice and training for chiropodists in the United Kingdom (UK).²⁴⁴ In the 1980s, as part of the Health Professions Legislation Review (HPLR), the Ontario government formally adopted the UK chiropody model. The applicant notes that at that time, chiropodists practised in hospitals and other community health facilities and were salaried employees.²⁴⁵

In its submission, the applicant explains that the HPLR endorsed what it refers to as “the implementation of the podiatric cap through legislation,”²⁴⁶ noting that this course of action was taken for a number of reasons. Specifically, the applicant notes that the profession of podiatry had failed to fulfill the criteria set by the HPLR to justify independent regulation.²⁴⁷ The applicant also notes that the lack of an educational facility in Ontario was an important consideration as to why no more podiatrists would be registered in the province. In addition, the existence of potential conflicts between physicians and podiatrists was put forward as a further explanation for the podiatric cap, because podiatrists “had developed something of an antagonistic relationship with physicians and had positioned podiatry as an alternative to mainstream medicine...”²⁴⁸

Committee transcripts from the Standing Committee on Social Development, which took place before third reading of the RHPA in 1991, provided an opportunity to review the RHPA and its corresponding profession-specific acts, including the *Chiropody Act, 1991*, and to glean further insights.²⁴⁹

During standing committee discussions about the professions of chiropody and podiatry, it was noted that, at the time, Ontario had a *Chiropody Act* that registered both chiropodists and podiatrists. The committee also heard that, at the time, podiatrists were performing limited bone surgery on the toes and forefoot. It was described to the committee that to perform this kind of surgery was an illegal act (as demonstrated by case law), because podiatrists were not authorized to do so by the governing legislation. It was explained that this act infringed on the practice of

²⁴⁴ COCOO submission, 11.

²⁴⁵ Ibid, 12.

²⁴⁶ COCOO submission, 17.

²⁴⁷ Ibid.

²⁴⁸ Ibid.

²⁴⁹ Legislative Assembly of Ontario, Committee Transcripts: Standing Committee on Social Development - 1991-Aug-06 - Bill 43, Regulated Health Professions Act, 1991, and Companion Legislation, accessed January 28, 2015, http://www.ontla.on.ca/web/committee-proceedings/committee_transcripts_details.do?locale=en&Date=1991-08-06&ParlCommID=133&BillID=&Business=Bill+43%2C+Regulated+Health+Professions+Act%2C+1991%2C+and+Companion+Legislation&DocumentID=17440.

medicine. Discussions from the Standing Committee suggest that a compromise was reached that resulted in no new podiatrists being permitted to register in Ontario, although existing podiatrists were permitted to perform bony surgery. Excerpts from the committee's explanation included the following passage:

The review [HPLR] consulted with the government of the day, of course, and the chiropodists and podiatrists. This analysis sets out the compromise that was achieved in full consultation with these groups whereby podiatrists would essentially be phased out of Ontario, but those podiatrists who are currently in practice and who were registered prior to the cutoff date that was selected would be permitted to perform legally the bone surgery which they have been performing illegally to date. The benefit to these podiatrists is clearly lawful. Their illegal practice is made lawful and they are recognized as legitimate providers of this service, but there are not going to be any more of them.²⁵⁰

Currently in Ontario, no individual may register with COCOO as a podiatrist. The *Chiropody Act, 1991*, states that "No person shall be added to the class of members called podiatrists after the 31st day of July, 1993."²⁵¹ However, individuals registered as podiatrists before July 1993 can continue to maintain their registration status as podiatrists. This prohibition is referred to by the applicant as the "podiatric cap,"

At the end of 2013, COCOO had a total of 637 in-province registrants. Of those, 568 were registered as chiropodists and 69 members were registered as podiatrists.²⁵² The applicant maintains that the entire podiatrist class cohort will largely or completely disappear over the next decade, due to attrition and retirement.²⁵³

²⁵⁰ Ibid.

²⁵¹ *Chiropody Act, 1991*

²⁵² COCOO submission, 15.

²⁵³ Ibid, 17.

Chapter IX: What HPRAC Heard

As outlined in Chapter V, for every referral, HPRAC engages in broad-based consultations that seek stakeholder input to help in its analysis and recommendation development for the Minister of Health and Long-Term Care.

HPRAC held an initial consultation session on the current model of foot care in Ontario from April 4 to July 4, 2014, to learn about the current model in Ontario and issues facing patients, providers and others. The consultations also provided context for HPRAC's second consultation on the regulation of chiropody and podiatry (see Chapter V).

Upon completion of the initial consultation, HPRAC began determining relevant public interest concerns and questions, and attempting to understand all perspectives on the regulation of chiropody and podiatry in Ontario, including those of patients/clients, key health care practitioners, advocates, regulators and others.

The Second Consultation Program

HPRAC's second consultation program examined the regulation of chiropody and podiatry in Ontario.

As part of the second program, HPRAC conducted a public consultation from December 18, 2014, to March 20, 2015. The submissions received were posted on HPRAC's website for a two-week review period, which ended on April 22, 2015. To ensure that the broader community of interest had the opportunity to participate in this referral, HPRAC invited organizations and individuals to complete a survey about COCOO's application for a scope-of-practice change under the RHPA. Survey respondents included:

- the public, including patients;
- regulatory health colleges;
- regulated health professions' associations;
- regulated health care professionals;
- academics and subject matter experts with an interest and/or expertise in the model of foot care and other relevant issues;
- organizations/groups with an interest in the model of foot care;
- educational institutions; and
- health care facilities.

HPRAC's goal for the consultation process was to both confirm broad themes and uncover unanticipated issues — not to create a quantitative summary of stakeholder interests or concerns.

HPRAC's website was the main communications vehicle for the consultation process. A chiropody and podiatry web page was established as a repository for relevant background material. The page included a link to an online survey, through which members of the public were invited to express their views.

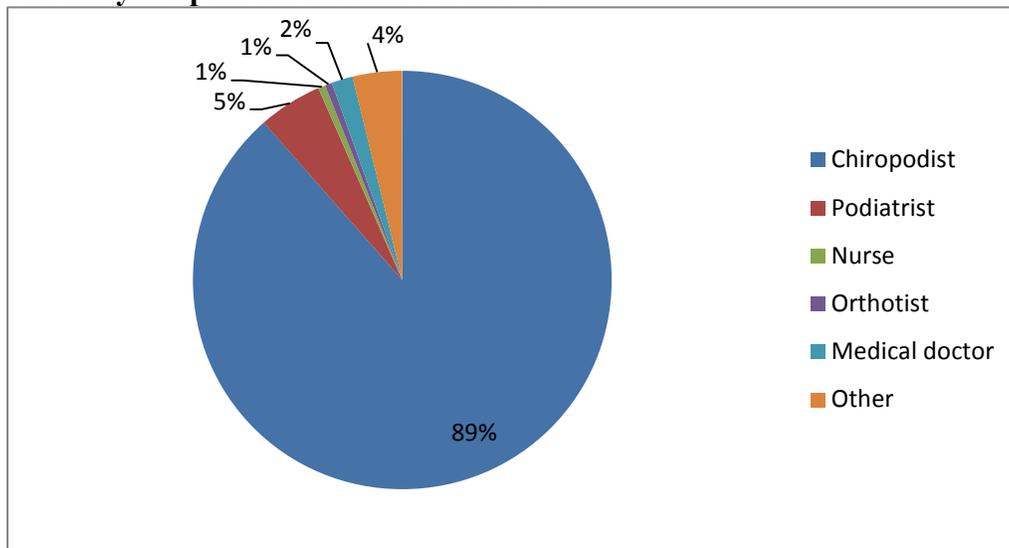
Participants were asked their view or the view of their organization on the applicant's proposal, including:

- issues relating to the regulation of chiropody and podiatry
- whether and how there should be changes to existing legislation regarding chiropodists and podiatrist
- issues regarding restricted titles
- whether the existing limitations on the podiatrist class of members should continue

Survey Responses

The majority of responses received were completed as online surveys. Stakeholders also sent completed copies of the survey to HPRAC’s office, or provided their views in the form of a letter. By the close of the consultation period, 223 stakeholders had made submissions to HPRAC.²⁵⁴ Two-hundred-and-one submissions were submitted online in survey form. Twenty-three submissions were mailed, faxed or emailed to HPRAC’s office, in survey form or in a letter. Ninety-seven per cent of surveys were submitted by individuals, and the same percentage of responses (97%) were received from respondents living in Ontario. Eighty-nine per cent of respondents identified themselves as chiropodists (see Figure 4).

Figure 4: Survey Respondents’ Self-Identification²⁵⁵

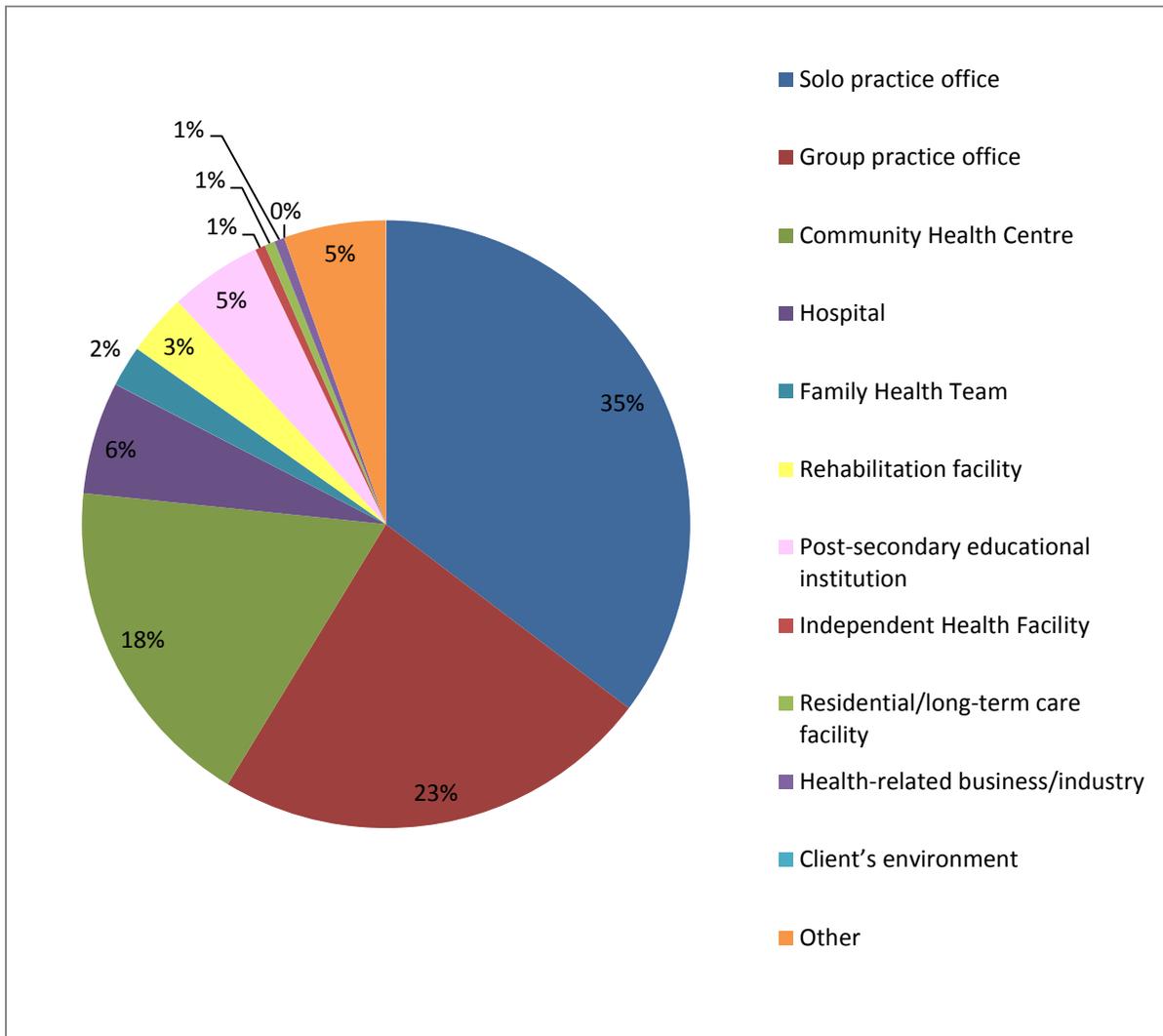


Respondents who classified themselves as foot care providers were asked to identify the practice setting in which they worked. More than half of respondents noted that they practised in a solo or group practice setting, whereas only 6% identified themselves as working in a hospital (see Figure 5).

²⁵⁴ One submission was received on behalf of three organizations, and three organizations and one individual made two submissions.

²⁵⁵ HPRAC, Question Pro Survey Response, Chiropody/Podiatry Survey, accessed May 11, 2015.

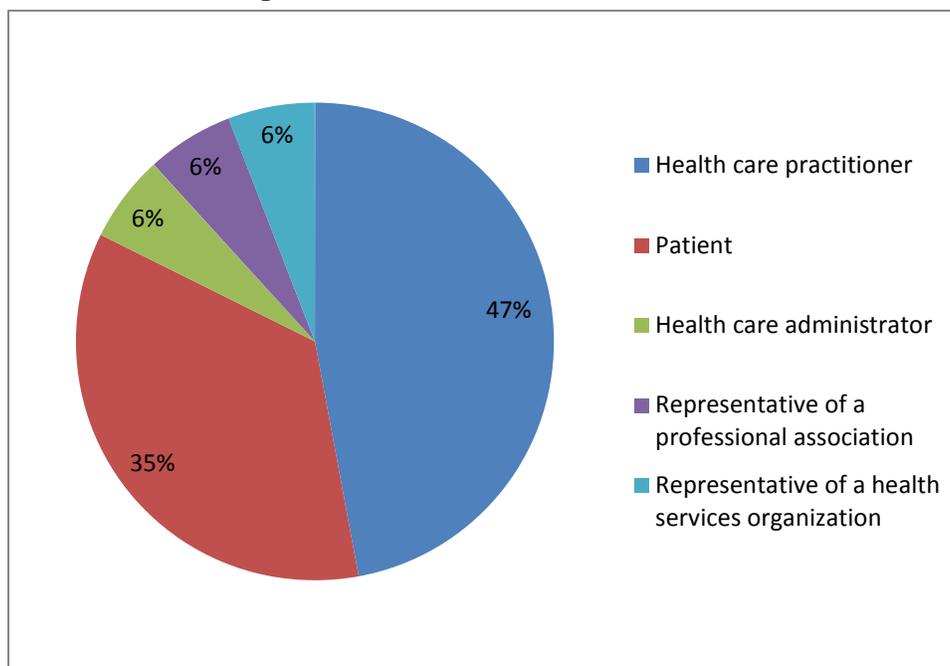
Figure 5: Foot Care Practitioners' Practice Settings²⁵⁶



For those survey respondents who identified as not practising foot care, the majority — 47% — identified themselves as health care practitioners, whereas 35% identified themselves as patients. The remaining survey respondents self-identified as health care administrators, or as representatives of professional associations or health service organizations (see Figure 6).

²⁵⁶ HPRAC, Question Pro Survey Response, Chiroprody/Podiatry Survey, accessed May 11, 2015.

Figure 6: Non-Foot Care Respondents' Self-Identification²⁵⁷



The majority of responses received were supportive of COCOO's application for an expanded scope of practice. Eighty-nine per cent of survey respondents indicated that the applicant has demonstrated that there should be a change in scope of practice for chiroprody and podiatry.²⁵⁸ An equal number of survey respondents (89%) agreed with the applicant's proposed scope of practice statement.²⁵⁹ A similar number of respondents (88%) identified that the applicant's proposal for a change in scope of practice protects the public interest.²⁶⁰

When asked if the proposed changes were in the public interest, the most important factors for respondents were that the proposal a) addresses critical gaps in professional services, b) addresses the changing public need for services and increases public awareness of available services and c) that it will improve access to care across the health care system.²⁶¹

For respondents who identified that the proposal was not in the public interest, the most important factors were that the proposal a) does not address patient safety (potential risk of harm), b) promotes professional self-interest over the public need and c) does not address critical gaps in professional services.²⁶²

Other findings from the survey indicated that 65% of survey respondents supported COCOO registering new individuals into the podiatrist class of membership.²⁶³ Finally, regarding risk of harm, more than half of respondents reported that the proposed change in scope of practice may result in a decreased risk of harm (see Figure 7).

²⁵⁷ HPRAC, Question Pro Survey Response, Chiroprody/Podiatry Survey, accessed May 11, 2015.

²⁵⁸ HPRAC, Question Pro Survey Response, Chiroprody/Podiatry Survey.

²⁵⁹ Ibid.

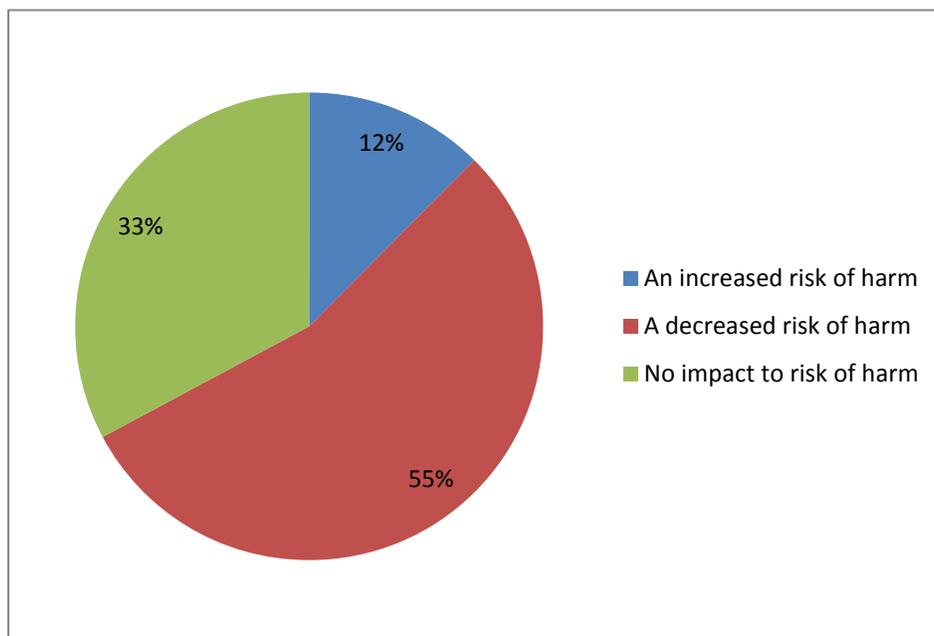
²⁶⁰ Ibid.

²⁶¹ Ibid.

²⁶² Ibid.

²⁶³ Ibid.

Figure 7: Stakeholder Identification of Risk of Harm Related to Proposed Change²⁶⁴



In order to better understand trends and themes, HPRAC considered this feedback as it relates to the criteria, and not as statistically significant quantitative data.

Written Comments

While comments from stakeholders were both extensive and broad in focus, certain comments and issues were more frequently raised in survey text boxes and written submissions. These comments are discussed below.

Access to Diagnostic Tests

Allowing chiropractors/podiatrists to perform diagnostic tests was raised by stakeholders in the context of improving efficiencies in foot care delivery. As one stakeholder explained, “designating ordering rights for appropriate labs, x-rays, and other diagnostics makes the system more seamless and reduces delays and ultimately makes a better experience for the patient.”²⁶⁵ Several stakeholders urged that expanding the scope of practice to include diagnostic testing would greatly assist in the timely delivery of efficient foot care.^{266,267,268,269} HPRAC heard that when diagnostic tests are not accessible from a podiatrist/chiropractor, patients must navigate their way through referral structures that often involve multiple health care practitioners.^{270,271}

²⁶⁴ HPRAC, Question Pro Survey Response, Chiropractic/Podiatry Survey, accessed May 11, 2015.

²⁶⁵ HPRAC, *Stakeholder Feedback on the Chiropractic/Podiatry Referral: The Regulation of Chiropractic & Podiatry, Part I: Surveys Submitted Online*, 119.

²⁶⁶ *Ibid.*, 112.

²⁶⁷ *Ibid.*, 96.

²⁶⁸ *Ibid.*, 123.

²⁶⁹ *Ibid.*, 105-7.

²⁷⁰ *Ibid.*, 119.

This process was reported by stakeholders to be placing a strain on busy physicians and on the health care system, and potentially compromising patient care and safety.^{272,273,274,275,276}

Interprofessional or Multidisciplinary Care

IPC was viewed by a number of stakeholders as essential to improving health care delivery and patient outcomes.^{277,278,279,280,281} Challenges for IPC were also identified by stakeholders, however; these included the lack of understanding of chiropractors' and podiatrists' scope of practice, and the lack of information sharing among health professionals. The Ontario Physiotherapy Association (OPA), for example, noted that "an inter-professional approach to foot and ankle care (recognizing the skills and competencies of all regulated professions who work in its field) is critical to ensuring that Ontarians have the care they need, when they need it, in the communities in which they live."²⁸²

Similarly, COFAS, OOA and COA noted that the focus should not be on expanding scopes of practice but on how the various scopes on a team of multi-disciplinary professionals interconnect with one another.²⁸³ Stakeholders often described a need for all health care professionals to work together with the patient and his/her family to develop, contribute to and deliver the patient's care plan.²⁸⁴ HPRAC heard that IPC is especially important for foot care patients,²⁸⁵ because follow-up care sometimes takes place over a number of years, involves multiple health care practitioners in the private and public health care sphere and takes place in various practice settings.

Chronic Disease Management and the Importance of Preventative Care

Many stakeholders spoke about putting greater emphasis on chronic disease management and preventative care, explaining that it could significantly contribute to improved care and patient outcomes, and lower costs to the health care system.^{286,287,288,289} For instance, stakeholders

²⁷¹ Ibid., 128.

²⁷² Ibid., 106.

²⁷³ Ibid., 119.

²⁷⁴ Ibid., 124.

²⁷⁵ Ibid., 103.

²⁷⁶ Ibid., 121.

²⁷⁷ HPRAC, *Stakeholder Feedback on the Chiroprody/Podiatry Referral: The Regulation of Chiroprody & Podiatry, Part II: Other Submissions*, 40. .

²⁷⁸ Ibid., 104.

²⁷⁹ Ibid., 13-14.

²⁸⁰ Ibid., 131.

²⁸¹ Ibid., 136.

²⁸² HPRAC, *Stakeholder Feedback on the Chiroprody/Podiatry Referral: The Regulation of Chiroprody & Podiatry, Part II: Other Submissions*, 136.

²⁸³ Ibid., 38.

²⁸⁴ HPRAC, *Stakeholder Feedback on the Chiroprody/Podiatry Referral: The Regulation of Chiroprody & Podiatry, Part I: Surveys Submitted Online*, 118.

²⁸⁵ Ibid., 109.

²⁸⁶ HPRAC, *Stakeholder Feedback on the Chiroprody/Podiatry Referral: The Regulation of Chiroprody & Podiatry, Part II: Other Submissions*, 10-2.

reported that preventative interventions and management modalities could reduce the likelihood of chronic diseases from worsening into other serious conditions (e.g., a foot amputation might be required as a result of not managing a diabetic foot ulcer proactively).^{290,291,292,293,294} One stakeholder explained the importance of preventative care in the following way: “it has been shown that education and prevention and conservative treatment can allow a patient to maintain a healthier lifestyle so they will not require outcomes such as infection requiring amputations or other related surgical methods.”²⁹⁵

The Canadian Federation of Podiatric Medicine (CFPM) stated that the most pressing challenges for foot care in Ontario are the result of the prevalence of chronic illness and an aging population. The organization further explained that putting an emphasis on podiatric surgery does not necessarily provide solutions for managing chronic diseases. For instance, CFPM argued that “many of the complications which might require surgery can be avoided by earlier intervention by specialist podiatrists/chiropractors capable of undertaking skilled assessment, early detection and wound management at low cost.”²⁹⁶ The organization went on to say that while “invasive surgery is an important element of modern practice, it is unlikely to provide solutions to the growing requirements for chronic disease management in an aging population.”²⁹⁷ It also noted that “there is broad agreement that the aging population and prevalence of chronic illness constitute the most pressing challenge for foot care in Ontario.”²⁹⁸

The importance of preventative care was underscored by COFAS, OOA and COA, who explained “that 2.3 million Canadians live with diabetes, 15% or 345,000 of whom will develop a diabetic foot ulcer in their lifetime; 50% of all lower limb amputations in Ontario are directly related to diabetes; and more than half of these may have been prevented by appropriate footwear and more effective nail and foot care.”²⁹⁹

²⁸⁷ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Regulation of Chiropody & Podiatry, Part I: Surveys Submitted Online*, 113.

²⁸⁸ *Ibid.*, 118.

²⁸⁹ *Ibid.*, 119.

²⁹⁰ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Regulation of Chiropody & Podiatry, Part II: Other Submissions*, 13.

²⁹¹ *Ibid.*, 49.

²⁹² *Ibid.*, 180.

²⁹³ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Regulation of Chiropody & Podiatry, Part I: Surveys Submitted Online*, 119.

²⁹⁴ *Ibid.*, 118.

²⁹⁵ *Ibid.*, 105.

²⁹⁶ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Regulation of Chiropody & Podiatry, Part II: Other Submissions*, 13.

²⁹⁷ *Ibid.*, 12.

²⁹⁸ *Ibid.*

²⁹⁹ *Ibid.*, 44.

Title and Role Clarity

Much like the first consultation, respondents also emphasized the need to standardize the title for the profession to “podiatrist,” and many submissions expressed concerns about how the profession is misunderstood by the public and other health professions.^{300,301,302,303}

A variety of stakeholders noted that the title “chiropody” is an antiquated term that needs to be discontinued.^{304,305,306} Stakeholders indicated an interest in attaining consistency with international foot care practitioners, who are typically identified as “podiatrists.”^{307,308,309} As noted by one stakeholder, “there is broad agreement that the term chiropody and chiropodist is outmoded and is no longer used...and the term podiatrist best reflects modern practice and near universal usage.”³¹⁰

Consistent with the issues noted above, many submissions pointed to another concern: confusion between what a podiatrist does versus what a chiropodist does — specifically, that the current foot care model is confusing for patients, other health care practitioners and insurance providers.^{311,312,313,314,315} HPRAC heard that many insurance providers do not recognize the chiropodist title and that other health care providers (e.g., physicians) often do not know where to send patients with foot care issues.³¹⁶ One of the most frequently observed consultation comments was that the scope of practice for chiropodists and podiatrists is not clear to the public and other health professionals and, as a result, create barriers to receiving timely, safe and appropriate foot care are created for patients.^{317,318,319,320,321,322}

One stakeholder explained that changing the profession’s title to podiatrist would address issues of confusion among the public and other health practitioners (i.e., not understanding the

³⁰⁰ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Regulation of Chiropody & Podiatry, Part I: Surveys Submitted Online*, 107.

³⁰¹ *Ibid.*, 108.

³⁰² *Ibid.*, 120.

³⁰³ *Ibid.*, 124.

³⁰⁴ *Ibid.*, 96.

³⁰⁵ *Ibid.*, 123.

³⁰⁶ *Ibid.*, 103.

³⁰⁷ *Ibid.*, 114.

³⁰⁸ *Ibid.*, 119.

³⁰⁹ *Ibid.*, 120.

³¹⁰ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Regulation of Chiropody & Podiatry, Part II: Other Submissions*, 10.

³¹¹ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Regulation of Chiropody & Podiatry, Part I: Surveys Submitted Online*, 108.

³¹² *Ibid.*, 113.

³¹³ *Ibid.*, 98.

³¹⁴ *Ibid.*, 123.

³¹⁵ *Ibid.*, 127.

³¹⁶ *Ibid.*, 106.

³¹⁷ *Ibid.*, 96.

³¹⁸ *Ibid.*, 97.

³¹⁹ *Ibid.*, 104.

³²⁰ *Ibid.*, 106.

³²¹ *Ibid.*, 119.

³²² *Ibid.*, 120.

profession’s scope of practice and competencies). According to this stakeholder “a title change is necessary”;³²³ the stakeholder further suggested that:

it will create less confusion amongst not only the public but other health professionals. A majority of the general public, family physicians, medical specialists and paramedical health professionals are not familiar with the term Chiropodist/Chiropody and our scope of practice. As such, many patients cannot be advised as to where to go for foot care or seek care themselves — they don't know where to go because they don't know who to go to. Instead patients either continue on without care or the health care system is burdened by patients being sent to see various medical specialists or going to the emergency room — often times for conditions that can be easily and readily addressed by a Chiropodist.³²⁴

Although a large number of stakeholders felt that adopting the podiatry title would help eliminate confusion, a small number of participants felt that only those who are competent and authorized to practise to the full podiatric scope should be authorized to call themselves podiatrists. Comments such as these were infrequent, but when they were mentioned, respondents requested that “chiropodists retain the chiropodist title until such time as all the competencies required to practise at the podiatrist level had been achieved.”³²⁵

Other Issues

The following noteworthy issues were raised by stakeholders but were not identified as frequently as those noted above.

The Importance of Education and Training

HPRAC heard that there are significant disparities between the chiropody and the podiatry education models.³²⁶ According to one stakeholder, “chiropody training at the outset would need to be increased to a podiatric training and acquisition of skills confirmed by an approved academic facility.”³²⁷

Certain stakeholders questioned whether chiropodists have the skills to safely undertake the podiatrists’ scope of practice, and whether training will be in place to support the required upgrading of skills. One stakeholder asked “how a chiropody student or practitioner could demonstrate requisite skill, knowledge and training to take on an advanced podiatric scope of practice when there are no adequate training programs to objectively measure competence.”³²⁸

³²³ Ibid., 119.

³²⁴ Ibid., 119

³²⁵ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Regulation of Chiropody & Podiatry, Part II: Other Submissions*, 135.

³²⁶ Ibid., 46.

³²⁷ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Regulation of Chiropody & Podiatry, Part I: Surveys Submitted Online*, 108.

³²⁸ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Regulation of Chiropody & Podiatry, Part II: Other Submissions*, 132.

Consistent with this comment, OMA highlighted concerns with COCOO not being able to identify or define proposed training or educational programs that could be offered in Ontario.³²⁹

Stakeholders also felt that current podiatrists practising in Ontario with a Doctor of Podiatric Medicine (DPM) designations would need upgrading/bridging courses before becoming eligible for the proposed scope increase.³³⁰ According to one stakeholder “podiatrists from the older podiatry class, i.e., graduates from the 70s and 80s who have a title of DPM, are in no way comparable to the new grads of Podiatry from the US or even Chiropody in Ontario. Increased medical education, including pharmacological education, as well as surgical training (both soft-tissue and bony) is far advanced in the newer curriculum.”³³¹

Related to the issue of education and training, a number of comments from stakeholders expressed an interest in ensuring that an education program exists for podiatrists based in Ontario.^{332,333,334} There were recommendations for adopting a podiatric education model that would mirror the model currently used in the United States, for example.^{335,336,337} OPMA recommended developing a university-level podiatric education model for Ontario that would be supported by a post-graduate degree program equivalent to the DPM program offered in the United States and Quebec (i.e., a four-year post-baccalaureate program).³³⁸ The Ontario Society of Chiropodists (OSC) advocated for the creation of a university-level podiatry program in Ontario and argued that “a made in Ontario approach should be examined to offer the highest possible standard of care and scope of practice, while supporting the broad aim that there is a single profession drawing on the skills and expertise of both chiropodists and podiatrists.”³³⁹ OSC also recommended “examining the US DPM model and all models of podiatry studies offered in Canada and internationally.”³⁴⁰

Funding Issues

The issue of access to foot care services was again brought to HPRAC’s attention in the context of public versus private payment in the second consultation. It was explained that patients primarily pay for foot care services out-of-pocket or by using private insurance.³⁴¹ Certain stakeholders felt that foot care services are expensive and should be publicly funded, particularly

³²⁹ Ibid., 131.

³³⁰ Ibid., 120.

³³¹ Ibid., 119-20.

³³² Ibid., 112.

³³³ Ibid., 108.

³³⁴ Ibid., 123.

³³⁵ Ibid., 96.

³³⁶ Ibid., 107.

³³⁷ Ibid., 112.

³³⁸ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Regulation of Chiropody & Podiatry, Part II: Other Submissions*, 151.

³³⁹ Ibid., 151.

³⁴⁰ Ibid.

³⁴¹ In Ontario, a maximum of \$135 worth of podiatric services annually are publicly funded by OHIP and certain foot care services may be paid for under OHIP if they are delivered by a family health team or other not-for-profit agency. Please see Part I: What We Learned,” for further information.

for vulnerable and/or high-needs patients (e.g., those with diabetes, the elderly, those with obesity, those with vascular problems, ODSP recipients, children and the homeless).^{342,343,344,345}

A small proportion of stakeholders spoke about to need to allocate government resources to preventative care services. RNAO “believes health system funds would be more effectively spent in preventing foot complications rather than treating them.”³⁴⁶ CFPM also shared similar thoughts about putting more resources into preventative care services/programs by stating that “diabetic foot amputation is estimated to cost the Ontario healthcare system \$95 million each year (Canadian Association of Wound Care, 2015). Effective, accessible preventative care makes sense, and an educated and competent chiropody workforce capable of providing such a service already exists.”³⁴⁷

Oversight Mechanisms

Although agreeing in principle with an expansion of scope, CPSO and OMA submissions raised issues regarding the oversight of podiatrists and podiatric surgery. CPSO indicated, through their considerations for HPRAC, that a number of mechanisms are necessary for the effective oversight and management of the performance of podiatry in Ontario. This included standards for professionals and premises (e.g., inspection program for private clinics and/or others practising in an out-of-hospital setting), and a need for policies and quality assurance mechanisms for professionals performing controlled acts.³⁴⁸ CPSO noted that there “may be value in developing Standards of Practice guidelines that explicitly set out the limits and expectations of the podiatrists’ scope of practice and performance of controlled acts.”³⁴⁹

OMA also made comments about the implementation of quality-assurance and inspection requirements for podiatric surgery centres, such as the ones used by independent health facilities (IHF) administered by the CPSO, and noted that “it would be unprecedented in Ontario to have such ‘surgery centres’ regulated by a body other than the College of Physicians and Surgeons of Ontario.”³⁵⁰

Consumer Protection

HPRAC heard from Orthotics Prosthetics Canada (OPC), OPMA and the Pedorthic Association of Canada (PAC) about the growing problem of the over-prescription of orthotic devices. OPMA noted that “there is valid cause for concern about the excessive prescription and dispensing of foot and ankle orthotics and about the dispensing of ineffective, even harmful, foot and ankle

³⁴² Ibid., 124.

³⁴³ Ibid., 105.

³⁴⁴ Ibid., 106.

³⁴⁵ Ibid., 109.

³⁴⁶ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Regulation of Chiropody & Podiatry, Part II: Other Submissions*, 180.

³⁴⁷ Ibid., 13.

³⁴⁸ Ibid., 108-9.

³⁴⁹ Ibid., 109.

³⁵⁰ Ibid., 40.

orthotics. Additional protections are warranted, in fact are overdue, to serve and protect the public interest.”³⁵¹

A small number of stakeholders recommended that the selling and dispensing of orthotic products should be regulated under the RHPA. For instance, PAC stated that the selling and dispensing of an orthotic device should “be a controlled act under the RHPA, authorized only to those professions that have the relevant scopes of practice and appropriate competencies.”³⁵²

There were concerns raised with this proposed approach, however. It was noted by OPMA that “bringing foot and ankle orthotics into the RHPA’s controlled act regime, however, would exclude unregulated practitioners from manufacturing orthotics, except by delegation.”³⁵³

A small number of comments suggested recognizing these other foot care professions (i.e., pedorthists, orthotists and prosthetists), either through the RHPA or through “title protection.” OPMA stated that, “excluding them would be unfair and contrary to public interest.”³⁵⁴

Expanding Assessment and Diagnosis to the Ankle

One of the most controversial issues to emerge from the consultation was the applicant’s request to expand the profession’s scope of practice to include assessment and diagnosis “to the ankle and structures affecting the ankle.” Stakeholders expressed differing views regarding this particular issue.^{355,356,357,358,359,360,361,362,363}

The Ontario Chiropractic Association (OCA) suggested that expanding the scope of practice of chiropodists and podiatrists to the ankle would broaden the scope to other body parts that are not within the competencies of the profession.³⁶⁴ For instance, OPA mentioned that “the foot and ankle complex is not isolated from conditions, injuries and functional issues affecting the entire person and is also subject to specific impairments and issues that, in turn impact overall function.”³⁶⁵ As explained by one stakeholder, structures affecting the foot and ankle could include “conditions of the hip, knee, lower back, pelvic, and upper and lower leg soft tissues, dysfunctions within the kinetic chain, serious neurological conditions impacting the motor or sensory function of the feet.”³⁶⁶

³⁵¹ Ibid., 142.

³⁵² Ibid., 175.

³⁵³ Ibid., 142.

³⁵⁴ Ibid., 143.

³⁵⁵ Ibid., 47-9.

³⁵⁶ Ibid., 106.

³⁵⁷ Ibid., 131.

³⁵⁸ Ibid., 134.

³⁵⁹ Ibid., 169.

³⁶⁰ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Regulation of Chiropody & Podiatry, Part I: Surveys Submitted Online*, 72-3.

³⁶¹ Ibid., 96.

³⁶² Ibid., 112.

³⁶³ Ibid., 120.

³⁶⁴ Ibid., 72-3.

³⁶⁵ Ibid., 134.

³⁶⁶ Ibid., 73.

OCA suggested that the ankle is not within the scope of podiatry and argued that it is unsubstantiated to include the ankle in the scope of practice because it is not relevant to the profession and is not within the profession's body of knowledge:

The "Relevance to the Profession" criterion requires the requested change to be rationally related to the practice of the profession, and to the qualifications and competencies of members of the profession. The "Body of Knowledge" criterion requires that the profession demonstrate that there is a systematic body of knowledge within the profession to perform the activities requested. The submission does not articulate the relevant body of knowledge that would justify and support the treatment by podiatrists of "structures affecting the foot and ankle." Such a definition seems to be broader than a number of other jurisdictions in Canada.³⁶⁷

In contrast, a small percentage of stakeholders who supported the inclusion of the ankle in the scope of practice felt that it would benefit patients, especially "seniors at long term care homes who have limited options to access foot and ankle care."^{368,369,370}

Two-Week Review Period

Following the close of the second consultation, stakeholder comments were publicly posted on HPRAC's website. HPRAC allowed for a two-week period in which stakeholders could make comments on any of the submissions that it received during the second consultation.

During this review period, HPRAC received a total of 18 submissions (10 submissions from individuals and eight submissions from organizations).

Responses from Individuals

As with the initial consultation session, the most frequently identified comments from stakeholders were related to the title for chiropodists and podiatrists. Other recurring issues that permeated a number of the submissions HPRAC received during this two-week consultation period included comments about expanding the scope of practice to the ankle and surgery on the ankle. For instance, individuals who supported the inclusion of surgery on the ankle noted that the vast majority of U.S. jurisdictions allow ankle care as part of the podiatrist's scope of practice. Stakeholders who did not support the inclusion of surgery on the ankle argued that including the ankle would broaden the scope of practice to include parts of the body in which a chiropodist and podiatrist is not trained or educated.

³⁶⁷ Ibid., 72.

³⁶⁸ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Regulation of Chiropody & Podiatry, Part II: Other Submissions*, 128.

³⁶⁹ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Regulation of Chiropody & Podiatry, Part I: Surveys Submitted Online*, 80.

³⁷⁰ Ibid., 120.

Responses from Organizations

Similar to those responses received by individuals, HPRAC received submissions from organizations that presented divergent perspectives on certain aspects of the regulation of chiropractic and podiatry in Ontario.

The applicant's submission during the two week review period highlighted the need for more robust oversight mechanisms for both professionals and premises (e.g., out-of-hospital inspections). The applicant agreed that the oversight of podiatric surgical facilities is necessary to protect public safety and the broader public interest. It also mentioned that it would enlist the help of CPSO because of that organization's expertise and knowledge on the matter.

Key Informant Interviews

A number of key informant interviews were conducted in order to identify stakeholders' interests and concerns to assist HPRAC with recommendation development. Information was sought via correspondence or through face-to-face meetings with persons or organizations with an identified expertise or stake in the issue.

In considering the application for an expanded scope of practice for chiropractors and podiatrists, HPRAC conducted interviews with the following key informants:

Organization	Representative
Alberta Medical Association	Dr. Mittelsteadt, physician
British Columbia Ministry Of Health, Policy and Projects, Professional Regulation and Oversight, Health Sector Workforce Division	Melissa Murdock, Director Laurianne Jodouin, Clinical Practice Advisor
Canadian Association of Wound Care/Diabetic Foot Canada	Mariam Botros, Director, Diabetic Foot Canada
Canadian Federation of Podiatric Medicine	Stephen Hartman, Chief Executive Officer Mike Turcotte, President Olga Lalonde, Chiropractor
Canadian Life and Health Insurance Association Inc.	Karen Voin, Director, Health Dental Policy
Central LHIN Centre for Complex Diabetes Care, North York General Hospital	Rose Dumsha, Clinical Team Manager, Diabetes Program Philip Galagac, Chiropractor
Centre for Complex Diabetes Care Health Sciences North	Joanne Guizzo, Clinical Manager, Ambulatory Care Clinics
College of Chiropractors of Ontario	Peter Stavropoulos, President
College of Podiatry (UK)	David Dunning, Chairman of Council, Society of Chiropractors & Podiatrists and Chairman of the Board of Trustees, College of Podiatry Michael Potter, Chairman of the College of Podiatry Academic Board Alan Borthwick, College of Podiatry Academic Board and Council member

	Wilfred Foxxe, Director of Education and Development, College of Podiatry Joanna Brown, Chief Executive, Society of Chiropodists & Podiatrists
College of Podiatric Surgeons of British Columbia	Valerie Osborne, Interim Registrar, College of Podiatric Surgeons of British Columbia Dr. David Brooks, Podiatric Surgeon
Danforth Foot Clinic	Anna Georgiou, Chiropodist
Grenville Foot Clinic	Justin Turner, Chiropodist
Grey Bruce Health Services, Diabetes Education Program	Lynda Hoffmeyer, Program Manager, Diabetes and Cardiac Rehab
Markham Podiatry	Allen Frankel, Podiatrist Tej Sahota, Chiropodist
Michener Institute for Applied Health Sciences	Catharine Gray, Academic Chair, Graduate Imaging and Chiropody Sydney Redpath, Senior Director, Academic Planning & Operations
Ministry of Health and Long-Term Care, Direct Services Division, Assistive Devices Program	David Schachow, Senior Manager Maureen Williams, Senior Program Coordinator
Ministry of Health and Long-Term Care, Health Human Resources Strategy Division, Health Workforce Policy Branch, Health Workforce Evidence and Innovation Unit	Julia Cho, Manager Stephanie Acker, Provincial Planner
Ministry of Health and Long-Term Care, Health System Accountability and Performance Division, Implementation Branch, Diabetes and Chronic Diseases Unit Implementation Branch	Rena Menaker, Manager, Implementation Allison Weinstein, Implementation Lead Seema Sethi, Project Implementation Manager (Acting) Clara Schneider, Implementation Consultant
Ministry of Health and Long-Term Care, Health System Accountability and Performance Division, X-ray Safety and Long-Term Care Homes Branch	Mary Nestor, Senior Manager Karen Simpson, Senior Manager
Ministry of Health and Long-Term Care, Health System Funding and Quality Division, Quality Based Procedures, Access to Care and Wait Times	Hindy Ross, Manager Allen Pykalo, Implementation Lead
North East Local Health Integration Network	Jennifer Michaud, Chronic Disease Prevention and Management
North East Local Health Integration Network	Monique Lapalme, French Language Services
Ontario Long Term Care Association	Nancy Cooper, Director, Quality & Education
Ontario Orthopaedic Association	Dr. Tim Daniels, Orthopaedic surgeon Josh Albert, The CCS Group
Pedorthic Association of Canada	Jonathan Strauss, Executive Director; Matthew Quattrociocchi, Practising Pedorthist Francesca Grosso, Consultant

Queen Square Family Health Team	Heba Sadek, Executive Director
Registered Practical Nurses Association	Dianne Martin, Executive Director Linda Pickles, Foot Care Nurse Heidi Birks, Professional Practice Associate
Southern Ontario Aboriginal Diabetes Initiative (SOADI)	Roslynn Baird, Executive Director Lindsay Cosh, Foot Care Coordinator
St. Michael's Hospital	Dr. Tim Daniels, Orthopaedic surgeon Suzanne Lu, Chiropodist
Women's College Hospital	Dr. Robyn Evans, Medical Director Dr. Gary Sibbald, Dermatologist

Individual Contributors	Title
Dr. David Armstrong	Podiatric surgeon
Dr. Thomas Forbes	Vascular surgeon
Dr. Jeff Hogan	Family physician, OMA sub-speciality designation in dermatology and infectious diseases
Dr. Mark MacLeod	Orthopaedic surgeon
Rajna Ogrin	Podiatrist
Robert Chelin	Podiatrist

Chapter X: What HPRAC Learned

As part of HPRAC’s deliberations and processes, it uses an independent, evidence-based approach when formulating its recommendations for the Minister.

Three major reviews were completed in order to inform HPRAC’s recommendations.³⁷¹ Information from these reviews was made publicly available during HPRAC’s consultation period:

- literature review on scopes of practice and models of foot care in other jurisdictions;
- literature review on education, regulation, collaboration, safety and economics of foot care in other jurisdictions; and
- jurisprudence review on chiropody, podiatry and the model of foot care in Ontario.³⁷²

Additional research was conducted by HPRAC to better understand the risk of harm and public interest issues related to the practice of chiropody and podiatry in Ontario. This process included additional research and key informant interviews to identify stakeholders’ interests and concerns. The *Final Report of the Competency Assessment Project*, conducted by the Professional Examination Service (PES), a consultant firm hired by the applicant, was also used extensively by HPRAC.³⁷³

During HPRAC’s analysis of the applicant’s proposal, a number of recurring observations were identified:

- The applicant failed to acknowledge the risk of harm associated with the controlled acts requested, particularly as it related to communicating a diagnosis, performing foot and ankle surgery or ordering and applying x-rays. As a result, the applicant did not demonstrate how it would mitigate that risk and ensure that practitioners have the requisite knowledge, skill, training and judgment to provide care according to evidence-based best practices.
- The applicant did not provide a well-reasoned, evidence-based rationale supporting the proposed expanded scope of practice.
- The proposed scope of practice increase focused on a model of care centred on advanced foot and ankle surgery; these procedures do not, as noted by stakeholders, address the most significant needs for Ontarians — routine, publicly accessible, preventative foot care.
- There were few, if any, limitations proposed to the requested controlled and authorized acts. The applicant did not provide clear anatomical boundaries for the surgeries it would

³⁷¹ For the full text of the reviews, see Volume 2.

³⁷² Content from the jurisprudence review does not appear in this report because the case law was outdated and therefore not applicable to the current legislative framework.

³⁷³ The Professional Examination Service (PES) competency assessment project for COCOO involved the evaluation of the college registrants’ “current educational and practical preparation to what is necessary to practise within a proposed expanded scope of practice.” The *Final Report of the Competency Assessment Project: The College of Chiropodists of Ontario*, adopted Alberta and British Columbia registration requirements as the benchmarks for its gap analysis of current COCOO registrations. The report was provided to HPRAC by COCOO in its submission for an expanded scope of practice.

perform nor did it provide clear limitations on the diseases that practitioners would diagnose.

- The applicant did not adequately demonstrate how it would ensure that practitioners have the requisite knowledge, skill and judgment to perform the requested acts and authorities. Few details were provided about the content of a bridging program for practitioners, what would satisfy residency requirements, if any, and whether or not accreditation would be required and, if so, what would constitute this requirement.

Outline

This chapter provides an overview of HPRAC’s analysis of the applicant’s proposal and is assessed as follows:

- new or expanded controlled and authorized acts;
- scope of practice increase;
- rationale for a unitary podiatry profession; and
- other considerations (title, revised drugs list and legislation that prohibits the registration of new podiatrists) .

HPRAC’s Assessment of the Proposed New or Expanded Controlled Acts and Authorities

In providing its review of the applicant’s submission for a scope of practice increase, HPRAC assessed each individual request submitted by the applicant against its criteria for a scope of practice change.

As described in Chapter VIII, the applicant is considered the subject matter expert and, as such, the onus is on the applicant to provide sufficient evidence to effectively assess the application for an expanded scope under the RHPA.

Communicating a Diagnosis

Applicant Request

“Communicating a diagnosis identifying a disease or disorder of the foot or ankle as the cause of a person’s symptoms (currently authorized to members of the podiatrist class only).”³⁷⁴

³⁷⁴ COCOO submission, 28.

What HPRAC Learned from the Applicant

The applicant's request presupposes an expansion, noting that "it is anomalous for any profession that is authorized to perform surgical procedures and to prescribe drugs not to be able to communicate a diagnosis to patients explaining the disease or disorder that the surgery or drugs are designed to address and to obtain informed consent to treatment."³⁷⁵ The applicant notes that health benefit insurers and other regulated health professionals often ask a chiropractor to provide a diagnosis.³⁷⁶

The applicant also states that the result of authorizing the profession to communicate a diagnosis, along with other controlled acts, would result in "substantially enhanced convenience for patients; more timely diagnosis and treatment; and healthcare system efficiencies."³⁷⁷ It was explained by the applicant that the process of having to return to their physician for a diagnosis and diagnostic tests can increase a patient's risk of harm.³⁷⁸

The applicant also provided self-report survey results from registrants specific to the act of communicating a diagnosis. HPRAC reviewed the data as a means to assess the membership's intention to perform a requested act against individuals' impression of their competency to perform the act. The survey found that 98% of registrants intend to perform this controlled act, and 82% believe they have the competencies to do so.³⁷⁹

The applicant does not demonstrate with evidence how it would eliminate this gap in competency to ensure proper communication of a diagnosis. This issue is discussed in greater detail later in this chapter, in "Rationale for a Unitary Podiatry Profession".

What HPRAC Learned from the Literature Reviews

The literature review on scopes of practice and models of foot care in other jurisdictions³⁸⁰ provided insight into the variations that exist between jurisdictions that permit podiatrists to diagnose. As outlined in the review, practitioners can diagnose in Manitoba, Connecticut, Wyoming, Victoria (Australia), South Carolina and British Columbia.³⁸¹ It is worth noting, however, that the literature review also found that British Columbia's *Podiatrists regulation* (2010) made under the *Health Professions Act*, (RSBC 1996, c. 183) and the *South Carolina Legislature* (South Carolina Code of Laws, 2013) prohibited any treatment of systemic diseases causing manifestations in the foot or lower limb.³⁸²

The literature review also provided evidence about the potential for podiatrists to provide inconsistent assessment and diagnosis of a patient's condition that could result in risk of harm. As identified in the review, in a study conducted by Thompson et al., in 2005, it was explained

³⁷⁵ Ibid., 30.

³⁷⁶ Ibid.

³⁷⁷ Ibid., 53.

³⁷⁸ Ibid., 59.

³⁷⁹ Ibid., 31.

³⁸⁰ HPRAC, *Chiropody & Podiatry: A Rapid Literature Review on Scopes of Practice and Models of Foot Care in Other Jurisdictions*, August 2014, accessed July 14, 2015, 14,

http://www.hprac.org/en/reports/resources/Chiropody_Podiatry_Literature_Review_1.pdf.

³⁸¹ Ibid., 14.

³⁸² Ibid., 5-6.

that classifying people based on their risk of foot disease is critical for appropriate foot care. In this study, evaluations were conducted of the assessment of foot health status in three patients among 17 podiatric clinicians. The study found that while clinicians used a standardized assessment form and risk classification system, substantial variation was found in assessing and diagnosing a patient's foot conditions. The result, according to the authors, was that the same patient would have received different care plans to manage her or his foot depending on which clinician she or he saw.³⁸³

What HPRAC Learned from the PES Report

The PES report provided by the applicant assessed registrant's ability to "formulate an appropriate diagnosis and/or differential diagnosis," and found no gaps for all registrants. However, gaps were identified in a number of other areas for registrants; this brought into question the ability of the profession to perform the duties that directly inform a diagnosis. For example, gaps were identified for all registrants when recognizing "the need for additional diagnostic studies, when indicated."³⁸⁴ Gaps were also identified, generally, under the ability of registrants to assess and manage the patient's general medical and surgical status and, specifically, as they related to formulating an appropriate differential diagnosis of the patient's general medical problem(s).³⁸⁵

In addition, the PES report found gaps under the ability to "perform (and/or order) and interpret appropriate diagnostic studies" for many forms of diagnostic tests. Specifically, gaps were found for fluoroscopy, nuclear medicine imaging, magnetic resonance imaging (MRI), computed tomography (CT) scans, vascular imaging, laboratory tests (hematology, serology/immunology, toxicology, etc.) pathology (anatomic and cellular) and other diagnostic studies.³⁸⁶ Gaps were not found in ultrasound for both chiropodists and podiatrists. Chiropodists were found to have gaps in fluoroscopy, whereas podiatrists did not; as well, chiropodists can interpret radiography while podiatrists can order and interpret.³⁸⁷

What HPRAC Learned from Stakeholder Consultations

During its consultations, HPRAC heard from stakeholders who both supported and opposed granting the controlled act of communicating a diagnosis to the applicant. During a key informant interview, representatives from the Michener Institute for Applied Health Sciences, which currently trains chiropodists in Ontario, described the current curriculum as preparing graduates to perform the controlled act.³⁸⁸ COFAS, OOA and COA, however, were not supportive of granting the act, noting in their submissions that there are "a large number of systemic pathologies that present first and foremost in the foot (and ankle) that podiatrists are not educated or competent to diagnose."³⁸⁹ OPA raised similar concerns, noting that the controlled

³⁸³ Thompson, L., Nester, C., Stuart, L. & Wiles, P., "Interclinician variation in diabetes foot assessment – a national lottery?" *Diabetic Medicine*, (2005): 22(2), 196-9.

³⁸⁴ *Ibid.*, 39.

³⁸⁵ *Ibid.*, 39.

³⁸⁶ *Ibid.*, 33.

³⁸⁷ *Ibid.*

³⁸⁸ Key informant interview, Michener Institute, April 17, 2015.

³⁸⁹ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Regulation of Chiropody & Podiatry, Part II: Other submissions*, 48.

act of communicating a diagnosis “carries with it a high risk of harm, and, therefore, cannot and has not been authorized casually.”³⁹⁰

Correspondence with the applicant noted that college registrants would, in fact, under the proposed scope of practice, be communicating a diagnosis for systemic diseases that manifest in the foot.³⁹¹ This would include the communication of a diagnosis of diseases such as diabetes and melanoma.³⁹²

What HPRAC Learned from Previous Referrals

HPRAC also consulted previous HPRAC reports, which considered recommendations related to granting the controlled act of communicating a diagnosis. In one of its reports to the Minister, *Advice to the Minister of Health: Nurse Practitioner Referral*, for example, HPRAC identified the act of communicating a diagnosis as significant, because it enables and facilitates other controlled acts.³⁹³ One of the primary risks of harm identified with the controlled act of communicating a diagnosis was that of misdiagnosis. The report concluded that:

a wrong diagnosis in and of itself can cause emotional, psychological and/or physical harm. If the wrong diagnosis is communicated to the patient and s/he relies on it, then the patient may choose the wrong path in terms of treatment decisions, may suffer trauma from being misdiagnosed, may not seek a second opinion, and may be put at significant risk by not treating the real cause of the problems.³⁹⁴

It is interesting to note that the report explains that treating a patient without a diagnosis is not prohibited by this controlled act. It also notes that while treatment may be limited if it involves controlled acts, risk of harm or breaches of standards of practice, practitioners can and do treat patients in the absence of communicating a diagnosis. As noted in Richard Steinecke’s book, respiratory therapists, who are not authorized to communicate a diagnosis, have a scope of practice statement that supports the assessment and treatment of patients.³⁹⁵

HPRAC’s Analysis

When considering whether to recommend the controlled act of communicating a diagnosis, HPRAC assessed the applicant’s proposal against its criteria for a scope of practice increase:

- **Relevance to the profession:** The applicant did not demonstrate, with evidence, that the profession has the qualifications and competencies to perform the controlled act of communicating a diagnosis. The PES report, which was provided by the applicant, states that gaps exist in a practitioner’s ability to perform the activities that directly inform her/his ability to communicate a diagnosis. The submission did not, however, provide HPRAC with sufficient information demonstrating an understanding of these gaps or how they

³⁹⁰ Ibid., 134-5.

³⁹¹ Letter from COCOO to Tom Corcoran, June 29, 2015.

³⁹² Ibid.

³⁹³ HPRAC, *Advice to the Minister of Health: Nurse Practitioner Referral*, March 1996, accessed July 14, 2015, http://www.hprac.org/en/reports/resources/Nurse_1996.pdf.

³⁹⁴ Ibid., 29

³⁹⁵ Steinecke, Richard. *A Complete Guide to the Regulated Health Professions Act*, Canada Law Book, 1995.

would be eliminated.

- **Risk of harm:** As noted by stakeholders, the applicant does not acknowledge the potential risk of harm associated with its submission, specifically the risk of harm arising from a misdiagnosis. As a result, the applicant does not demonstrate how it would mitigate any risk associated with communicating a diagnosis and how patients would be treated with evidence-based best practices. Most importantly, HPRAC concluded that the potential risk of harm of a misdiagnosis far outweighs the potential risk of harm resulting from a delayed diagnosis.
- **Body of knowledge, education and accreditation:** The applicant did not demonstrate, with evidence, that there is a systematic body of knowledge within the profession to safely and competently communicate a diagnosis. Nor did the applicant demonstrate that members of the profession have, or will have, the knowledge, training, skills and judgment necessary to communicate a diagnosis.
- **Public need:** The profession has not demonstrated that a significant public need would be met through granting the controlled act of communicating a diagnosis. As noted in Chapter V, HPRAC heard that one of Ontarians’ most significant needs is accessible and affordable routine preventative foot care (non-surgical care). HPRAC also reflected on the fact that chiropodists can currently perform their entire legislated scope of practice without the ability to communicate a diagnosis. As well, HPRAC heard in key informant interviews that chiropodists currently communicate with a patient’s physician about critical and ongoing potential health care issues of their patients. As such, it appears to HPRAC that the needs of patients are being met without this controlled act.

HPRAC’s Recommendation

Do not grant authority to communicate a diagnosis.

Applying and Ordering Prescribed Forms of Energy

Applicant Request

“Applying or ordering the application of a prescribed form of energy (not currently authorized for either chiropodists or podiatrists).”³⁹⁶

What HPRAC Learned from the Applicant

The applicant maintains that access to prescribed forms of energy is necessary for “bony and soft tissue pathology, diagnostic ultrasound of the foot, ankle and leg to evaluate and/or guide diagnostic procedures within arterial, venous, subcutaneous and musculoskeletal structures, plethysmography to assess vascular pathology, nerve conduction velocity studies and EMGs in

³⁹⁶ COCOO submission, 28.

order to identify and assess nerve damage.”³⁹⁷ Prescribed forms of energy include: Magnetic Resonance Imaging (MRI), diagnostic ultrasound, and electricity for electromyography etc. The applicant notes that in both Alberta and British Columbia, chiropractors have the authority to order and apply prescribed forms of energy.³⁹⁸

The applicant provided self-report survey results from registrants specific to the act of applying and ordering certain prescribed forms of energy. HPRAC reviewed the data as a means to assess the membership’s intention to perform a requested act, against individuals’ impression of their competency to perform the act. The survey found that:

- 61% of registrants intend to perform an electromyography, and 21% believe they have the competencies to do so;
- 77% of registrants intend to perform nerve conduction studies, and 31% believe they have the competencies to do so;
- 78% of registrants intend to perform electromagnetism for MRIs, and 32% believe they have the competencies to do so; and
- 79% of registrants intend to perform diagnostic ultrasound, and 31% believe they have the competencies to do so.³⁹⁹

The applicant did not demonstrate with evidence how it would eliminate this gap in competency to ensure proper application of prescribed forms of energy. This issue is discussed in greater detail later in the chapter, in “Rationale for a Unitary Podiatry Profession”.

What HPRAC Learned from the PES Report

The PES report, as noted in the “Communicating a Diagnosis,” section of this chapter found gaps with all registrants with regards to their ability to perform and interpret appropriate diagnostic studies, including gaps in MRI, CT and vascular imaging. Gaps were not identified for diagnostic ultrasound.⁴⁰⁰ The applicant’s submission did not provide HPRAC with sufficient information demonstrating an understanding of these gaps or how they would be eliminated.

What HPRAC Learned from Stakeholder Consultations

During its consultations, HPRAC heard that podiatrists in Quebec who have acquired additional postgraduate training are authorized to apply or order (in privately funded labs) the application of prescribed forms of energy, such as MRIs and diagnostic sonography.⁴⁰¹ OPA also supported qualified podiatrists having the authority to apply or order forms of energy.⁴⁰²

³⁹⁷ Ibid., 34.

³⁹⁸ Ibid.

³⁹⁹ Ibid.

⁴⁰⁰ Professional Examination Service, 33.

⁴⁰¹ HPRAC, *Stakeholder Feedback on the Chiropractic/Podiatry Referral: The Regulation of Chiropractic & Podiatry, Part II: Other submissions*, 6.

⁴⁰² Ibid., 135.

HPRAC's Analysis

When considering whether to recommend the controlled act of ordering or applying a prescribed form of energy, HPRAC assessed the applicant's proposal against its criteria for a scope of practice increase:

- **Relevance to the profession:** The applicant did not demonstrate with evidence that the profession has the qualifications and competencies to perform the controlled act. The PES report provided by the applicant provides a number of instances in which gaps exist related to applying or ordering a prescribed form of energy. The applicant's submission did not provide HPRAC with sufficient information demonstrating an understanding of these gaps or how they would be eliminated.
- **Risk of harm:** As noted by stakeholders, the applicant does not acknowledge the potential risk of harm associated with its submission, specifically the risk of harm arising from prescribed forms of energy. As a result, the applicant did not demonstrate how it would mitigate any risk associated with the technologies used when performing this controlled act or demonstrate how it would ensure that practitioners have the requisite training and competencies to ensure care is being provided according to evidence-based best practices.
- **Body of knowledge, education and accreditation:** The applicant did not demonstrate that there is a systematic body of knowledge within the profession to perform the activities being requested. Indeed, the applicant's own self-reporting survey overwhelmingly demonstrated that its members felt that they do not currently have the competency to perform these activities. The applicant failed to demonstrate that members of the profession have, or will have, the knowledge, training, skills and judgment necessary to apply or order the prescribed forms of energy.
- **Public need:** The profession has not demonstrated that a significant public need would be met through granting the controlled act of applying a prescribed form of energy. Nor was a clear rationale provided demonstrating that a gap in services currently exists for Ontarians.
- **Economic impact:** The applicant has not adequately addressed the potential economic impact of access to the proposed act. The vast majority of chiropody services are not publicly funded (unless they are paid for through the budget of a publicly funded program) and only a very small amount of podiatric services are publicly funded (to a maximum of \$135 annually).⁴⁰³ Because the applicant has not requested public payment of this particular service, any diagnostic tests involving a prescribed form of energy would likely be paid for privately. These services may be available within the public system at minimal or no cost to the patient.

HPRAC also found a number of gaps in logic as it relates to the practical application of the requested controlled act. For example, in the event that practitioners were granted the ability to order and apply MRIs it was unclear to HPRAC where these MRIs would be performed, where the technology would be housed and, ultimately, who would read the images produced by these tests.

⁴⁰³ Ontario Podiatric Medical Association, Patient Information Sheet, accessed July 14, 2015, <http://www.opma.ca/Resources/Documents/OPMA%20OHIP%20%20Priv%20Ins%20-%20Patient%20fact%20sheet%20-%20V1%208%20-%20July%202014.pdf>.

HPRAC’s Recommendation

Do not grant authority to apply or order prescribed forms of energy.

Ordering Laboratory Tests

Applicant Request

“Ordering prescribed laboratory tests (Not currently authorized for either chiropractors or podiatrists) under the Laboratory and Specimen Collection Center Licensing Act and Regulation 682 thereunder and the Medical Laboratory Technology Act and regulations.”⁴⁰⁴

What HPRAC Learned from the Applicant

The applicant presupposes an expansion of its scope of practice, stating that it is “anomalous, if not nonsensical, for chiropractors and podiatrists to be authorized to perform surgical procedures below the dermis, but not be authorized to order the laboratory tests necessary to plan, perform and follow-up on those procedures safely and effectively.”⁴⁰⁵ According to the applicant, since chiropractors do not have the ability to order laboratory tests, patients must be referred back to their family physician for laboratory tests and that this “inconveniences patients and unnecessarily adds costs for the healthcare system.”⁴⁰⁶

The applicant explains that podiatrists in British Columbia, Alberta⁴⁰⁷ and the United States may order laboratory tests consistent with their scope of practice.⁴⁰⁸ In Quebec, podiatrists are authorized to order privately paid for laboratory tests such as biopsies and cultures; they are not authorized to order blood tests, however.⁴⁰⁹ It was also explained that in the UK, chiropractors and podiatrists may not order or take laboratory tests unless authorized by the provider by which they are employed.⁴¹⁰

What HPRAC Learned from the PES Report

As noted previously gaps were identified in the PES report related to laboratory tests (hematology, serology/immunology, toxicology, microbiology, etc.) for all registrants (excluding podiatrists); however, podiatrist members were identified as being able to order (as a non-billable service) and interpret.⁴¹¹

⁴⁰⁴ COCOO submission, 28.

⁴⁰⁵ COCOO submission, 105.

⁴⁰⁶ Ibid., 36.

⁴⁰⁷ Ibid., 37.

⁴⁰⁸ Ibid., 85.

⁴⁰⁹ HPRAC, *Stakeholder Feedback on the Chiropractic/Podiatry Referral: The Regulation of Chiropractic & Podiatry, Part II: Other submissions*, 6.

⁴¹⁰ Ibid., 87.

⁴¹¹ Professional Examination Service, 33.

What HPRAC Learned from Stakeholder Consultations

During a key informant interview with the Michener Institute, it was explained to HPRAC that graduates of the program are prepared to order diagnostic tests.⁴¹²

HPRAC's Analysis

When considering whether to recommend the ability to order laboratory tests, HPRAC assessed the applicant's proposal against its criteria for a scope of practice increase:

- **Relevance to the profession:** The applicant did not demonstrate with evidence that the profession has the qualifications and competencies to perform the controlled act. The PES report, which was provided by the applicant, provides a number of instances in which gaps exist related to interpreting laboratory tests. The submission did not provide HPRAC with sufficient information demonstrating an understanding of these gaps or how they would be eliminated.
- **Risk of harm:** As noted by stakeholders, the applicant does not acknowledge the potential risk of harm associated with its submission, specifically if laboratory test results were to be misinterpreted, resulting in a misdiagnosis and the improper use of a controlled act. As a result, the applicant does not demonstrate how it would mitigate any risk associated with ordering laboratory tests and how it would ensure that practitioners have the requisite training and competencies to ensure care is being provided according to evidence-based best practices.
- **Body of knowledge, education and accreditation:** The applicant did not demonstrate that there is a systematic body of knowledge within the profession to perform the activities being requested. Nor did the applicant demonstrate that members of the profession have, or will have, the knowledge, training, skills and judgment necessary to order and interpret laboratory tests.
- **Public need:** The profession has not demonstrated that a significant public need would be met through granting access to this authorized act. The applicant does not, in a satisfactory manner, show what these tests would be used for nor was a clear rationale provided demonstrating that a gap in services currently exists for Ontarians. Furthermore, as explained in the section, "Communicating a Diagnosis," chiropodists can currently perform their duties while awaiting laboratory tests. For example, a chiropodist or podiatrist could prescribe an antibiotic ointment while awaiting laboratory test results ordered by a physician. In addition, the applicant failed to demonstrate, with evidence, that the ability to order laboratory tests would result in improved patient outcomes. There is little in the application, for example, to demonstrate that podiatrists in the United States, where laboratory tests can be ordered, provide significantly better patient outcomes than do podiatrists in the UK, where laboratory tests cannot be ordered unless authorized by the provider by which a podiatrist is employed.
- **Economic impact:** The applicant has not adequately addressed the potential economic impact of access to the proposed act. The vast majority of chiropody services are not

⁴¹² Key informant interview, Michener Institute, April 17, 2015.

publicly funded (unless paid for through the budget of a publicly funded program) and only a very small amount of podiatric services are publicly funded (to a maximum of \$135 annually).⁴¹³ Since the applicant has not requested public payment of laboratory services, any diagnostic tests would likely be paid for privately. These services may be currently available within the public system at minimal or no cost to the patient.

HPRAC's Recommendation

Do not grant authority to order laboratory tests.

Radiographs

Applicant Request

“Operate radiographic equipment, prescribe radiographs within the podiatry scope of practice and be designated as “radiation protection officers” under the Healing Arts Radiation Protection Act or its successor (Currently authorized for members of the podiatrist class and for DPM chiropodists).”⁴¹⁴

What HPRAC Learned from the Applicant

As with other controlled act requests submitted by the applicant, the application document notes that the ability to order and take x-rays is necessary for appropriate and timely diagnosis and treatment.⁴¹⁵

Certain podiatrists and chiropodists are currently eligible to perform the proposed controlled act. As described by the applicant, the *Healing Arts Radiation Protection Act* (HARPA) currently authorizes a graduate of a four-year course of instruction in chiropody “to order and take x-rays, operate radiographic equipment and to be designated as a radiation protection officer (RPO).”⁴¹⁶ Currently, 14% of college registrants have the requisite training to become an RPO.⁴¹⁷

The applicant also provided self-report survey results from registrants specific to the act of ordering and applying radiographs. HPRAC reviewed the data as a means to assess the membership’s intention to perform a requested act against individuals’ impression of their competency to perform the act. The survey found that:

- 96% of registrants intend to prescribe x-rays, and 73% believe they have the competencies to do so; and
- 59% of registrants intend to take x-rays, and 29% believe they have the competencies to do so.⁴¹⁸

⁴¹³ Ontario Podiatric Medical Association.

⁴¹⁴ COCOO submission, 29.

⁴¹⁵ COCOO submission, 37.

⁴¹⁶ Ibid., 37.

⁴¹⁷ Ibid.

⁴¹⁸ Ibid.

The applicant does not demonstrate with evidence how it would eliminate this gap in competency to ensure proper ordering and application of radiographs. This issue is discussed in greater detail later in this chapter, in “Rationale for a Unitary Podiatry Profession”.

What HPRAC Learned from Its Literature Reviews

Other jurisdictions vary in terms of practitioners being permitted to order and apply radiographs. In New Zealand, for example, a podiatrist must have post-graduate qualifications to become a podiatric radiation protection officer who is qualified to use radiological equipment.⁴¹⁹ In British Columbia, podiatrists may apply x-rays for diagnostic and imaging purposes. In contrast, South Carolina podiatrists are only permitted to use x-rays for the purpose of a diagnosis, which is to ascertain a disease or ailment by symptoms and findings.⁴²⁰ In Quebec, podiatrists are authorized to own radiographic equipment and take radiographs, as well as order them from private labs if a permit has been granted to do so.⁴²¹

What HPRAC Learned from the PES Report

The PES report found that all registrants have the competency to interpret both plain and stress radiographs; however, only the podiatrist class of registrants have the competency to order these tests.⁴²²

What HPRAC Learned from Stakeholder Consultations

CPSO noted that while it does not object to properly trained podiatrists applying radiation and operating radiographic equipment, “over-exposure to radiation is a legitimate patient safety concern and accordingly would suggest that HPRAC and COCOO provide guidance to podiatrists on the safe use of radiation for diagnostic purposes.”⁴²³

During key informant meetings with the Michener Institute, the current program curriculum was described as preparing graduates to operate and apply radiographic equipment.⁴²⁴

HPRAC’s Analysis

When considering whether to recommend the ability to apply and order radiographs HPRAC assessed the applicant’s proposal against its criteria for a scope of practice increase:

- **Risk of harm:** As noted by stakeholders, the applicant does not acknowledge the potential risk of harm associated with its submission, specifically the potential risk of harm associated with over-exposure to x-rays. As a result, the applicant does not demonstrate

⁴¹⁹ Ibid., 93.

⁴²⁰ HPRAC, *Chiropody & Podiatry: A Rapid Literature Review on Scopes of Practice and Models of Foot Care in Other Jurisdictions*.

⁴²¹ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Regulation of Chiropody & Podiatry, Part II: Other submissions* 6.

⁴²² Professional Examination Service, 33.

⁴²³ Consultation comment, 108.

⁴²⁴ Key informant interview, Michener Institute, April 17, 2015.

how it would mitigate any risk associated with the application of the act and that care is being provided according to evidence-based best practices.

- **Body of knowledge, education and accreditation:** The applicant did not demonstrate that there is a systematic body of knowledge within the profession to perform the activities being requested. Nor did the applicant demonstrate that members of the profession have, or will have, the knowledge, training, skills and experience necessary to apply or order radiographs. Indeed, the applicant’s own self-report survey overwhelmingly demonstrated that members felt they did not have the competency to perform the act, and the applicant did not demonstrate how these competency gaps would be eliminated.
- **Public need:** The applicant has not demonstrated that a significant public need would be met through granting the controlled act of applying and ordering radiographs. Nor was a clear rationale provided demonstrating that a gap in services currently exists for Ontarians.
- **Economic impact:** The applicant has not adequately addressed the potential economic impact of access to the proposed act. The vast majority of chiropody services are not publicly funded (unless paid for through the budget of a publicly funded program) and only a very small amount of podiatric services are public funded (to a maximum of \$135 annually).⁴²⁵ Since the applicant has not requested public payment of its services, any radiographs would likely be paid for privately. These services may be currently available within the public system at minimal or no cost to the patient.

Although the training required to become an RPO is significant, access to this controlled act currently exists for certain chiropodists and podiatrists. HPRAC deliberated on how changing the current legislative requirements could result in an increased risk of harm.

HPRAC’s Recommendation

Do not grant authority to apply or order radiographs.

Procedure on Tissue below the Dermis

Applicant Request

“Performing a procedure on tissues below the dermis to treat conditions of the ankle or foot (Currently authorized with respect only to the foot).”⁴²⁶

Tissue below the dermis, as explained by the applicant, would include both soft and bony tissue.⁴²⁷ Under the *Chiropody Act, 1991*, chiropodists may cut into soft tissue, whereas podiatrists may cut into both soft and bony tissue.⁴²⁸

⁴²⁵ Ontario Podiatric Medical Association.

⁴²⁶ COCOO submission, 28.

⁴²⁷ Ibid., 31.

⁴²⁸ *Chiropody Act, 1991*.

What HPRAC Learned from the Applicant

The applicant explained in its application that expansion of its scope of practice to the ankle is recommended in order to “acknowledge the interconnectedness between the ankle and the foot...”⁴²⁹ The applicant notes that the addition of the ankle is consistent with practices in other jurisdictions, including 48 U.S. states, the District of Columbia, British Columbia and Alberta.⁴³⁰

While “podiatric surgeons” in the UK may perform surgical procedures on the foot and ankle,⁴³¹ the scope of practice of “podiatrists” and “chiropodists” in the UK does not include bone surgery.⁴³² Similarly, many podiatrists in Europe (e.g., those in Finland, France, Germany and Sweden) are not authorized to conduct any subcutaneous surgery. Unlike other European jurisdictions, podiatrists in Italy are allowed to perform both soft and bony surgery on the ankle and foot.⁴³³

In Appendix E of the submission, the applicant provided a series of articles that summarize the cost benefits of a podiatric surgery scope of practice. Citing a study from 1987, the applicant summarized the following aspects of the paper: 60% of elective insured surgery was performed by doctors of podiatric medicine (DPMs), the average procedure charge submitted by an orthopaedist was 17% greater than that submitted by a DPM and orthopaedists were five times more likely to perform a procedure on an inpatient basis with extended hospital stays.⁴³⁴

Although information related to the jurisdiction where the study took place and why there may have been variation in charged incurred was absent, the applicant also noted that although DPMs conducted a greater number of procedures, the charges per average surgery were 30% lower.⁴³⁵

The applicant also referenced a 2008 Australian study, which suggests that “podiatric surgery is less costly than orthopaedic surgery in all categories of procedure on average by \$3,635 per procedure and a relative gain in well-being worth \$5,016 per procedure relative to orthopaedic surgery.”⁴³⁶ As with the study noted above, HPRAC was unable to determine the nature and complexity of the procedures performed in this study. Depending on the type of procedure and the level of complexity, costs reported in the study may have been affected.

The applicant also provided self-report survey results from its registrants specific to the act of performing a procedure on tissue below the dermis. HPRAC reviewed the data as a means to assess the membership’s intention to perform a requested act against individuals’ impression of their competency to perform the act. The survey found that 63% of registrants already perform or intend to perform this controlled act, and 34% believe they have the competencies to do so.⁴³⁷

⁴²⁹ Ibid., 31.

⁴³⁰ Ibid..

⁴³¹ Ibid.

⁴³² Ibid., 88.

⁴³³ Ibid., 94.

⁴³⁴ COCOO submission, Appendix B, e-2.

⁴³⁵ Ibid.

⁴³⁶ Ibid.

⁴³⁷ Ibid., 34.

The applicant did not demonstrate with evidence, however, how it would eliminate this gap in competency to ensure proper application of prescribed forms of energy. This issue is discussed in greater detail later in the chapter, in “Rationale for a Unitary Podiatry Profession”.

What HPRAC Learned from its Literature Reviews

A 2009 Australian study compared the number of procedures performed by podiatric surgeons in the private sector to that of orthopaedic surgeons in the public sector. The study found that for the provision of great toe joint surgery, “podiatric surgeons performed the surgery 2-16 times more often compared to orthopaedic surgeons and suggested extending the role of podiatric surgeons within the Australian public sector.”⁴³⁸

In its review of models of foot care in different jurisdictions, the literature review found that 50 states and the District of Columbia permit treatment of the foot, whereas 44 states and the District of Columbia allow treatment at or above the ankle.⁴³⁹ In New York, one of the states that permits treatment above the ankle, complex ankle surgeries may only be carried out by podiatrists who have advanced surgery privileges.⁴⁴⁰

What HPRAC Learned from the PES Report

The PES report includes an extensive discussion of the profession’s preparedness to perform foot and ankle surgery. The report, provided by the applicant, explains that the existing curriculum of George Brown College⁴⁴¹ and the curriculum of the Michener Institute do not prepare graduates to “perform osseous (bone) surgery, to manage such surgical cases, or to administer general anesthesia.”⁴⁴² The report also notes that, for members of the podiatric profession who received their degree prior to 1995, it is not known whether all of these individuals have actually been performing these activities and that “some sort of bridging program may be required...”⁴⁴³

The PES report identifies extensive gaps for forefoot surgery for all registrants, excluding the podiatry class of registrants, including digital surgery, first ray surgery, soft tissue surgery and osseous foot surgery.⁴⁴⁴ Gaps were identified for all registrants, including the podiatric class for procedures related to fusion, management of a fracture and excision of a tumour.⁴⁴⁵ Gaps were also found for all registrants, including podiatrists, for almost all aspects related to reconstructive rearfoot/ankle surgery.⁴⁴⁶

As explained previously, the report acknowledges gaps for all registrants (including podiatrists) as it relates to a practitioner’s ability to “assess and manage the patient’s general medical and

⁴³⁸ HPRAC, *Chiropody & Podiatry: A Rapid Literature Review on Scopes of Practice and Models of Foot Care in Other Jurisdictions*, 9.

⁴³⁹ *Ibid.*, 6.

⁴⁴⁰ *Ibid.*, 16.

⁴⁴¹ As noted in the Professional Examination Service report the George Brown program was taken over by the Michener Institute around 1990. (Professional Examination Service, 9).

⁴⁴² Professional Examination Service, 19.

⁴⁴³ *Ibid.*.

⁴⁴⁴ *Ibid.*, 34-6.

⁴⁴⁵ *Ibid.*.

⁴⁴⁶ *Ibid.*, 37-8.

surgical status”; this included the ability to perform and interpret findings from medical history and physician exams, formulate a diagnosis of the patient’s general medical problems, recognize the need for additional diagnostic studies, formulate and implement an appropriate plan of management, etc.⁴⁴⁷ Furthermore, gaps were identified for competencies acquired during residency training.⁴⁴⁸

What HPRAC Learned from Stakeholder Consultations

Stakeholder comments on this issue, particularly organizations’ comments, raised a number of issues with the request. COFAS, OOA and COA reiterated findings from the PES report, noting that both Michener Institute and George Brown College graduates do not have the knowledge to perform osseous surgery, manage surgical cases or administer general anesthesia. This was confirmed in key informant interviews with the Michener Institute, which explained that the current curriculum does not prepare students for bone surgery, and that inclusion of bone surgery into the curriculum would be difficult for the program to integrate.⁴⁴⁹ COFAS, OOA and COA noted that not only would it be unprecedented to have podiatry surgical centres regulated by a body other than CPSO,⁴⁵⁰ but that podiatrists do not have the “sufficient knowledge of the broader musculoskeletal system that is required to make a surgical assessment of a condition that presents in the foot or ankle.”⁴⁵¹

Physician stakeholders also raised a number of questions with regard to the applicant’s request. CPSO, for example, highlighted that surgery involving the ankle is both complex and intricate, and recommended that HPRAC consider whether podiatrists have the sufficient education and training to safely and effectively perform ankle surgery.⁴⁵² OMA was more pointed with its concerns, stating that it is not confident that a “podiatry model where all practitioners can theoretically perform surgery of the ankle is in the best interest of patient safety.”⁴⁵³ OMA further noted that the applicant’s submission is unclear as to how it would monitor practitioners who have not demonstrated competencies and those with restrictions on their title. It also conveyed in the consultation that it was “troubled” that the applicant’s proposal did not include a clear definition and framework of ankle surgery, noting that it would “expect both a precise definition of ankle surgery as well as specific supporting evidence that this type of surgery is appropriate for podiatrists practicing in Ontario.”⁴⁵⁴

OPA had similar concerns about the lack of specificity around the requested expansion, requesting the deletion of references to “structures affecting the foot and ankle” for the scope increase and that any potential podiatry act include a clear anatomical boundary for the scope of practice.⁴⁵⁵ While not specific to ankle surgery and the potential risk of harm associated with the act, CFPM noted that while invasive surgery is an important element of modern practice, “it is

⁴⁴⁷ Ibid., 39.

⁴⁴⁸ Ibid., 40.

⁴⁴⁹ Key informant interview, Michener Institute, April 17, 2015.

⁴⁵⁰ Ibid., 40.

⁴⁵¹ HPRAC, *Stakeholder Feedback on the Chiropody/Podiatry Referral: The Regulation of Chiropody & Podiatry, Part II: Other submissions*, 48.

⁴⁵² Ibid., 106.

⁴⁵³ Ibid., 131.

⁴⁵⁴ Ibid..

⁴⁵⁵ Ibid., 134.

unlikely to provide solutions to the growing requirements for chronic disease management in an aging population.”⁴⁵⁶

HPRAC’s Analysis

When considering whether to recommend the controlled act of performing a procedure on tissue below the dermis, HPRAC assessed the applicant’s proposal against its criteria for a scope of practice increase:

- **Relevance to the profession:** The applicant has not demonstrated with evidence that the profession has the qualifications and competencies to perform the controlled act. The PES report, which was provided by the applicant, states that significant gaps exist for all registrants of the college, especially as they relate to rearfoot surgery, ankle surgery and possessing the ability to assess and manage a patient’s general medical and surgical status. The applicant’s submission did not provide HPRAC with sufficient information demonstrating an understanding of these gaps or how they would be eliminated.
- **Risk of harm:** As noted by stakeholders, the applicant does not acknowledge the potential risk of harm associated with its submission, specifically the risk of harm associated with foot and ankle surgery. As a result, the applicant does not demonstrate how it would mitigate any risk associated with performing surgery on the ankle or structures affecting the foot and ankle or how patients would be treated with evidence-based best practices. Although delivery of health care outside a hospital setting in the community is consistent with current government policies and programs, the applicant provided little detail on a potential out-of-hospital inspection program, how it would ensure safe delivery of surgery outside of the hospital setting and how it would ensure that practitioners are both competent and properly educated and accredited to perform the proposed surgery. HPRAC fully acknowledges that surgery performed outside of a hospital setting is not inherently dangerous; however, the lack of detail presented by the applicant on how it would ensure podiatric surgical sites outside of hospitals are administered in such a way that protects the public interest suggests a lack of preparedness to administer a program that would ensure patient safety. Moreover, the lack of potential limitations on the requested act or proposed anatomical boundaries for the act would likely result in practitioners having a scope of practice granting access to the foot, ankle and lower leg that would likely increase the potential risk of harm to patients.
- **Body of knowledge, education and accreditation:** The applicant did not demonstrate that there is a systematic body of knowledge within the profession to perform the requested activities. As demonstrated by the PES report, the vast majority of current registrants within the college, including podiatrists, do not possess the knowledge to perform surgery on the rear foot and ankle. Moreover, the current provider of foot care education in the province of Ontario, the Michener Institute, indicated that it would be a significant challenge to prepare students for foot and ankle surgery. As well, details from the applicant on how the profession would ensure that registrants have the proper education and accreditation to perform complex foot and ankle surgery are unclear. Few details were provided on the requirements for a proposed bridging program, whether accreditation

⁴⁵⁶ Ibid., 12.

would be required and, if so, who would undertake the accreditation and what the accreditation would look like and what requirements would exist, if any, around residency.

- **Public need:** The profession has not demonstrated that a significant public need would be met through granting the ability to perform surgery on the foot and ankle. HPRAC heard on multiple occasions, in multiple consultations and through key informant interviews, that the most pressing need related to foot care is routine, accessible foot care, not complex foot and ankle surgery. This is not to say that HPRAC does not recognize the need for timely care for individuals requiring foot and ankle surgery. However, given the existing resources and infrastructure currently in place in Ontario hospitals, HPRAC sees the potential for a reduction in wait times by making full use of these well-established resources. For example, HPRAC learned that wait times for foot and ankle surgery are on the decline in certain parts of Ontario.⁴⁵⁷ While it is difficult to discern the exact cause of the decline, recent improvements may in part be due to funding that was provided by the Ministry to the Local Health Integration Networks (LHINs) for foot and ankle surgery in 2014/15. HPRAC was presented with information noting that the wait times for hips and knees, and for other procedures, were significantly reduced through the introduction of the Ontario Wait Time Strategy in 2004. The Ministry anticipates further improvements with the introduction of Quality-Based Procedures (QBPs), which focus on delivering better quality care through evidence-based best practices.⁴⁵⁸
- **Economic impact:** The applicant has not adequately addressed the potential economic impact of access to the proposed act. The vast majority of chiropody services are not publicly funded (unless paid for through the budget of a publicly funded program) and only a very small amount of podiatric services are publicly funded (to a maximum of \$135 annually).⁴⁵⁹ Since the applicant has not requested public payment of its services, or access to hospital privileges, any surgery would likely be paid for privately. These services may be currently available within the public system at minimal or no cost to the patient. HPRAC heard on multiple occasions that many patients cannot afford minimally expensive offloading devices and routine foot care; as a result, it was unclear to HPRAC how the average Ontarian could afford the cost of complex foot and ankle surgery. Moreover, while the applicant provides rough estimations of the costs of quality assurance programs for bridged practitioners, this did not include the cost of the bridging program itself, accreditation program, residency program and costs to COCOO to develop standards of practice. Given the small numbers of registrants in the profession, HPRAC questions how individual members could afford to bear the costs associated with this scope of practice increase request.

HPRAC's Recommendation

- Do not grant authority for chiropodists to perform bone surgery on the foot.
- Do not grant authority for chiropodists and podiatrists to perform soft and bony surgery on the ankle.

⁴⁵⁷ Key informant interview, MOHLTC, Access to Care and Wait Times, April 17, 2015.

⁴⁵⁸ Ibid.

⁴⁵⁹ Ontario Podiatric Medical Association.

Prescribing, Dispensing and Selling a Drug

Applicant Request

Prescribing, dispensing and selling a drug designated in the Regulations (Chiropractors and podiatrists are currently authorized to prescribe, but not to dispense or sell drugs).⁴⁶⁰

What HPRAC Learned from the Applicant

The applicant has requested an expanded scope of practice that includes dispensing and selling drugs. In its application, COCOO describes how many of the drugs fabricated for conditions related to the foot and ankle are rarely available over the counter and are often provided by pharmaceutical companies to chiropractors and podiatrists for dispensing.⁴⁶¹ While it is not clear from the application the instances in which practitioners would be prescribing, dispensing or selling drugs (e.g., after a particular procedure, or in the course of treating a specific condition, disease or disorder), the applicant does provide a tentative list of drugs it identifies as required for the proposed scope. These drugs include, but are not limited to, codeine, hydrocodone, oxycodone and morphine.⁴⁶²

Practitioners in different jurisdictions were found to have inconsistent privileges related to drugs. As noted by the applicant, in Alberta, podiatrists may prescribe schedule 1 drugs (those listed in the *Pharmacy and Drug Act*), prescribe and dispense benzodiazepine class of drugs (and those permitted in the *Controlled Drugs and Substances Act*) and dispense, compound, and sell schedule 1 and 2 drugs listed in the *Pharmacy and Drug Act*.⁴⁶³ In British Columbia, podiatrists can prescribe, compound and dispense or administer drugs.⁴⁶⁴ In Australia, podiatrists can dispense or administer drugs, but require additional training to prescribe and dispense other drugs.⁴⁶⁵ In New Brunswick, podiatrists may not prescribe, dispense or administer drugs.⁴⁶⁶

What HPRAC Learned from Its Literature Reviews

The literature reviews provided further jurisdictional information on the use of drugs by practitioners, specifically that in Manitoba, practitioners can prescribe drugs,⁴⁶⁷ as can those in Wyoming.⁴⁶⁸ In Connecticut, practitioners can prescribe, administer and dispense,⁴⁶⁹ whereas

⁴⁶⁰ COCOO submission, 29.

⁴⁶¹ Ibid., 35.

⁴⁶² Ibid.

⁴⁶³ Ibid.

⁴⁶⁴ Ibid., 36.

⁴⁶⁵ Ibid., 92.

⁴⁶⁶ Ibid., 82.

⁴⁶⁷ HPRAC, *Chiropractic & Podiatry: A Rapid Literature Review on Scopes of Practice and Models of Foot Care in Other Jurisdictions*, 14.

⁴⁶⁸ Ibid., 17.

⁴⁶⁹ Ibid., 14.

in the UK, practitioners are limited to accessing and supplying a limited range of prescription-only medicines.⁴⁷⁰

What HPRAC Learned from Stakeholder Consultations

Stakeholder comments on this requested controlled act were minimal; however, CPSO raised potential issues related to the request. It noted that misuse, diversion and abuse of prescription narcotics and other controlled substances is a serious public health and safety issue in Ontario.⁴⁷¹ As such, CPSO recommended that if the expanded authority is granted, COCOO support and appropriately monitor those practitioners who prescribe these drugs; moreover, requiring that practitioners complete training and education was strongly recommended before any prescribing, dispensing or selling of drugs occurred.⁴⁷²

HPRAC's Analysis

When considering whether to recommend the ability to prescribe, dispense and sell drugs, HPRAC assessed the applicant's proposal against its criteria for a scope of practice increase:

- **Risk of harm:** As noted by stakeholders, the applicant does not acknowledge the potential risk of harm associated with its submission, specifically as it relates to narcotics, the misuse of which was identified by CPSO as a serious public health and safety concern. As a result, the applicant does not demonstrate with evidence how it would mitigate any risk associated with the application of the act or how it would ensure that practitioners have the requisite training and competencies to ensure that care is being provided according to evidence-based best practices.
- **Body of knowledge, education and accreditation:** The applicant did not demonstrate that there is a systematic body of knowledge within the profession to dispense and sell drugs, including the opioids it is requesting. Nor did the applicant demonstrate that members of the profession have, or will have, the knowledge, training, skills and judgment necessary to dispense and sell drugs, or that they have the ability to safely and judiciously dispense the opioids requested. Moreover, the applicant failed to demonstrate that chiropractors and podiatrists can fill a similar role to that of pharmacists, who act as gatekeepers for drug prescribing and who possess extensive knowledge and expertise about drug interactions.
- **Public need:** The applicant has not demonstrated that a significant public need would be met through granting of this expanded controlled act. While the applicant states that drugs specific to the foot and ankle are rarely available over the counter, no evidence was presented suggesting that these drugs are not available in the extensive network of pharmacies already present in Ontario. In addition, the applicant failed to demonstrate with evidence that the ability to dispense and sell drugs would result in improved patient outcomes.

⁴⁷⁰ Ibid., 17.

⁴⁷¹ Consultation comment, 107.

⁴⁷² Ibid.

HPRAC's Recommendation

Do not grant authority to dispense and sell drugs.

Setting or Casting a Fracture

Applicant Request

“Setting or casting a fracture of a bone or dislocation of the joint, in the foot or ankle (Not currently authorized for either chiropodists or podiatrists).”⁴⁷³

What HPRAC Learned from the Applicant

The applicant states that during the performance of joint-remodelling surgical procedures (arthroplasties) and surgical cuts into the bone (osteotomies), podiatrists dislocate joints and fracture bones. The applicant explains that the authority to set and cast fractures is required in order to comply with standards of care and provide an appropriate continuum of care.⁴⁷⁴

Furthermore, the applicant advises that the ability to set and cast fractures will enable podiatrists to “treat abnormalities of bony structures in both acute and planned surgical reconstructive settings”⁴⁷⁵ and reduce the use of hospital emergency rooms.⁴⁷⁶

The applicant also provided self-report survey results from registrants that were specific to setting or casting a fracture. HPRAC reviewed the data as a means to assess the membership’s intention to perform a requested act against individuals’ impression of their competency to perform the act. The survey found that:

- 63% of registrants intend to perform this controlled act on the foot, and 24% believe they already have the competencies to do so; and
- 49% of registrants intend to perform this controlled act on the ankle, and 15% believe they have the competencies to do so.⁴⁷⁷

The applicant did not demonstrate with evidence how it would eliminate this gap in competency to ensure the proper setting and casting of a fracture. This issue is discussed in greater detail later in this chapter, in “Rationale for a Unitary Podiatry Profession”.

What HPRAC Learned from the Literature Reviews

In other jurisdictions, specifically Alberta and British Columbia, setting a fracture is part of a podiatrist’s scope of practice.⁴⁷⁸ In New York, however, although a podiatrist with advanced ankle surgery may engage in ankle fracture fixation, a podiatrist shall “not include treating any part of the human body other than the foot, treating fractures of the malleoli...or cutting

⁴⁷³ COCOO submission, 28.

⁴⁷⁴ Ibid., 31.

⁴⁷⁵ Ibid., 32.

⁴⁷⁶ Ibid..

⁴⁷⁷ Ibid., 31-2.

⁴⁷⁸ Ibid., 32.

operations upon the malleoli unless the podiatrist obtains an issuance of a privilege to perform podiatric standard ankle surgery or podiatric advanced ankle surgery.”⁴⁷⁹

What HPRAC Learned from the PES Report

The PES report provided by the applicant identifies gaps for all registrants, including podiatrists, in many areas related to fractures. These gaps include the management of closed fractures and dislocations, including pedal fractures,⁴⁸⁰ the open management of fracture and metatarsophalangeal joint dislocation,⁴⁸¹ the open management of tarsometatarsal fracture/dislocation,⁴⁸² the open repair of the adult mid-foot/rear foot/ankle, etc.⁴⁸³ The submission did not provide HPRAC with sufficient information demonstrating an understanding of these gaps or how they would be eliminated.

HPRAC’s Analysis

When considering whether to recommend the ability to set or cast a fracture, HPRAC assessed the applicant’s proposal against its criteria for a scope of practice increase:

- **Relevance to the profession:** The applicant has not demonstrated with evidence that the profession has the qualification and competencies to perform the controlled act. The PES report, which was provided by the applicant, provides a number of instances in which gaps exist related to the ability to set or cast fractures for all registrants. The submission did not provide HPRAC with sufficient information demonstrating the applicant’s understanding of these gaps or how they would be eliminated.
- **Risk of harm:** As noted by stakeholders, the applicant does not acknowledge the potential risk of harm associated with its submission. As a result, the applicant does not demonstrate with evidence how it would mitigate any risk associated with the application of the act or how it would ensure that practitioners have the requisite training and competencies to ensure care is being provided according to evidence-based best practices.
- **Body of knowledge, education and accreditation:** The applicant did not demonstrate that there is a systematic body of knowledge within the profession to perform the requested activities. Nor was it shown that members of the profession have, or will have, the knowledge, training, skills and experience necessary to set and cast a fracture.
- **Public need:** The profession has not demonstrated with evidence that a significant public need would be met by access to privately paid-for setting and casting of a fracture. It was not clear to HPRAC which procedures would be used and under what circumstances a fracture would be set or cast.
- **Economic impact:** The vast majority of chiropody services are not publicly funded (unless paid for through the budget of a publicly funded program) and only a very small amount of

⁴⁷⁹ HPRAC, *Chiropody & Podiatry: A Rapid Literature Review on Scopes of Practice and Models of Foot Care in Other Jurisdictions*, 15-16.

⁴⁸⁰ Professional Examination Service, 34.

⁴⁸¹ *Ibid.*, 35.

⁴⁸² *Ibid.*, 36.

⁴⁸³ *Ibid.*, 38.

podiatric services are public funded (to a maximum of \$135 annually).⁴⁸⁴ Since the applicant has not requested public payment of their services, any setting or casting of fractures would likely be paid for privately. Because these services may be currently available within the public system at no or minimal cost to the patient, it was unclear to HPRAC how likely it is that there would be any significant reduction in visits to emergency departments.

Administering a Substance by Injection

Applicant Request

“Administering, by injection, a substance in the Regulations (Currently authorized for both chiropodists and podiatrists, but limited to injections into the foot).”⁴⁸⁵

What HPRAC Learned from the Applicant

The applicant advises that it is in the best interests of the patient that podiatrists require the authority to administer substances by injection elsewhere in the body for the current and proposed scope of practice.⁴⁸⁶ The applicant goes on to explain that, as per clinical best practices, podiatrists need access to perform injections in the thigh, buttocks, shoulder, abdomen, arm, hand and wrist, as well as the ankle and foot.⁴⁸⁷ It was further noted that the accepted standard for the administration of the drugs requested for the expanded controlled acts (e.g., codeine, hydrocodone, oxycodone, morphine, etc.) is outside of the foot.⁴⁸⁸ In reviewing the applicant’s submission, it was not clear which substances registrants would be injecting. Moreover, neither the clinical best practices nor the accepted standard referenced by the applicant was discussed in detail or provided to HPRAC.

What HPRAC Learned from the Literature Reviews

A review of the jurisdictions in which foot care practitioners may perform injections produced varied results. In Quebec, podiatrists are not restricted as to where they may administer a substance.⁴⁸⁹ In Wisconsin⁴⁹⁰ and California,⁴⁹¹ podiatrists may use general anesthetic, but may only do so when it is administered under the direction of a physician. In Wyoming and the UK, anesthesia may only be locally administered.⁴⁹²

⁴⁸⁴ Ontario Podiatric Medical Association.

⁴⁸⁵ COCOO submission, 28.

⁴⁸⁶ Ibid., 33.

⁴⁸⁷ Ibid.

⁴⁸⁸ Ibid., 34.

⁴⁸⁹ Consultation comment, 6.

⁴⁹⁰ HPRAC, *Chiropody & Podiatry: A Rapid Literature Review on Scopes of Practice and Models of Foot Care in Other Jurisdictions*, 5.

⁴⁹¹ Ibid., 14.

⁴⁹² Ibid., 17.

What HPRAC Learned from the PES Report

The PES report notes that “podiatrists in the United States are not trained to administer general anesthesia. US podiatrists may perform surgeries that require the use of general anesthesia or monitored anesthesia care; however, it must be administered by an anesthesiologist.”⁴⁹³ The report, provided by the applicant, identifies that for the management of injections and aspirations, gaps were found for the ankle for all registrants (excluding podiatrists). For anesthesia management, including general, spinal and epidural anesthesia, gaps exist for all registrants, including podiatrists. Gaps did not exist for local and regional anesthesia management.⁴⁹⁴ The submission did not provide HPRAC with sufficient information demonstrating an understanding of these gaps or how they would be eliminated.

What HPRAC Learned from the Consultations

During consultation comments, CPSO again underscored the need for practitioners to have the necessary knowledge, skill and judgment to assess and monitor anesthesia use. It also explained that, for patient safety reasons, “the administration of anesthesia directly into the central nervous system (e.g. epidural blocks) must be restricted to anesthesiologists.”⁴⁹⁵

HPRAC’s Analysis

When considering whether to recommend the ability to administer a substance by injection, HPRAC assessed the applicant’s proposal against its criteria for a scope of practice increase:

- **Relevance to the profession:** The applicant has not demonstrated, with evidence, that the profession has the qualification and competencies to perform the controlled act. The PES report provided by the applicant notes a number of instances in which gaps exist related to administering anesthesia. The submission did not provide HPRAC with sufficient information demonstrating the applicant’s understanding of these gaps or how they would be eliminated.
- **Risk of harm:** As noted by stakeholders, the applicant does not acknowledge the potential risk of harm associated with its submission, specifically as it relates to administering anesthesia. As a result, the applicant does not demonstrate how it would mitigate any risk associated with performing this controlled act or how it would ensure that practitioners have the requisite training and competencies to ensure that care is being provided according to evidence-based best practices.
- **Body of knowledge, education and accreditation:** The applicant did not demonstrate that there is a systematic body of knowledge within the profession to perform the requested activities. Nor was it shown that members of the profession have, or will have, the knowledge, training, skills and experience necessary to administer a substance by injection beyond the current scope of practice.
- **Public need:** The profession has not demonstrated that a significant public need would be

⁴⁹³ Professional Examination Service, 19.

⁴⁹⁴ Ibid., 38.

⁴⁹⁵ Consultation comment, 106.

met through granting the expansion of the controlled act of administering a substance by injection. Nor was a clear rationale provided demonstrating that a gap in services currently exists for Ontarians. Most importantly, the applicant failed to clearly explain for which procedures injections would be required or what substances would be injected, making it difficult for HPRAC to properly assess the applicant's request.

HPRAC's Recommendation

Do not grant authority to administer an injection outside of the foot.

Scope of Practice Increase

Applicant Request

“The creation of a unitary podiatry profession in Ontario.”⁴⁹⁶ In order to enable this unitary profession COCOO is requesting a Podiatry Act which would include the following scope of practice statement: “The practice of podiatry is the assessment or diagnosis of the foot and ankle and the treatment and prevention of diseases, disorders or dysfunctions of the foot, ankle and structures affecting the foot or ankle by therapeutic, orthotic or palliative means.” (Additions to the current scope of practice statement are underlined for ease of reference).⁴⁹⁷

HPRAC's Analysis

It is HPRAC's understanding that two key elements form the basis of the applicant's request for an expanded scope of practice: expanding the profession's practice to include the ankle and structures affecting the foot and ankle, and adding the ability to diagnose for chiropodists.

As outlined in the sections above, HPRAC has not recommended the authority to perform a procedure on tissue below the dermis on the ankle, nor has it recommended access to the controlled act of communicating a diagnosis.

Because the controlled acts authorized to a profession inform (and are informed by) a profession's scope of practice, HPRAC is not recommending a scope of practice increase for the profession that includes the ankle and structures affecting the foot and ankle, and the ability to diagnose.

HPRAC's Recommendation

- Do not recommend a scope of practice increase that includes the ankle or structures affecting the foot and ankle.
- Do not recommend a scope of practice increase that includes the ability to diagnose.

⁴⁹⁶ Ibid., 27.

⁴⁹⁷ Ibid., 28.

Rationale for a Unitary Podiatry Profession

HPRAC's decision not to recommend a scope of practice increase clearly affects the creation of a unitary podiatry profession that includes a focus on foot and ankle surgery. Although a unitary podiatry profession is unlikely without the new or expanded controlled and authorized acts requested, there were other important considerations that have not yet been addressed that HPRAC reflected on when deciding whether or not to recommend a unitary podiatry profession. These considerations related primarily to the applicant's proposal as it relates to the "grand-parenting" and bridging of existing practitioners.

In the applicant's proposal there are instances throughout that suggest a lack of engagement with the risk regarding implementation and quality assurance for practitioners who would be grand-parented or bridged.

For example, the applicant notes that the decision to perform any or all of the new controlled acts would be "left entirely to individual grand-parented practitioners."⁴⁹⁸ As such, the proposal notes that "the performance of any the new and expanded authorized acts will not be mandatory by current College registrants and by students who are in-stream at the Michener chiropody program, but will be mandatory for all other first-time registrants."⁴⁹⁹ Although the applicant does explain that Michener Institute graduates and grand-parented registrants will be required to demonstrate requisite knowledge, skill and judgement,⁵⁰⁰ the aforementioned wording of the submission seems to suggest that if the proposal were adopted new COCOO registrants who are future Michener Institute graduates will be authorized to perform the expanded scope. This is troubling to HPRAC, given that the PES report and key informants from the Michener Institute clearly indicated that the program does not prepare students to perform foot and ankle surgery.

Consistent with the concerns raised above, details about what would be required of potential registrants to perform this expanded scope were significantly lacking in the submission. The applicant states that "new registrants and grand-parented registrants wishing to perform the more complex surgical procedures authorized within the proposed scope of practice will be expected to complete or have completed surgical residencies in accredited hospitals."⁵⁰¹ However, during the two-week consultation period, the applicant stated that the applicant/college has "not taken the position that completion of the podiatric residency will be an entry to practice requirement."⁵⁰² Seemingly contradictory statements such as these suggest to HPRAC a lack of thoughtful consideration about implementation that may ultimately put the public at risk.

The applicant explains in its submission that it would create a publicly available roster of "those practitioners who have been deemed by the College as competent to perform the authorized acts. The roster would list those practitioners on an authorized act-by-authorized act basis."⁵⁰³ While a roster is certainly one tool available to the college to inform the public of which practitioners are qualified to perform complex ankle and foot surgery, HPRAC was unconvinced of the extent to

⁴⁹⁸ Ibid., 53.

⁴⁹⁹ Ibid., 57.

⁵⁰⁰ Ibid..

⁵⁰¹ Ibid., 58.

⁵⁰² COCOO letter to HPRAC Secretariat, April 22, 2015.

⁵⁰³ COCOO submission, 68-69.

which the public would understand and make use of this roster and, most importantly, that the roster would protect the public from untrained practitioners. The lack of proposed oversight and enforcement mechanisms to accompany the roster did not sufficiently convince HPRAC that patient health and interests would be adequately protected.

The applicant also stated that there are cohorts of registrants “who are competent to perform any and all of the new or expanded authorized acts.”⁵⁰⁴ This statement seems to run counter to certain aspects of the PES report, which notes that “If Ontario podiatrists will be administering general anaesthesia as part of the expanded scope, a potential gap in training exists related to administration of general anaesthesia. Podiatrists in the United States are not trained to administer general anaesthesia.”⁵⁰⁵ The applicant’s claim is further complicated by the fact that the PES report identified that all registrants, including the podiatry class of registrant, have a number of gaps in rear foot/ankle surgery competency⁵⁰⁶ and in the ability to assess and manage a patient’s general medical and surgical status.⁵⁰⁷

The viability of a bridging program for chiropodists wishing to become podiatrists was also brought into question. HPRAC learned that in the early 2000s, Temple University in Philadelphia designed a flexible DPM program for chiropodists to be awarded a DPM degree. The program was designed to accommodate chiropodists working full-time and could be completed in three to five years. However, the program was never fully operationalized because of changes to the Michener Institute’s program and because of the fact that when the program’s placement and assessment tests were offered, no one signed up.⁵⁰⁸

After reviewing the applicant’s submission, HPRAC was left with a number of substantive inquiries that brought into question whether or not COCOO is sufficiently prepared or capable of facilitating the proposed scope of practice. Stakeholders raised both questions and concerns with the applicant’s plans for grand-parenting and bridging current registrants. CPSO for example, provided a fulsome list of questions about specific details of the proposal, which summarized issues and concerns for stakeholders. It raised the following questions:

How will the proposed podiatry residency requirements and programs achieve parity with other jurisdictions such as BC and Alberta? Will candidates be eligible for Certification in Foot Surgery if they successfully complete a podiatric medicine and surgery program that is 36 months in length, rather than 24 months, in keeping with recent changes in residency training accreditation requirements seen in other jurisdictions? Who will be responsible for the bridge education and residency plan for current chiropodists in Ontario wishing to qualify as podiatrists? How will COCOO ensure parity of this bridge education with other jurisdictions, especially where participants will have differing levels of educational backgrounds (podiatry vs. chiropody)? How will COCOO ensure the bridge education program is sufficiently comprehensive and robust to allow chiropodists to practise as podiatrists with the requisite knowledge, skill and judgment? Will bridge education programs be

⁵⁰⁴ Ibid., 68.

⁵⁰⁵ Professional Examination Service, 19.

⁵⁰⁶ Ibid., 37.

⁵⁰⁷ Ibid., 39.

⁵⁰⁸ HPRAC, *Chiropody & Podiatry: A Rapid Literature Review on Education, Regulation, Collaboration, Safety, and Economics of Foot Care in Other Jurisdictions*, 7-8. .

accredited? What are COCOO’s long-term plans regarding a mechanism for vetting registrant applicants with respect to education and residency qualifications?⁵⁰⁹

COCOO’s application and its submission during the two-week consultation period (which occurred after the posting of these questions) does not contain meaningful, substantive, evidence-based information that responds to these critical questions. This omission was a factor in HPRAC’s decision to not recommend the proposed scope of practice and, by extension, a unitary podiatric scope of practice.

HPRAC’s Recommendation

Do not recommend a unitary podiatry profession that includes surgery on the foot and ankle.

Other Proposed Changes

In its additional questions to the applicant, HPRAC asked “If HPRAC does not recommend a scope of practice change for the professions, what other changes could be made to improve the delivery of foot care in Ontario?”⁵¹⁰ The issues discussed below were provided by the applicant as potential alternatives to a scope of practice change.

Statutory Protected Title

Applicant Request

“As part of its application for an expanded scope of practice and the desire for the creation of a unitary podiatry profession, the applicant has requested the revision or replacement of the *Chiropody Act, 1991*. Consistent with this change, COCOO has asked for continuation of statutory protection of the titles ‘podiatrist’ and ‘chiropodist’, including variations and abbreviations, but has also asked for protection of the following titles: podiatric surgeon and foot surgeon.”⁵¹¹

What HPRAC Learned from the Applicant

In its submission, the applicant notes that the titles of “podiatrist” and “podiatric surgeon” are accepted titles for regulated health care professionals in a number of jurisdictions, including Alberta⁵¹² and British Columbia.⁵¹³ It also notes that this trend towards adopting the title “podiatrist/podiatry” has been increasing during the last two decades and that this designation has been adopted by all provinces except Ontario.⁵¹⁴

⁵⁰⁹ Consultation comment, 109-110.

⁵¹⁰ COCOO submission, additional questions, 31.

⁵¹¹ Ibid., 27-28.

⁵¹² Ibid., 39.

⁵¹³ Ibid., 40.

⁵¹⁴ Ibid., 74.

As part of its application, the applicant notes that “jurisdictions’ adoption of the ‘podiatry’ professional title and descriptor has not necessarily been accompanied by scope of practice changes. Sometimes the ‘podiatry’ title has simply been superimposed on a chiropody scope of practice.”⁵¹⁵ However, as explained by the applicant, in many cases, the adoption of the podiatry title coincides with some expansion in scope of practice beyond the chiropody model.⁵¹⁶

It was also suggested by the applicant that, by creating a unitary profession under a single, better-known title, podiatrists’ IPC will be facilitated by addressing issues of confusion typically associated with the title chiropodist.⁵¹⁷ For example, the applicant references OSC, which notes that the term “chiropodist” discourages referrals from other health care professionals. While the college notes that it does not have any evidence to substantiate this claim (beyond its receipt of inquiries about the difference between a chiropodist and podiatrist) it goes on to explain that the new title will reduce confusion and provide a greater understanding of what these practitioners do.⁵¹⁸

What HPRAC Learned from Its Literature Reviews

The literature reviewed by HPRAC mirrored certain elements described by the applicant, notably that the terms “podiatry/podiatrist” and “chiropody/chiropodist” are often used interchangeably.⁵¹⁹ In addition, it was noted in the literature that the term “podiatry” and its additional competencies have replaced the term “chiropody.” Sanders et al. note that, in 1957, the term “chiropodist” was changed in the United States because of public confusion with the title.⁵²⁰ While certain jurisdictions adopted the podiatric title and scope of practice, others have only adopted the title; for example, a 2013 study from the UK found that podiatric services closely mirror those of chiropodists in Ontario, including the management of lower limb soft tissue disorders, gait analysis, the manufacture of orthotics, etc.⁵²¹

What HPRAC Learned from Stakeholder Consultations

In its consultations, HPRAC heard from stakeholders who held opposing views about transitioning to the title “podiatrist.” While many stakeholder comments were given in the context of granting a new title alongside an expanded scope of practice, OSC claimed that a unified title and scope of practice would enhance access and remove barriers to inter-jurisdictional mobility,⁵²² whereas OPA noted that allowing all practitioners to call themselves podiatrists would create confusion for the public and health care practitioners, and would obscure training and competence levels.⁵²³

⁵¹⁵ Ibid., 83.

⁵¹⁶ Ibid.

⁵¹⁷ Ibid., 40.

⁵¹⁸ COCOO submission additional questions, 17.

⁵¹⁹ Hayes, C., & Bussey, S., “Podiatric medicine unravelled,” *British Journal of Healthcare Assistants* (2011): 5(12), 596-9.

⁵²⁰ HPRAC, *Chiropody & Podiatry: A Rapid Literature Review on Scopes of Practice and Models of Foot Care in Other Jurisdictions*, 23.

⁵²¹ Ibid., 21.

⁵²² Consultation comment, 150.

⁵²³ Ibid., 135.

In its submission, CPSO requested that both the applicant and HPRAC consider whether podiatrists have the training to warrant the title “surgeon,” stating that, if HPRAC recommends the titles “podiatric surgeon” and “foot surgeon,” “provisions regarding title protection of ‘foot surgeon’ be worded in such a way that it does not exclude use of the title by orthopaedic surgeons who have focused specifically on foot surgery.”⁵²⁴

HPRAC’s Analysis

HPRAC concluded that transitioning the profession to a unified title was in the public interest for a variety of reasons. The title “podiatrist” is internationally accepted, whereas the title “chiropracist” is increasingly seen as outdated. HPRAC also heard extensively from stakeholders, both in the first and second consultations (see Chapters V and IX), that the profession’s title is one of the most pressing issues for chiropracists.

Finally, the current naming convention, which uses two distinct titles for one profession (chiropracist and podiatrist) was seen as counterintuitive to HPRAC; a unified title would facilitate understanding for both professionals and for the public. HPRAC reflected on naming conventions and determined that choosing one title, with different certificates of registration, would be the simplest to understand for the public and other health care professionals. This naming convention would be similar to that of nurses, who have multiple certificates of registration. HPRAC has therefore recommended that those practitioners currently registered as “chiropracists” should be transitioned to the title “podiatrist,” whereas those currently registered as “podiatrists” should be registered as “podiatric surgeons.” This recommendation relates only to title and has no impact on the requested scope of practice change.

HPRAC’s Recommendation

- Transition those practitioners currently registered as “chiropracists” to the title “podiatrist.”
- Transition those practitioners currently registered as “podiatrists” to the title “podiatric surgeon.”
- Transition the title of the college from the College of Chiropracists of Ontario to the College of Podiatrists of Ontario (or something that responds to the change of professions registered with the college). The title of the *Chiroprody Act, 1991*, would also require a change.
- The college should engage in a communications strategy to advise other health professionals and the public about the change in title.
- Do not protect the title “foot surgeon.”

These recommendations relate to the profession’s title only and do not have any impact on the scope of practice.

⁵²⁴ Ibid., 108.

Changes to Drugs List

Applicant Request

The College is proposing changes to the list of drugs that may be prescribed and administered by the profession.⁵²⁵

Discussion

Given that HPRAC has recommended few changes to the profession's access to controlled acts, there is no need for the profession to have access to new drugs. However, HPRAC understands that the issue of outdated drug lists is a challenge that almost all health regulatory colleges face and therefore may require review by the Ministry.

HPRAC's Recommendation

The Ministry consider re-evaluating the current list of medications available to the profession as new and more effective drugs not previously approved under governing regulations may be available.

Registration of New Podiatrists in Ontario

Applicant Request

Removal of what the applicant refers to as the podiatric cap.⁵²⁶

What HPRAC Learned from the Applicant

The applicant believes it is “self-evident that the podiatric cap must disappear with the move to a North American podiatric model.”⁵²⁷ This opinion, as noted by the applicant, is shared by OSC, OPMA, CFPM and CPMA.⁵²⁸

The applicant notes that the legislation that prohibits the registration of new podiatrists in Ontario limits podiatrists from other jurisdictions from practising podiatry in Ontario.⁵²⁹ Furthermore, its proposal posits that the current legislation, which prohibits the registration of new podiatrists, is the only reason “a Mutual Recognition Agreement for chiropody and podiatry under the Agreement on Internal Trade has not been agreed to amongst the Canadian provinces and territories.”⁵³⁰

⁵²⁵ COCOO submission, 29.

⁵²⁶ COCOO submission, additional questions, 31.

⁵²⁷ COCOO submission, 18.

⁵²⁸ Ibid..

⁵²⁹ Ibid., 49.

⁵³⁰ Ibid., 18.

As well, according to the applicant, the effects of the legislation prohibiting new podiatrists in Ontario is resulting in a disproportionate proportion of current podiatrists in Ontario practising part-time, rather than retiring, causing distortions to wait times.⁵³¹ The existing legislation has also, according to the applicant, had an impact on timely access to bone and more complex soft tissue surgical procedures,⁵³² and has substantially complicated college operations, requiring it to deny applicants' registration as podiatrists for graduates of DPM programs from Quebec, the United States and other jurisdictions.⁵³³

The applicant suggests that allowing new individuals to register as podiatrists in the province will prompt growth in the profession. This growth will, according to the applicant, attract podiatrists to underserved areas, diminish demand for orthopaedic surgeons delivering foot care surgery and result in more seamless delivery of care, reducing referrals to general practitioners and other health care professionals.⁵³⁴ The applicant also notes, however, that there is "no evidence available to the College indicating that the podiatric cap has a significant influence on access to care within the non-surgical parts of the current scope of practice and authorized acts of the profession."⁵³⁵

What HPRAC Learned from Stakeholder Consultations

During stakeholder consultations, a number of organizations registered their support for allowing the registration of more podiatrists in the province. Respondents from Quebec explained confusion with the podiatric cap, especially in what it describes as the current environment of projected health human resources shortfalls.⁵³⁶ While both OMA⁵³⁷ and OPA⁵³⁸ noted the podiatric cap as a barrier to timely care and professional development, OMA did so in the context of acknowledging limited public funding for podiatric services.⁵³⁹ Similarly, the RNAO supported the removal of the podiatric cap, but under specific conditions: "that the government commits to publicly-funding podiatric services, and that an accredited Ontario podiatry program be developed."⁵⁴⁰ Finally, CPSO acknowledged that there is "potential value to patients in Ontario in removing the 'podiatry cap.'"⁵⁴¹

HPRAC's Analysis

Initial considerations of the applicant's request for removal of the legislation that prohibits the registration of new podiatrists (the podiatric cap) focused on the Health Professions Legislative Review, which in the mid-1980s saw the government of the day decide, by prohibiting the registration of future podiatrists, that the profession of podiatry in Ontario would, "essentially

⁵³¹ COCOO submission, additional questions, 35.

⁵³² Ibid., 39.

⁵³³ COCOO submission, 18.

⁵³⁴ Ibid., 48.

⁵³⁵ COCOO submission, additional questions, 34.

⁵³⁶ Consultation comment, 8.

⁵³⁷ Ibid., 132.

⁵³⁸ Ibid., 134.

⁵³⁹ Ibid., 132.

⁵⁴⁰ Ibid., 181.

⁵⁴¹ Ibid., 105.

be phased out of Ontario.”⁵⁴² While HPRAC’s assessment of the applicant’s request certainly took into consideration the decision-making of that government, its analysis was divided into two major overarching considerations: public need and risk of harm.

HPRAC was guided, in part, by whether or not the people of Ontario have been able to access medically necessary foot care services since the registration of new podiatrists was prohibited. After having reviewed the applicant’s submission, conducting two separate consultations and engaging in extensive key informant meetings, HPRAC did not discover any evidence of significant public need for podiatric services, especially those relating to surgery. Moreover, HPRAC did not hear that the legislation that prohibits registration of new podiatrists in Ontario had caused systemic issues in the health care system in Ontario. HPRAC did hear, however, that access to routine, affordable, basic foot care was a significant issue for Ontarians, and that, as noted by the applicant, there is little evidence to suggest that a podiatric (surgical) scope of practice would mitigate this issue.

Although HPRAC learned that wait times in most LHINs for foot and ankle surgery are longer than MOHLTC guidelines, it believes that this issue could be most effectively resolved through increasing resources in hospitals to support orthopaedic surgeons providing foot and ankle surgery. Increasing resources by providing funding to surgical suites in hospitals would reduce wait times for foot and ankle surgery while also ensuring that all Ontarians can access this care, regardless of their ability to pay.

In terms of the risk of harm, HPRAC deliberated on the applicant’s readiness to safely and effectively ensure that podiatrists are providing the safest possible care for Ontarians. The absence of a currently functioning inspection program of podiatric surgical suites caused HPRAC to doubt the applicant’s readiness to manage practitioners with such a scope.

Finally, over the course of numerous referrals, including this referral, HPRAC has repeatedly heard of the importance of IPC for quality patient care. When considering removal of the legislation that prohibits the registration of new podiatrists, HPRAC considered podiatrists’ primary practice locations and the applicant’s lack of a request for chiropractors and podiatrists to be integrated into hospitals, FHTs and other IPC teams. HPRAC therefore concludes that removal of the prohibition would only serve to encourage the private delivery of independent podiatric care.

HPRAC’s Recommendation

The Ministry maintain the current legislation that prohibits the registration of new podiatrists in Ontario until such time that the Ministry determines that there is a significant need for podiatric surgical services that cannot be accommodated through the use of existing health human resources in the province that are publicly funded. In the event that the Minister determines such a need exists, the Ministry may wish to consider whether an increase in the number of podiatrists is both required and appropriate to meet this need (e.g. the profession has the knowledge, skill, training and judgement to provide safe care, a rigorous inspection and quality assurance program is in place, etc.).

⁵⁴² Legislative Assembly of Ontario, Committee Transcripts: Standing Committee on Social Development - 1991-Aug-06 - Bill 43, Regulated Health Professions Act, 1991, and Companion Legislation.

Chapter XI: Conclusions and Other Considerations

After concluding this review of the model of foot care in Ontario and the applicant's request for an expanded scope of practice, HPRAC members were unified in their understanding that the applicant and stakeholders raised a number of issues that are of great importance to many Ontarians, which are outlined in the chapter below.

Quality-Based Procedures for Foot and Ankle Surgery

During HPRAC's review of the request for a change in scope of practice, specifically as it related to foot and ankle surgery, it became clear to HPRAC that there is a need for greater access to such surgeries. While it is difficult to link cause and effect for the recent decline in wait times in certain areas of the province for foot and ankle surgeries, it may be the result of funding that was recently provided by the Ministry to the LHINs for these procedures. HPRAC therefore suggests that the Minister consider establishing foot and ankle surgery as a QBP in the province. During key informant interviews, HPRAC learned that the province has met with great success in lowering wait times for certain surgeries, specifically knee and hip surgery, with the introduction of the Ontario Wait Time Strategy. MOHLTC anticipates further improvements with the introduction of QBPs. HPRAC therefore recommends designating these foot and ankle surgeries as QBPs.

Foot Care Providers and IPC

As the referral progressed, it became clear to HPRAC how important foot care is to Ontarians, particularly the elderly and those with diabetes. However, as outlined in Part II: Chapter IX of this report, chiropodists and podiatrists typically operate as independent practitioners in solo practice offices. Two distinct but interrelated issues confronted HPRAC as a result of this particular model of foot care. Firstly, there is a lack of integration of chiropodists and podiatrists with other health care providers, creating barriers to IPC. By integrating chiropodists and podiatrists into IPC teams, whether as part of family health teams, in the centres of excellence discussed in Part I or in other settings, many of the concerns raised by the applicant (e.g., "circular referrals") would be largely addressed and would also ensure that Ontarians have access to the critical care that chiropodists and podiatrists offer.

Secondly, stakeholders repeatedly brought to HPRAC's attention the need for publicly funded foot care. HPRAC heard numerous stories of Ontarians being unable to afford basic foot care services and devices offered by chiropodists and podiatrists. These services would significantly improve patients' quality of life and could potentially result in cost avoidance for the Ministry (e.g., by preventing the need for costly amputations). As such, the Minister may wish to examine

how it can help integrate chiropodists and podiatrists into IPC teams where foot care services are publicly accessible.

Inspection Program

Although HPRAC deliberated on the risk of harm that would accompany the proposed expansion of the scope of practice, specifically as it related to foot surgery being performed in podiatrists' offices, information about the practice of current practitioners was of some concern. While it is unclear to HPRAC how many of the podiatrists currently registered in the province are performing foot surgery, HPRAC learned that no inspection program currently exists for podiatrists who perform surgery outside of the hospital setting. Given the potential risk associated with surgery, HPRAC is suggesting that the Minister consider requesting that COCOO develop an inspection program for podiatrists who are performing surgery in an out-of-hospital setting. COCOO may wish to consider consulting with CPSO and other colleges, such as the Royal College of Dental Surgeons of Ontario (RCDSO), to develop such a program.

Policy Considerations

When considering HPRAC's criteria against the information provided by the applicant, HPRAC was reminded of the numerous stakeholder comments that underscored the importance and need for routine, preventative, publicly accessible foot care. This care was generally at odds with the advanced, privately funded surgical care model advocated by the applicant.

However, this juxtaposition raised policy questions that were not within HPRAC's purview to assess, specifically a) whether foot care services and devices should be publicly funded and b) whether the foot care needs of Ontarians require a greater role for chiropodists and podiatrists in foot surgery or if the needs of Ontarians can be met through the existing supply of health care providers. For example, the applicant notes that wait times for foot and ankle surgery are lengthy and that the supply of orthopaedic surgeons is limited, yet the Deputy Minister of Health and Long-Term care noted at the Standing Committee on Public Accounts that forefoot surgery wait times are not related to a shortage of orthopaedic surgeons. The Deputy Minister explained that the province has a surplus of approximately 50 orthopaedic surgeons, noting that the issue of wait times has more to do with the issue of access to elective operating times.⁵⁴³ The Minister may wish to consider this issue before proceeding with any significant changes to the profession.

⁵⁴³ Legislative Assembly of Ontario, Committee Transcripts: Standing Committee on Public Accounts- 2014-Dec-03 - 2013 Annual Report, Auditor General: Ministry of Health and Long-Term Care, accessed August 4, 2015, http://www.ontla.on.ca/web/committee-proceedings/committee_transcripts_details.do?locale=en&Date=2014-12-03&ParlCommID=9001&BillID=&Business=2013+Annual+Report%2C%0AAuditor+General%3A%0A%0AMinistry+of+Health%0Aand+Long-Term+Care%0A&DocumentID=28426.

Appendix A

Recommendations & Points for Consideration

Recommendations

Using its criteria for a review of a professional scope of practice,⁵⁴⁴ HPRAC has provided a number of recommendations. The recommendations are discussed in detail in Part II: Chapter X of this report.

Controlled and Authorized Acts

- Do not grant authority to communicate a diagnosis.
- Do not grant authority to apply or order prescribed forms of energy.
- Do not grant authority to order laboratory tests.
- Do not grant authority to apply or order radiographs.
- Do not grant authority for chiropodists to perform bone surgery on the foot.
- Do not grant authority for chiropodists and podiatrists to perform soft and bony surgery on the ankle.
- Do not grant authority to dispense and sell drugs.
- Do not grant authority to administer an injection outside of the foot.

Scope of Practice

- Do not recommend a scope of practice increase that includes the ankle or structures affecting the foot and ankle.
- Do not recommend a scope of practice increase that includes the ability to diagnose.
- Do not recommend a unitary podiatry profession that includes surgery on the foot and ankle.

Other Proposed Changes

- Transition those practitioners currently registered as “chiropodists” to the title “podiatrist.”
 - Transition those practitioners currently registered as “podiatrists” to the title “podiatric surgeon.”
-

- Transition the title of the college from the College of Chiropodists of Ontario to the College of Podiatrists of Ontario (or something that responds to the change of professions registered with the college). The title of the *Chiropody Act, 1991*, would also require a change.
- The college should engage in a communications strategy to advise other health professionals and the public about the change in title.
- Do not protect the title “foot surgeon.”
- The Ministry consider re-evaluating the current list of medications available to the profession as new and more effective drugs not previously approved under governing regulations may be available.
- The Ministry maintain the current legislation that prohibits the registration of new podiatrists in Ontario until such time that the Ministry determines that there is a significant need for podiatric surgical services that cannot be accommodated through the use of existing health human resources in the province that are publicly funded. In the event that the Minister determines such a need exists, the Ministry may wish to consider whether an increase in the number of podiatrists is both required and appropriate to meet this need (e.g. the profession has the knowledge, skill, training and judgement to provide safe care, a rigorous inspections and quality assurance program is in place, etc.).

Points for Consideration

There are additional matters that HPRAC considered coming out of its analysis of the model of foot care and review of the regulation of chiropody and podiatry, which are both central and related to the profession specifically, and foot care generally, that HPRAC would like to bring to the attention of the Minister. These are discussed in detail in Parts I and II of this report:

Part I: Model of Foot Care

- The Minister may wish to consider enhancing access to foot care services and devices by examining whether the health care system can avoid costly foot surgeries (especially amputations) through a focus on prevention.

Part II: Regulation of Chiropody and Podiatry

- The Minister may wish to consider establishing foot and ankle surgery as a quality-based procedure to reduce wait times and improve efficiencies.
- The Minister may wish to consider how chiropodists and podiatrists can be further integrated into IPC teams where foot care services are publicly accessible.
- The Minister may wish to consider asking COCOO to develop some form of inspection program for podiatrists who are performing surgery in an out-of-hospital setting.
- The Minister may wish to consider policy questions that were raised but were beyond the scope of the referral, which include: a) whether foot care services and devices should be publicly funded and b) whether the foot care needs of Ontarians require a greater role for chiropodists and podiatrists in foot and ankle surgery or if the needs of Ontarians can be met through the existing supply of health care providers.

Appendix B

List of Controlled Acts

A “controlled act” is any one of the following done with respect to an individual:

1. Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis.
2. Performing a procedure on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, or in or below the surfaces of the teeth, including the scaling of teeth.
3. Setting or casting a fracture of a bone or a dislocation of a joint.
4. Moving the joints of the spine beyond the individual’s usual physiological range of motion using a fast, low amplitude thrust.
5. Administering a substance by injection or inhalation.
6. Putting an instrument, hand or finger,
 - i. beyond the external ear canal,
 - ii. beyond the point in the nasal passages where they normally narrow,
 - iii. beyond the larynx,
 - iv. beyond the opening of the urethra,
 - v. beyond the labia majora,
 - vi. beyond the anal verge, or
 - vii. into an artificial opening into the body.
7. Applying or ordering the application of a form of energy prescribed by the regulations under this Act.
8. Prescribing, dispensing, selling or compounding a drug as defined in the *Drug and Pharmacies Regulation Act*, or supervising the part of a pharmacy where such drugs are kept.
9. Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses other than simple magnifiers.
10. Prescribing a hearing aid for a hearing impaired person.
11. Fitting or dispensing a dental prosthesis, orthodontic or periodontal appliance or a device used inside the mouth to protect teeth from abnormal functioning.
12. Managing labour or conducting the delivery of a baby.
13. Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response.

Appendix C

First Consultation Questionnaire

Purpose of the Survey:

The Minister of Health and Long-Term Care, the Hon. Deb. Matthews, has asked the Health Professions Regulatory Advisory Council (HPRAC) to "review issues relating to the regulation of chiropody and podiatry and provide advice as to whether and how there should be changes to existing legislation regarding these related professions". The Minister asked that the Council include "an analysis of the current model of foot care in Ontario, issues regarding restricted titles, and whether the existing limitations on the podiatrist class of members should continue."

At this time, HPRAC is seeking input on the current model of foot care in Ontario. The public will be invited to share views on other aspects of the referral in the future.

Many organizations and individuals have extensive experience and interest in health care, health professions regulation, and the public interest. HPRAC wants to ensure that this experience and interest are fully reflected in its recommendation-making process.

Stakeholder feedback will be publicly posted according to HPRAC's access to information guidelines. To view the guidelines, please visit this website: <http://hprac.org/en/privacy.asp>.

To view the RHPA in its entirety, please visit this website: http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_91r18_e.htm.

Due to limitations within the survey, please do not use the "back" button on your web browser.

Participant Information

I am responding

As an individual

On behalf of an organization

Organization name (if applicable)

Name (optional)

Email address (optional)

Geographical location (choose one)

- Ontario
- Alberta
- British Columbia
- Manitoba
- New Brunswick
- Newfoundland and Labrador
- Nova Scotia
- Prince Edward Island
- Quebec
- Saskatchewan
- Northwest Territories
- Nunavut
- Yukon
- United States*
- International

*If "United States" is selected, answer the following question:

I am a:

- Practicing Doctor of Podiatric Medicine (DPM)
- Non-practicing Doctor of Podiatric Medicine (DPM)
- Other

Primary occupational type (choose one)

- Regulated health professional
- Member of profession transitioning to regulatory status (i.e., future members of regulatory colleges for homeopathy, naturopathy and psychotherapy)
- Representative/employee of educational institution

Representative/employee of general interest group/association
Representative/employee of government ministry/agency
Representative/employee of regulatory college
Representative/employee of health sector interest group
Representative/employee of health services organization
Representative/employee of local health integration network (LHIN)
Representative/employee of regulated health professional association
Representative/employee of unregulated health professional association
Unregulated health professional
Other

Membership with health regulatory college (if applicable)

College of Audiologists and Speech Language Pathologists of Ontario
College of Chiropractors of Ontario**
College of Chiropractors of Ontario
College of Dental Hygienists of Ontario
Royal College of Dental Surgeons of Ontario
College of Dental Technologists of Ontario
College of Denturists of Ontario
College of Dietitians of Ontario
College of Kinesiologists of Ontario
College of Massage Therapists of Ontario
College of Medical Laboratory Technologists of Ontario
College of Medical Radiation Technologists of Ontario
College of Midwives of Ontario
College of Nurses of Ontario
College of Occupational Therapists of Ontario
College of Opticians of Ontario
College of Optometrists of Ontario
Ontario College of Pharmacists
College of Physicians and Surgeons of Ontario
College of Physiotherapists of Ontario
College of Psychologists of Ontario
College of Respiratory Therapists of Ontario

**If membership with College of Chiropractors of Ontario is chosen, answer the following:

I graduated from a:

Chiropractic program

Podiatry program

Type of employer/organization (choose one)

Educational institution

General interest group/association

Government ministry/agency

Health professions regulatory college

Health sector interest group/association

Health services organization

Local health integration network (LHIN)

Regulated health professional association

Unregulated health professional association

Other

Not Applicable

1) Tell us your (or your organization's) views on the current model of foot care in Ontario. What do you (or your organization) see as the major issues facing patients, practitioners, and others?



Access to Information

Comments submitted will be considered by HPRAC and will help it to determine appropriate recommendations to make to the Minister of Health and Long-Term Care. To ensure transparency and encourage open dialogue, the feedback received by HPRAC may be posted on its website in accordance with its Privacy Statement, which is available at: www.hprac.org/en/privacy.asp.

Please note that unless requested and otherwise agreed to by HPRAC, any information or comments received from organizations will be considered public information and may be used and disclosed by HPRAC. HPRAC may disclose materials or comments, or summaries of them, to other interested parties (during and after the consultation period). An individual who makes a submission and who indicates an affiliation with an organization in his or her submission will be considered to have made his or her submission on behalf of the affiliated organization.

HPRAC will not disclose any personal information contained in the submission of an individual who does not specify an organizational affiliation in his or her submission without the individual's consent unless required to do so by law. However, HPRAC may use and disclose the content of the individual's submission to assist it in fulfilling its statutory mandate.

HPRAC reserves the right to refuse to post a submission, in whole or in part, that, in its sole discretion, is unrelated to the issue under consultation and is abusive, obscene, harassing, threatening or includes defamatory comments. If you have any questions about the collection of this information, you can contact HPRAC at 416-326-1550.

Appendix D

Second Consultation Questionnaire

Purpose of the Survey

The Minister of Health and Long-Term Care has asked the Health Professions Regulatory Advisory Council (HPRAC) to "review issues relating to the regulation of chiropody and podiatry and provide advice as to whether and how there should be changes to existing legislation regarding these related professions". The Minister asked that HPRAC include "an analysis of the current model of foot care in Ontario, issues regarding restricted titles, and whether the existing limitations on the podiatrist class of members should continue."

In keeping with the Minister's request, in the spring of 2014 HPRAC held a consultation session on the model of foot care in Ontario.

HPRAC is now seeking input on:

- **issues relating to the regulation of chiropody and podiatry**
- **whether and how there should be changes to existing legislation regarding chiropodists and podiatrist**
- **issues regarding restricted titles**
- **whether the existing limitations on the podiatrist class of members should continue**

Many organizations and individuals have extensive experience and interest in health care, health professions regulation, and serving the public interest. HPRAC wants to ensure that this experience and interest are fully reflected in its recommendation-making process.

Stakeholder feedback will be publicly posted according to HPRAC's access to information guidelines. To view the guidelines, please visit this website: <http://hprac.org/en/privacy.asp>.

To view the *Regulated Health Professions Act, 1991* (RHPA) in its entirety, please visit this website: http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_91r18_e.htm.

Introduction

HPRAC has prepared criteria that it relies on in the development of advice to the Minister of Health and Long-Term Care concerning a potential change in the scope of practice of a regulated health profession in Ontario. HPRAC's recommendations will be based on its assessment of the profession's ability to meet the criteria for a change in its scope of practice, and the need for such a change. The [application guide](#) describes HPRAC's criteria for a scope of practice review, instructions to the applicant, and related matters.

HPRAC's Criteria for Scope of Practice Reviews

Relevance to the Profession

The applicant's proposal should demonstrate that the requested change in scope of practice is rationally related to the practice of the profession and to the qualifications and competencies of members of the profession. It should describe whether the proposed change to the scope of practice provides recognition and authority for existing competencies, or seeks to expand the scope of the practice of the profession.

Risk of Harm

If the proposed change in scope of practice presents an increased risk of harm to the public, the applicant's proposal should demonstrate how risk will be mitigated, and how the training and competencies of members of the profession provide assurance that patients or clients will be cared for within evidence-based best practices.

Relevance to the Health Care System and Relationship to other Professions

The applicant's proposal should demonstrate that a change in the scope of practice is consistent with the evolution of the health care delivery system, and particularly with changing dynamics between health professionals who work in integrated, team-based and collaborative care models.

Sufficiency of Supervision and Need for Autonomy

The applicant's proposal should demonstrate that a change in the scope of practice is the most appropriate, effective and efficient means to provide clinical and patient care services, that delegation or supervisory structures currently available are inadequate, and that the authority for independent or autonomous professional activity is required in the provision of patient care.

Body of Knowledge

The applicant's proposal should show that there is a systematic body of knowledge within the profession to perform the activities being requested and that this change in role is broadly accepted within the profession.

Education and Accreditation

The applicant's proposal should demonstrate that members of the profession have, or will have, the knowledge, training, skills and experience necessary to carry out the duties and responsibilities involved in the proposed change in scope of practice. In addition, it should demonstrate that the education programs are appropriately accredited by an approved accreditation body.

Leadership's Ability to Favour the Public Interest

The applicant's proposal should show that the profession's leadership will distinguish between the public interest and the profession's self-interest and will favour the public interest at all times.

Profession's Support and Willingness to Comply with Regulation

The applicant's proposal should demonstrate that the profession supports the proposed change in scope of practice and that compliance with regulatory requirements is likely among the membership.

Economic Impact

The applicant's submission should demonstrate an understanding and appreciation of the economic impact of the proposed change in scope of practice for the profession, the public and the health care system.

Public Need

The applicant's submission should demonstrate that a significant public need would be met through the proposed change in scope of practice.

Please consider HPRAC's criteria - and reflect on the applicant's proposal - while participating in this survey.

Participant Information

I am responding

As an individual

On behalf of an organization

Organization name (if applicable)

Name (optional)

Email address (optional)

Geographical location (choose one)

Ontario

Alberta

British Columbia

Manitoba

New Brunswick

Newfoundland and Labrador

Nova Scotia

Prince Edward Island

Quebec

Saskatchewan

Northwest Territories

Nunavut

Yukon

United States

International

Do you practise foot care?

Yes [skip to "I practice in the following setting:"]

No [skip to "I am participating in this referral as a:"]

[If yes] I practice in the following setting:

Solo practice office

Other group practice office

Community Health Centre (CHC)

Hospital

Family Health Team (FHT)

Rehabilitation facility

Post-secondary educational institution

Independent health facility (IHF)

Residential/long-term care facility

Health-related business/industry

Client's environment

Other place of work

I am a:

Chiropracist

Podiatrist

Nurse (if yes)

Registered Nurse (RN)

Registered Practical Nurse (RPN)

Nurse Practitioner (NP)

Pedorthist

Orthotist

Prosthetist

Medical doctor (if yes)

General practitioner

Sports medicine doctor

Orthopaedic surgeon
Dermatologist
Cosmetic surgeon
Other
Personal support worker
Other

[If no] I am participating in this referral as a:

Health care practitioner
Patient
Family member of patient
Business owner
Health care administrator
Educator
Regulator
Representative of a professional association
Representative of a health sector association
Representative of a government ministry/agency/ Local Health Integration Network (LHIN)
Representative of a health services organization
Other

Membership with health regulatory college (if applicable)

College of Audiologists and Speech-Language Pathologists of Ontario
College of Chiropractors of Ontario
College of Chiropractors of Ontario
College of Dental Hygienists of Ontario
Royal College of Dental Surgeons of Ontario
College of Dental Technologists of Ontario
College of Denturists of Ontario
College of Dietitians of Ontario
College of Kinesiologists of Ontario
College of Massage Therapists of Ontario
College of Medical Laboratory Technologists of Ontario

College of Medical Radiation Technologists of Ontario

College of Midwives of Ontario

College of Nurses of Ontario

College of Occupational Therapists of Ontario

College of Opticians of Ontario

College of Optometrists of Ontario

Ontario College of Pharmacists

College of Physicians and Surgeons of Ontario

College of Physiotherapists of Ontario

College of Psychologists of Ontario

College of Respiratory Therapists of Ontario

College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario

Not Applicable

(1) Has the Applicant demonstrated with evidence that there should be a change in the scope of practice for chiroprody and podiatry?

- Yes
- No

(2) HPRAC's recommendations will be based on its assessment of the profession's ability to meet the criteria for a change in its scope of practice, and the need for such a change.

Please identify the degree to which the Applicant has satisfied HPRAC's criteria for a change in scope of practice.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The proposed change in scope of practice is rationally related to the practice of the profession and to the qualifications and competencies of members of the profession.					
Risk of harm will be adequately mitigated.					
The proposed change in scope of practice is consistent with the evolution of the health care delivery system.					
The proposed change in scope of practice is consistent with changing dynamics between health professionals who work in integrated, team-based and collaborative care models.					
The proposed change in scope of practice is the most appropriate, effective and efficient means to provide clinical and patient care services.					
Delegation or supervisory structures currently available are inadequate.					
The authority for independent or autonomous professional activity is required in the provision of patient care.					
There is a systematic body of knowledge within the profession to perform the activities being requested.					
Members of the profession have, or will have, the knowledge, training, skills and experience necessary to carry out the duties and responsibilities involved in the proposed change in scope of practice.					
The profession's leadership will distinguish between the public interest and the profession's self-interest and will favour the public interest at all times.					
The profession supports the proposed change in					

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
scope of practice.					
Compliance with regulatory requirements is likely among the membership.					
The economic impacts of the proposed change in scope of practice for the profession, the public and the health care system have been adequately demonstrated.					
There is a significant public need which would be met through the proposed change in scope of practice.					

(3) Currently, section 4 of the *Chiropody Act, 1991* describes the scope of practice statement for the profession in Ontario as:

“The practice of chiropody is the assessment of the foot and the treatment and prevention of diseases, disorders or dysfunctions of the foot by therapeutic, orthotic or palliative means.”

The Applicant has proposed a revised scope of practice statement:

“The practice of podiatry is the assessment or diagnosis of the foot and ankle and the treatment and prevention of diseases, disorders or dysfunctions of the foot, ankle and structures affecting the foot or ankle by therapeutic, orthotic or palliative means.”

Do you agree with the scope of practice statement proposed by the Applicant?

Yes

No

Please state your level of agreement with the proposed changes to the scope of practice statement.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Replacing the term chiropody with the term podiatry					
Performing a diagnosis					
Expanding the assessment and diagnosis to the ankle					
Expanding the treatment and preventing of diseases, disorders or dysfunctions of the foot to the ankle and structures affecting the foot and ankle					

(4) Currently, chiropodists are authorized to:

- Cut into the subcutaneous tissues of the foot
- Administer, by injection into feet, a substance designated in the regulations
- Prescribe drugs designated in the regulations
- Administer, by inhalation, a substance designated in the regulations

In addition to the acts listed above, podiatrists are authorized to:

- Communicate a diagnosis identifying a disease or disorder of the foot as the cause of a person’s symptoms
- Cut into the bony tissues of the forefoot
- Prescribe certain additional drugs.

The Applicant has proposed expanded authorities that are listed below. Please state your level of agreement with the proposed changes. (The information appearing in the chart below has been taken from the Applicant's proposal.)

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Communicating a diagnosis identifying a disease or disorder of the foot or ankle as the cause of a person’s symptoms (currently authorized to members of the podiatrist class only)					
Performing a procedure on tissues below the dermis to treat conditions of the ankle or foot (currently authorized with respect only to the foot)					
Setting or casting a fracture of a bone or dislocation of the joint, in the foot or ankle (not currently authorized for either chiropodists or podiatrists)					
Administering, by injection, a substance in the Regulations (currently authorized for both chiropodists and podiatrists, but limited to injections into the foot)					
Applying or ordering the application of a prescribed form of energy (not currently authorized for either chiropodists or podiatrists)					
Prescribing, dispensing and selling a drug designated in the Regulations (chiropodists and podiatrists are currently authorized to prescribe, but not to dispense or sell)					
Order prescribed laboratory tests (not currently authorized for either chiropodists or podiatrists)					
Operate radiographic equipment, prescribe radiographs within the podiatry scope of practice and be designated as “radiation protection officers” under the Healing Arts					

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Radiation Protection Act. <i>(currently authorized for members of the podiatrist class and for Doctor of Podiatric Medicine (DPM)-trained chiropodists)</i>					

5) The Applicant is proposing that the current chiropody and podiatry model of practice in Ontario be replaced with an expanded podiatric model of practice.

Should the model of practice change as described in the Applicant’s proposal?

Yes

No

(6) Are there other important points, NOT identified by the Applicant, that also support a scope of practice change?

Yes [skip to “What other important points, NOT identified by the Applicant...” below]

No [skip to question 7]

[If yes] What other important points, NOT identified by the Applicant, support a change in scope of practice?

(7) Can the goals/benefits of the Applicant’s proposal for a change in scope of practice be achieved by means other than a scope of practice change?

Yes [skip to “How can the goals/benefits of the Applicant’s proposal for a change...” below]

No [skip to question 8]

[If yes] How can the goals/benefits of the Applicant’s proposal for a change in scope of practice be achieved by means other than a scope of practice change?

(8) Currently, only a member of the College of Chiropodists of Ontario is permitted to use the restricted title “chiropodist” or “podiatrist”.

The Applicant has proposed that “chiropodist” and “podiatrist” continue to be restricted titles. In addition, the Applicant is proposing that “podiatric surgeon” and “foot surgeon” become restricted titles.

Please state your level of agreement with respect to restricted titles that were proposed by the Applicant.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Continuation of statutory protection for the title "podiatrist"					
Continuation of statutory protection for the title "chiropracist"					
Statutory protection for the title "podiatric surgeon"					
Statutory protection for the title "foot surgeon"					

(9) Does the Applicant’s proposal for a change in scope of practice protect the public interest?

Yes [skip to “Rank the top THREE factors...are in the public interest” directly below]

No [skip to “Rank the top THREE factors...are not in the public interest” further below]

[If Yes] Rank the top THREE factors, assigning numbers 1-3 in terms of importance, with 1 being most important, that best support your view that the proposed changes to the scope of practice of the profession are in the public interest.

- The proposal addresses critical gaps in professional services
- The proposal addresses trends in illness and disease
- The proposal addresses a changing public need for services and increased public awareness of available services
- The proposal addresses wait times for related health care services
- The proposal addresses changing technology
- The proposal addresses demographic trends
- The proposal will promote collaborative scopes of practice
- The proposal will address patient safety
- The proposal will address wellness and health promotion
- The proposal will address health human resources issues such as supply of practitioners
- The proposal addresses professional competencies that are not currently recognized
- The proposal will address access to services in remote, rural or under serviced areas
- The proposal favours the public interest over professional self-interests
- The proposal will improve access to care, across the health care system
- The proposal will not result in higher health care costs

[If No] Rank the top THREE factors, assigning numbers 1-3 in terms of importance, with 1 being most important, that best support your view that the proposed changes to the scope of practice of the profession are not in the public interest.

- The proposal does not address critical gaps in professional services
- The proposal does not address trends in illness and disease
- There isn’t a changing public need for services and increased public awareness of available services
- The proposal does not address wait times for related health care services
- The proposal does not address changing technology
- The proposal does not address demographic trends
- The proposal does not promote collaborative scopes of practice
- The proposal does not address patient safety (potential risk of harm)

The proposal does not address wellness and health promotion
The proposal does not address health human resources issues such as supply of practitioners
Professional competencies are currently recognized to an adequate extent
The proposal does not address access to services in remote, rural or under serviced areas
The proposal promotes professional self-interests over the public interest
The proposal will not improve access to care
The proposal will result in higher health care costs

(10) The Minister asked HPRAC to examine “whether the existing limitations on the podiatrist class of members should continue.” This question is on the existing limitations on the podiatrist class of members (described by the Applicant as the “podiatric cap”) and is not related to the scope of practice of chiropodists.

Among other things, podiatrists in Ontario are authorized to communicate a diagnosis and cut into the bony tissue of the forefoot. Under the current legislative scheme chiropodists cannot perform these acts.

Should the College of Chiropodists of Ontario be authorized to register new individuals into the podiatrist class of membership as long as they meet the educational and practice requirements?

Yes [skip to “Rank the top THREE factors...the legislation should be changed...” directly below]
No [skip to “Rank the top THREE factors...the legislation should not be changed...” further below]

[If Yes] Rank the top THREE factors, assigning numbers 1-3 in terms of importance, with 1 being most important, that best support your view that the legislation should be changed to permit the registration of podiatrists.

A change in legislation will address critical gaps in professional services
A change in legislation will address trends in illness and disease
A change in legislation is required because of the changing public need for services, and increased public awareness of available services
A change in legislation will address wait times for related health care services
A change in legislation will address demographic trends
A change in legislation will promote collaborative scopes of practice
A change in legislation will address patient safety
A change in legislation will address wellness and health promotion
A change in legislation will address health human resources issues such as supply of practitioners
A change in legislation will address the professional competencies that are not currently recognized
A change in legislation will improve access to foot care resulting in improvements to the efficient delivery of care
A change in legislation will address access to services in remote, rural or under serviced areas
A change in legislation will promote excellence and continuous improvement within the profession on an ongoing basis
A change in legislation will enable practitioners trained and educated to a podiatry scope of practice to provide podiatric care
A change in legislation will improve the quality of care

[If No] Rank the top THREE factors, assigning numbers 1-3 in terms of importance, with 1 being most important, that best support your view that the legislation should not be changed to permit the registration of podiatrists.

A change in legislation will not address critical gaps in professional services

- A change in legislation will not address trends in illness and disease
- A change in legislation is not required because there is no change to the public need for services, or the awareness of available services
- A change in legislation will not address wait times for related health care services
- A change in legislation will not address demographic trends
- A change in legislation will not promote collaborative scopes of practice
- A change in legislation will not address patient safety (potential risk of harm)
- A change in legislation will not address wellness and health promotion
- A change in legislation will not address health human resources issues such as supply of practitioners
- A change in legislation will not address the professional competencies that are currently unrecognized
- A change in legislation will not improve the efficient delivery of care
- A change in legislation will not address access to services in remote, rural or under serviced areas
- A change in legislation will not promote excellence and continuous improvement within the profession on an ongoing basis
- A change in legislation will not enable practitioners trained and educated to a podiatry scope of practice to provide podiatric care
- A change in legislation will not improve the quality of care

(11) What will be the impact of the proposed change in scope of practice on the following:

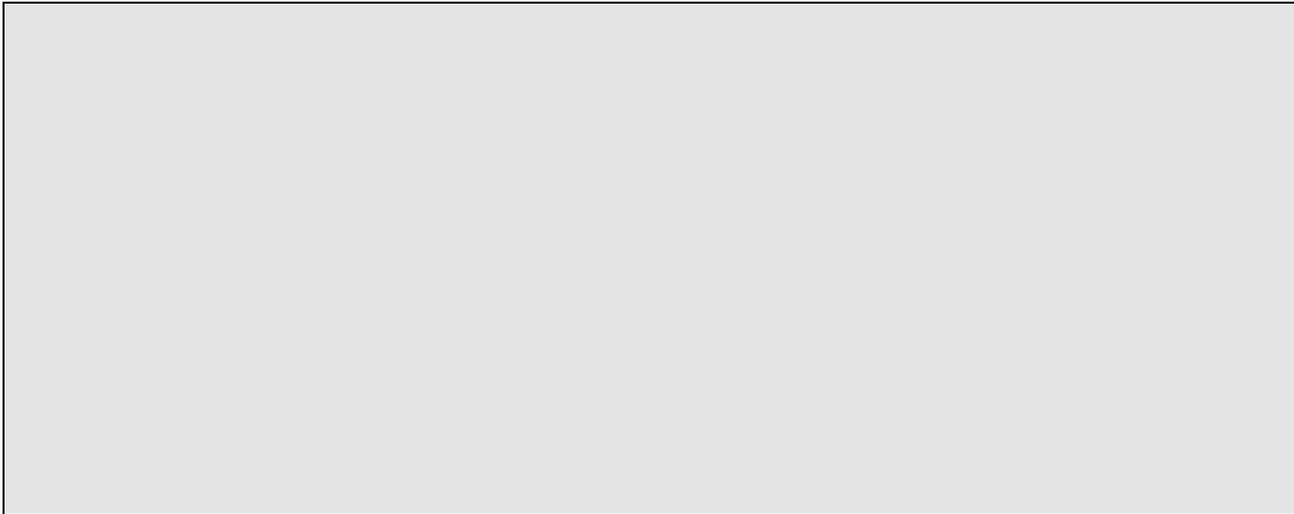
	Impact will be positive	Neutral	Impact will be negative
Costs to patients			
Costs to the health care system			
Patients' understanding of the scope of practice of Ontario's foot care health practitioners			
Patient experience			
Interprofessional care			
Service efficiency			
Access to foot care			
Wait times			
Consumer protection measures			
Costs to the educational sector			
Costs to the regulatory sector			

(12) The proposed change in scope of practice may result in the following:

- An increased risk of harm [skip to "How can increases to risk of harm be mitigated?" below]
- A decreased risk of harm [skip to question 13]
- No impact to risk of harm [skip to question 13]

[If "An increased risk of harm"] How can increases to risk of harm be mitigated?

(13) Do you have any other comments to make regarding the Applicant's submission?



Access to Information

Comments submitted will be considered by HPRAC and will help it to determine appropriate recommendations to make to the Minister of Health and Long-Term Care. To ensure transparency and encourage open dialogue, the feedback received by HPRAC may be posted on its website in accordance with its Privacy Statement, which is available at: www.hprac.org/en/privacy.asp.

Please note that unless requested and otherwise agreed to by HPRAC, any information or comments received from organizations will be considered public information and may be used and disclosed by HPRAC. HPRAC may disclose materials or comments, or summaries of them, to other interested parties (during and after the consultation period). An individual who makes a submission and who indicates an affiliation with an organization in his or her submission will be considered to have made his or her submission on behalf of the affiliated organization.

HPRAC will not disclose any personal information contained in the submission of an individual who does not specify an organizational affiliation in his or her submission without the individual's consent unless required to do so by law. However, HPRAC may use and disclose the content of the individual's submission to assist it in fulfilling its statutory mandate.

HPRAC reserves the right to refuse to post a submission, in whole or in part, that, in its sole discretion, is unrelated to the issue under consultation and is abusive, obscene, harassing, threatening or includes defamatory comments. If you have any questions about the collection of this information, you can contact HPRAC at 416-326-1550.

Appendix E

COCOO Application



COLLEGE OF CHIROPODISTS OF ONTARIO

Regulating Chiropodists and Podiatrists in Ontario

Mr. Thomas Corcoran, ICD.D, MBA, B.Sc., P.Eng.
Chair
& Council Members of the Health Professions Regulatory Advisory Council,
56 Wellesley St W.,
12th Floor
Toronto, Ontario, Canada
M5S 2S3

Re: Review of the Chiropody and Podiatry Professions

Enclosed please find:

1. Our completed formal Application in response to HPRAC Application Guide" Review as a professional Scope of Practice under the *Regulated Health Professions Act, 1991*" (August, 2014), plus Appendices; and
2. Our responses to HPRAC's "18 Additional Questions" plus Appendices.

We have provided both in hard copy and electronic formats.

The College had several objectives when we asked the Minister of Health and Long-Term Care for this Review in 2006. We wanted to:

Correct gaps and anomalies in the current scope of practice to allow chiropodists and podiatrists to provide a safe, continuum of care in the best interest of patients and for health system efficiency.

Expand the scope of practice to reflect a North American podiatry model whose efficacy has been amply demonstrated elsewhere and in order to enhance patient choice and access to more advanced footcare.

Address regulatory inefficiencies and anomalies by adopting a unitary profession with a single title and scope and revoking the "podiatric cap".

These remain our objectives.

We commend our submissions to your attention. We will, of course, make ourselves available to respond to any questions or requests from HPRAC. And we look forward to your response and to completion of this long-awaited and very important Review.

Yours sincerely,

Peter Stavropoulos, DCh, DPM,
President

REVIEW

of the Chiropody and Podiatry Professions

Application to the
Health Professions Regulatory Advisory Council

*" Better Patient Care and Better Value for Healthcare Dollars by Adopting
a Podiatry Model of Foot and Ankle Care"*

Submitted by
The College of Chiropodists of Ontario

November 28, 2014

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Question 22: "If the proposed changes scope of practice involves an additional controlled act being authorized to the profession, specify the circumstances (if any) under which a member of the profession should be permitted to delegate that act. In addition, please describe any consultation process that has occurred with other regulatory bodies that have authority to perform and delegate this controlled act." 67

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GLOSSARY OF TERMS

"APPLICANT" means the College of Chiropractors of Ontario.

"CHIROPODIST(S)" means a registrant or registrants of the College of Chiropractors of Ontario who are neither members of the podiatrist class nor are DPM Chiropractors.

"PODIATRIST(S)" means a registrant or registrants of the podiatrist class of members created by subsection 3. (1) of the *Chiropractic Act, 1991*.

"DPM CHIROPODIST(S)" means a registrant or registrants of the College who have been awarded a Doctor of Podiatric Medicine/DPM degree from a podiatry program accredited by the Council on Podiatric Medical Education (CPME) and who practises in Ontario as a chiropractor.

"PODIATRIC CAP" refers to the prohibition against the registration of any new members of the podiatrist class after July 31, 1993, pursuant to subsection 3. (2) of the *Chiropractic Act, 1991*.

"COLLEGE" means the College of Chiropractors of Ontario.

"DCh" means "Diploma in Chiropractic"

"DSc" means "Doctor of Surgical Chiropractic"

"DPM" means "Doctor of Podiatric Medicine", the degree granted by one of the nine US podiatry programs and by the Université de Québec.

"OPMA" means the Ontario Podiatric Medical Association, the voluntary professional association for podiatrists in Ontario practising as members of the podiatrist class, or as chiropractors.

"OSC" means the Ontario Society of Chiropractors, a voluntary professional association for chiropractors registered to practise in Ontario.

FORWARD

History of the Chiropody & Podiatry Professions in Canada and Ontario

The history of podiatry and chiropody in Canada and the evolution of the associated professions, their scopes of practice and their titles are complicated. In some respects, they are unique and not without some controversy, particularly in Ontario.

Podiatry and chiropody are among the least understood healthcare professions in Ontario – by the public, other healthcare practitioners and other stakeholders. In our stakeholder consultations we have found that few understand or claim to understand what the professions do, their competencies, the differences between the two and where and how they practise. This lack of understanding among other healthcare professions creates a major obstacle to interprofessional collaboration.

Understanding the history and evolution of chiropody and podiatry is vital to understanding the current situation. It is also vital to understanding the College's recommendation to adopt a podiatry model of regulation and care in Ontario. The purpose of this Forward, therefore, is to explain that history and evolution as they have unfolded and place them within the broader Canadian and International contexts.

Specialized care of foot ailments has been documented as far back as circa 4000 BC in Egypt. The origins of chiropody can be traced to the early 17th century in the United Kingdom. So-called "corn cutters" had plied their trade in England and the Continent for some time. In 1781, an English corn cutter by the name of David Lowe translated or plagiarized a French instructional pamphlet "L'art de Soigner les Pieds" into an English document entitled "Chiropodologia", from which the terms "Chiropodist" and "Chiropody" progressively came into common usage. By 1800 "Kelly's London Directory" listed chiropodists practising in the City¹. Thereafter, "chiropody" and the services provided by "chiropodists" became increasingly accepted as a reputable and effective profession.²

Around the middle of the 20th century a divergence began whereby the UK chiropody model continued to be the dominant model, but changes began in the United States. In 1958, the US National Association of Chiropody decided to change its name to the National Association of Podiatry.³ Thereafter, chiropody schools in the United States began to expand the scope and depth of their curricula. They also started to call themselves podiatry schools and changed the degrees they granted from "Doctor of Surgical Chiropody/DSc." to "Doctor of Podiatric Medicine/DPM". They also started to require an undergraduate

¹ Kippen, David; foottalk.blogspot.ca/2008/12/potted-history-of-podiatry/HTML.

² Ontario. Committee on the Healing Arts. "Report 1970". Ian R. Dowie, Professor Horace Krever and Professor M.C. Urquhart. OC-3038/66. (Toronto: Queen's Printer, 1970. (Volume 2)). Digitalized report. 335.

³ The National Association of Podiatry, subsequently was renamed the American Podiatry Association and is now the American Podiatric Medical Association.

degree in the sciences as a prerequisite to entry. One of the distinguishing characteristics of the US podiatry education programs was their incorporation of the "medical teaching model" and their affiliation or association with medical schools.⁴ This transition was completed by all the US podiatry programs by the early 1970s when all graduates of US podiatry programs received the DPM degree. Hence, the podiatry model of footcare was and is often referred to as the "DPM model".

All 31 Mexican states and the Federal District of Mexico adopted the "DPM model". When combined with the several Canadian provinces that did the same, the model is also increasingly referred to as the "North American podiatry model", although (as will be explained) a number of jurisdictions outside of North America have adopted the model as well.

Nevertheless, there is no unitary or static "North American podiatry model" any more than there is a unitary or static "UK chiropody model". Individual jurisdictions often make scope of practice and other modifications to address local exigencies and changing circumstances and requirements.

Prior to the Second World War, British-trained chiropodists were Canada's primary source of footcare specialists. With the advent of the war, chiropodists trained in US chiropody schools became the principal source of new practitioners. The predominance of US-trained practitioners persisted until the late 1970s. As explained above, however, from the early 1960s on, new US-trained practitioners increasingly held DPM degrees and referred to themselves and were increasingly referred to as "podiatrists". As such, Ontario was drawn towards the podiatry model. Nevertheless, Ontario legislation continued to refer to practitioners as "chiropodists".

While Ontario persisted in its commitment to the UK chiropody model, Alberta and British Columbia progressed to podiatry models having scopes of practice equivalent to podiatry models in the US states. Québec adopted a podiatry model with a scope more limited than podiatrists in British Columbia and Alberta, but greater than podiatrists in Ontario. Saskatchewan and Manitoba have more recently adopted the podiatry titles and professional descriptors, but their scopes of practice are much the same as the current chiropody scope in Ontario. Manitoba, however, is apparently considering transitioning to the North American podiatry model. Saskatchewan legislation provides for a separate group of practitioners called "podiatric surgeons" authorized to practice what amounts to a North American podiatry scope of practice. The "podiatrist" title is statutorily protected in New Brunswick by a private act that came into force and effect in 1983 and has been amended by subsequent private acts.^{5 6} New Brunswick podiatrists are authorized to perform procedures on the soft tissues of the foot, but may not

⁴ Masoeta, Richard. "Positioning of podiatric Medicine within the South African Health Care System". Johannesburg: University of Johannesburg, 2005. Digitalized Report. 48.

⁵ New Brunswick. "An Act Respecting Podiatry: Chapter 101, Acts of New Brunswick". Queen's Printer: New Brunswick. 1983.

⁶ New Brunswick. "An Act to Amend An Act Respecting Podiatry: Chapter 35, Acts of New Brunswick". Queen's Printer: New Brunswick. 2005.

perform bone surgery, prescribe, dispense or administer drugs, order or take x-rays, or order or take "forms of energy" as defined in Ontario. The New Brunswick podiatry profession is very small (10-12 members) and the majority of practitioners are DCh graduates from Ontario. Neither podiatrists nor chiropodists are regulated as such in any other province or territory of Canada.⁷

The latest National Occupational Standard (2011) issued by Employment and Social Development Canada⁸ (ESDC) defines the "Main Duties" of Canadian podiatrists and chiropodists for Canadian regulatory, data collection and policy purposes as follows:

- "Doctors of podiatric medicine are primary care practitioners who diagnose diseases, deformities and injuries of the human foot and communicate diagnoses to patients. They treat patients using braces, casts, shields, orthotic devices, physical therapy, or prescribed medications. Doctors of podiatric medicine may also perform surgery on the bones of the forefoot and the subcutaneous soft tissues of the foot.
- Chiropodists and diploma or first-degree trained podiatrists diagnose diseases, deformities and injuries of the human foot and treat patients using braces, casts, shields, orthotic devices, physical therapy and subcutaneous soft-tissue foot surgery".⁹

ESDC defines the "Employment Requirements" for Canadian podiatrists and chiropodists as follows:

"Doctors of Podiatric Medicine (DPM)

- A four-year doctoral degree program in podiatric medicine available in the United States and in Québec, normally following completion of a bachelor's degree program, is required.
- A medical residency is required in Alberta and British Columbia.

⁷ Health Professions Regulatory Advisory Council. "Prescribing and Use of Drugs by Non-Physician Health Professionals: A Jurisdictional Review of the Professions of Chiropody & Podiatry". HPRAC. 2008. 2.

⁸ Because of the small size of the professions, labour market data for chiropodists and podiatrists is only available under the broader "Other professional occupations in health diagnosing and treating" (NOC 3123) occupational group. This group also includes orthoptists, osteopaths and naturopaths. According to the Labour Market and Socio-Economic Information Directorate, Ontario Region: "Looking ahead, the professions in this occupational group are expected to grow at quite a healthy pace over the short-term. This is primarily due to the aging demographics of the province. As the population ages, the demand for practitioners in this occupational group is projected to increase" (E-mail to D. Gracey from N. Sasquib, January 23, 2014).

⁹ Canada. Human Resources and Skills Development Canada. "National Occupational Classification 2011". Queen's Printer. 2011. Digitalized Document.

<<http://www5.hrsdc.gc.ca/noc/english/noc/2011/pdf/PrintableVersionNOC2011.pdf>>. 278.

- A doctor of podiatric medicine (DPM) degree is required to practise podiatry in Québec, Ontario, Alberta and British Columbia.

Chiropodists and podiatrists

- A three-year diploma program in chiropody (DCh) obtained in Canada
or
A first-degree program in podiatric medicine (D.Pod.M.) obtained abroad (United Kingdom) is usually required.
- A licence (sic) is required in New Brunswick, Québec, Ontario, Manitoba, Saskatchewan, Alberta and British Columbia".¹⁰

Meanwhile in the UK, the traditional UK chiropody model persisted until the early 1990s. In 1994 a report by the "Chiropody Task Force" was commissioned jointly by the Department of Health and the National Health Service¹¹. The report was commissioned

"... in recognition of the key service chiropodists provide to large sections of the community, and in particular, the central role played by the small professional group in helping to keep the growing elderly profession mobile, independent and active for longer in the community, improving the quality of life of the individual..." and

*"... to ensure that all NHS chiropody services are in a position to respond positively to the challenges posed by the NHS Reforms in Care in the Community Plans-especially in ensuring that the planning and development of NHS chiropody services are set within the context of locally assessed needs-and to its commitment to achieving the aims of the 1989 WHO St. Vincent declaration insofar as these would entail providing better chiropody services to diabetics."*¹²

The Health and Care Professions Council (HCPC), now regulates a total of 13,058 chiropodists and podiatrists. At the risk of oversimplification, however, the majority of practitioners practise within a "chiropody" scope of practice. "Podiatric surgeons" are characterized by the College of Podiatrists as podiatrists who have undertaken specialist training in foot and ankle surgery. They typically treat bone, joint as well as soft tissue disorders. In many ways, the UK chiropody/podiatry model is very similar to Ontario's current chiropody model, with the podiatrist class being analogous to the podiatric surgeon group of practitioners in the UK. Important exceptions include a more limited scope of practice for members of the podiatrist class in Ontario and, of course, the existence of the podiatric cap in Ontario.

¹⁰ "National Occupational Classification 2011". 2011. 278.

¹¹ United Kingdom. Department of Health. NHS Chiropody Task Force. "FEETfirst". National Health Services Executive, 1085. 16M9, 1994.

¹² FEETfirst, Ibid. Page 4.

This Application contains a much more detailed description of the current status of the UK chiropody/podiatry model in the response to Question 30.

The scope of practice of UK General Podiatrists has expanded incrementally since 1994. For example, effective August 20, 2013, Podiatrists who successfully complete a course approved by the Health and Care Professions Council are authorized to prescribe and administer medications for diabetic ulcers, arthritis and other conditions of the foot. In making the announcement, the Minister (the Rt Hon. Norman Lamb) explained,

“This change will not only benefit patients by making it more convenient to get treatment but it will also free up valuable GP time.”¹³

Titles and Scopes of Practice

Today, the professional title "chiropodist" and the professional descriptor "chiropody" have been largely displaced in most comparable jurisdictions by "podiatrist" and "podiatry", but not necessarily triggered by or coincident with scope of practice changes. In all other North American jurisdictions outside of Ontario, the use of "chiropodist" and "chiropody" has been, or is being, phased out (See Figure 1).¹⁴

¹³ Lamb, Norton. MP. "Millions of patients to benefit from easier access to medication and fewer trips to hospitals". Department of Health. 20 August, 2013. Web. < <https://www.gov.uk/government/news/millions-of-patients-to-benefit-from-easier-access-to-medication-and-fewer-trips-to-hospitals>>.

¹⁴ "History of Chiropody/Podiatry in Ontario." *Podiatric Medicine Service*. Podiatric Medicine Services, 2012. Web. <<http://podiatricmedicineservices.com/history-of-chiropody-podiatry-in-ontario/>>.

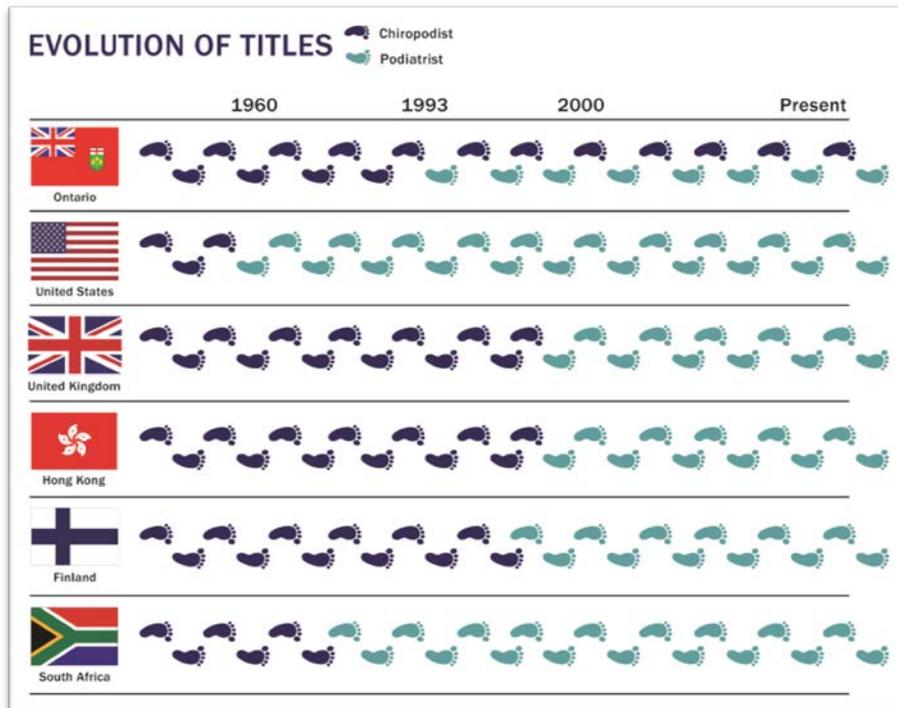


Figure 1. Evolution of Titles by Jurisdiction

Regulation of the Profession and Changing Scopes in Ontario

In 1925, chiropodists along with several other professions such as chiropractors were regulated for the first time in Ontario under the *Drugless Practitioners Act*.¹⁵ Prior to the *Drugless Practitioners Act* anyone, regardless of training, could hold themselves out as chiropodists and could practise chiropody. In order to be accepted into the medically-based institutions of healthcare, the chiropody profession worked hard to establish its own identity and differentiate itself from the "alternative medicine" professions that were grouped within the *Drugless Practitioners Act*.¹⁶ An important component of that strategy was to obtain a regulatory statute specific to chiropody and separate and apart from the *Drugless Practitioners Act*.

That strategy achieved success in 1944. The *Chiropody Act, 1944* came into force and effect and chiropodists began to be regulated by the Board of Regents, Chiropody. In 1950 and 1955 the Board of Regents amended its registration requirements to require a DSc degree as a condition of registration. This resulted in the exclusion of nearly every British-trained chiropodist. In retrospect, the strategy that resulted in the *Chiropody Act, 1944* focused too much on obtaining a separate Act and too little on putting in place a scope of practice that reflected practitioners' competencies and health system needs.

¹⁵ "Report 1970". 1970. 336.

¹⁶ O'Reilly, Patricia. "Health Care Practitioners". Toronto: University of Toronto Press, 2000. 51.

Accordingly, the *Chiropody Act* and subsequent amendments continued to reflect the UK chiropody scope of practice.

This exclusion of most British practitioners, combined with a limited scope of practice and the absence of any education program in Ontario meant that the number of chiropodists remained low in Ontario from the 1940s onward. Throughout the 1950s there were never more than 67 registered chiropodists in Ontario, increasing to only 69 by 1969.¹⁷ The resultant ratio of practitioners to population was 1:100,000 versus 1:30,000 in the United States and 1:20,000 in the United Kingdom.¹⁸

In 1966, the Government of Ontario commissioned the Committee on the Healing Arts (CHA) and in 1972 and 1973 the Ontario Council of Health (OCH) issued sequential reports on chiropody. Both the CHA and the OCH recommended a chiropody model of footcare delivery based on the scope of practice and training for chiropodists in the UK. The Report of the Committee on the Healing Arts stated that “the Committee regards chiropody primarily as the British regard it, as supplementary to medicine”.¹⁹ Furthermore the Committee recommended that a course in chiropody, similar to the training programs for British chiropodists, be set up in Ontario at a College of Applied Arts and Technology or equivalent and be no longer than three years. The Committee also recommended that anyone trained to the level of a British practitioner be allowed to practise in Ontario to augment the number of existing practitioners. Additionally, the Committee recommended that chiropodists' scope of practice not include surgery involving subcutaneous tissue, although it noted that the Courts had twice ruled such surgery to be within the existing chiropody scope of practice.²⁰ Similarly the Committee recommended that nothing beyond local anesthetics and no drugs be authorized for administration by chiropodists.²¹

The Report of the Ontario Council of Health Task Force on Chiropody (1972) took largely the same tack as the CHA with some minor variations and additional recommendations. The CHA and the Report of the OCH shared the same views on surgery, anaesthetics and drugs, with the notable exception by the OCH that chiropodists be allowed to use keratolytic agents, fungicides and antibiotics.²² Additionally, the OCH recommended chiropodists work with physicians and other health personnel and that hospitals, community health centres and other health delivery institutions be encouraged to include chiropodists in their health teams. Both the OCH and the CHA agreed that chiropodists should be licensed practitioners.²³

¹⁷ “Report 1970”. 1970. 337.

¹⁸ “Report 1970”. 1970. 334.

¹⁹ “Report 1970”. 1970. 348.

²⁰ “Report 1970”. 1970. 342.

²¹ “Report 1970”. 1970. 349.

²² Ontario Council of Health. “Report of Task Force on Chiropody”. Dr. Irwin M. Hillard, Dr. J.R.D. Bayne, and Dr. W.R. Harris. 1972. 7.

²³ “Report of Task Force on Chiropody”. 1972. 2.

In 1980, the Ontario government announced the introduction of a chiropody model adopted from the chiropody model that existed in the United Kingdom at the time. The intention was for chiropodists to be located in hospitals and other community health facilities as salaried employees. The Ministry of Health took a very active role in promoting the profession by funding new chiropody clinics in hospitals across the province, particularly in areas of the province that were underserved in footcare. The objective was to achieve a provider-to population ratio of 1:30,000 and equitable province-wide coverage.

Another objective was also to have practitioners trained in Ontario and to that end the Ministry funded a chiropody education program. British-trained chiropodists were recruited initially to augment the number of “podiatrists”, as were Ontario nurses who had completed additional training in footcare.

In March, 1980 the Ontario government introduced a Bill (Bill 167, "The Chiropody Amendment Act") to make two amendments to the *Chiropody Act, 1944*. Those amendments were represented as bringing the *Chiropody Act* into line with the *Health Disciplines Act* that governed a number of other healthcare professions. The amendments increased lay representation on the Board of Regents and authorized the Lieutenant Governor in Council to make regulations under the Act. At the same time the government announced that "podiatrists" (sic) practising in Ontario, as well as Ontario residents training in podiatry in the United States who return to Ontario to practise, would continue to be covered by OHIP.²⁴ It is noteworthy that the Legislature was presented with a clear choice at the time. The Liberal Opposition had already brought forward a private member's Bill (Bill 149) proposing amendments to the *Health Disciplines Act* to adopt a US style podiatry model and to bring the regulation of podiatrists under the *Health Disciplines Act*. Bill 149 died on the Order Paper after passage of Bill 167.

Ontario legislation defines a traditional UK-style chiropody model of practice and regulation in which podiatrists are authorized to perform additional controlled acts and other authorities.

The historical record indicates the decision to adopt a chiropody model in 1980 came about for several reasons:

- There weren't enough chiropodists/podiatrists to satisfy the demand for footcare in Ontario. In 1980, there were no more than 75 podiatrists/chiropodists practising in Ontario and large areas of the province were underserved or had no service at all. On this point, the Parliamentary Assistant to the Minister of Health (Mr. Turner) said during the debate on Bill 167:

²⁴ Timbrell, Dennis. "Foot-Care Services" *Edited Hansard*. Ontario. Legislative Assembly. 31st Assembly, 13 March, 1980. *Legislative Assembly of Ontario*.

"Podiatrists have delivered a service that is obviously well received by recipients in the province. The simple fact is there are just not enough of them."²⁵

- There wasn't an educational program for podiatrists in Canada and no likelihood of one being established in the foreseeable future.
- There were sufficient numbers of physicians and orthopedic surgeons to address the demand for all but routine footcare. As the Minister of Health (Mr. Timbrell) said at the time: "The significant difference between chiropody and podiatry is that the latter includes surgical procedures. In Ontario there are considered to be sufficient surgeons, particularly orthopedic surgeons, to provide surgical management of foot disorders."²⁶
- The UK chiropody model fit better with Ontario's healthcare delivery paradigm of the time, which was hospital and physician-centric.

There have been suggestions that in 1980 the Ontario government aimed to wind-down the podiatry profession. The documentary history does not support that suggestion. In response to an accusation to that effect from a member of the Opposition, the Parliamentary Assistant to the Minister of Health stated: "I want to assure the members there is no plot on behalf of this ministry or the government to terminate the services of podiatrists."²⁷

The Education Program

To achieve the government's objective of having chiropodists trained in Ontario, a chiropody program encompassing six semesters over a two-year period was set up and funded by the Ministry of Health at George Brown College. Graduates received a Diploma in Chiropody/DCh. The program was subsequently expanded to seven semesters over three years, with the first intake of "three-year" students in 1986 and the first graduation of "three-year DChs" occurring in 1989. From 1980 to 1989, the Diploma was issued by George Brown. From 1989 to 1996, the Diploma was issued jointly by George Brown and the Michener. From 1997 onwards the Diploma was issued by the Michener.²⁸ The clinical elements of the

²⁵ Timbrell, Dennis. "Chiropody Amendment Act" *Edited Hansard*. Ontario. Legislative Assembly. 31st Assembly, 04 November, 1980. *Legislative Assembly of Ontario*.

²⁶ "Foot-Care Services". 13 March, 1980.

²⁷ "Chiropody Amendment Act". 04 November, 1980.

²⁸ The Michener Institute provided this historical information. In its submission to HPRAC as part of the consultation on Ontario's current footcare model, The Michener claimed that it took over the program in 2003, but that is clearly incorrect.

program were provided from time-to-time at Toronto General Hospital and elsewhere. There were also at least two "gap" years over the last three decades as part of the program's restructuring, wherein there was no intake of new students.

The chiropody education program has gone through a number of iterations over the last three decades and is now characterized as an Advanced Diploma of Health Sciences (Chiropody), is delivered in seven semesters over three years and requires an undergraduate degree for admission. Among current registrants of the College, 64 are graduates of the George Brown two-year program; 87 are graduates of the George Brown three-year program; and 172 are graduates of some combination of the George Brown and Michener three-year programs from 1989 onwards. The chiropody program at the Michener remains the only chiropody educational program offered in North America and one of the very few diploma-level chiropody programs left in the world.

The Health Professions Legislation Review (HPLR)

The Health Professions Legislation Review was commissioned in 1983 as an independent review of the regulation of Ontario's healthcare professions and the appropriate regulatory framework. In the matter of the chiropody and podiatry professions, the Review essentially accepted the Ministry's recent decision to adopt the UK chiropody model. On April 30, 1986 the Minister of Health (Mr. Elston) indicated that eight professions, including chiropodists and podiatrists, would be clustered or jointly regulated under one governing body. The professions thus grouped were to share a common governing council under a single professional act. The Minister provided several reasons for this "clustering", but did not indicate which applied to chiropody and podiatry, although the persistent, small size of the podiatry profession was probably a major factor.²⁹

Late in its work, the Review recommended the recognition of podiatrists as a class of members within the chiropody profession with additional authorized acts. The Review did so in order to acknowledge and utilize the additional competencies that currently-practising podiatrists possessed. This "bifurcation" was resisted by the Board of Regents, Chiropody, but was ultimately entrenched in the *Chiropody Act, 1991*.³⁰

²⁹ Ontario. Ministry of Health. *Recommendations of the Health Professions Legislation Review*. "Striking a New Balance: a Blueprint For The Regulation of Ontario's Health Professions". ISBN 0-7729-5112-X. Queen's Printer, January 1989. Digitalized report. 11.

³⁰ Springer, Andrew, on behalf of the Board of Regents of Chiropody. "Standing Committee on Social Development - August 12, 1991 - Bill 43, Regulated Health Professions Act, 1991, and Companion Legislation" *Edited Hansard*. Ontario. Legislative Assembly. 35th Assembly, 12 August, 1991. <http://www.ontla.on.ca/web/committee-proceedings/committee_transcripts_details.do?locale=en&Date=1991-08-12&ParlCommID=133&BillID=&Business=Bill+43%2C+Regulated+Health+Professions+Act%2C+1991%2C+and+Companion+Legislation&DocumentID=17037#P437_125878>.

Under the *Chiropody Act, 1991*, chiropodists registered with the Board of Regents who had graduated with a US DSc or DPM were grand-parented into the podiatrist class of members. Members of the podiatrist class have the same legislated scope of practice as chiropodists, but have additional authorized acts namely "communicating a diagnosis" and performing surgery on the bones of the forefoot. Podiatrists also have access to a few drugs in addition to those authorized for chiropodists.

Members of the podiatrist class and any chiropodists who have graduated from a four-year chiropody education program are also authorized to order and take radiographs, to own and operate radiographic equipment and be radiation protection officers under the *Healing Arts Radiation Protection Act (HARP)*. At this time, among the chiropodist members only members of the podiatrist class and those DPM graduates who have registered in Ontario as chiropodists have registered under HARP.

The College had a total of 637 in-province registrants at the conclusion of 2013; 568 chiropodists, including a number of who have DPM degrees; and 69 members of the podiatrist class. In addition the College has received 23 requests for applications to apply to the College and register from DPM graduates.

Distribution of Chiropractors and Podiatrists by LHIN¹

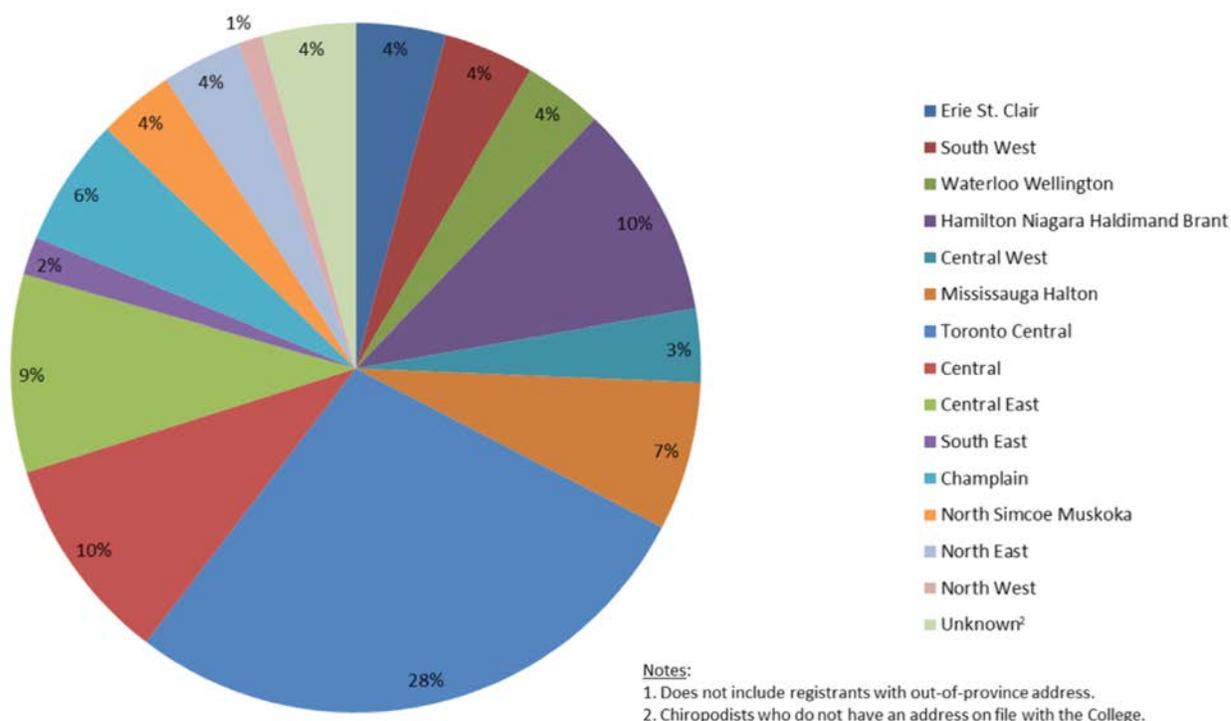


Figure 3. The Distribution of Chiropractors and Podiatrists by 14 LHIN.

The Ontario-Wide Distribution of Chiropractors and Podiatrists:

LHIN	Number of Chiropractors	Number of Podiatrists
East St. Clair	42	1
South West	46	2
Waterloo Wellington	39	7
Hamilton Niagara Haldimand Brant	96	10
Central West	69	5
Mississauga Halton	108	9
Toronto Central	190	27
Central	112	20
Central East	104	11
South East	66	4
Champlain	24	0
North Simcoe Muskoka	33	3
North East	34	1
North West	9	0

The “Podiatric Cap”

Subsection 3. (2) of the *Chiropody Act, 1991* reads as follows:

"No person shall be added to the class of members called podiatrists after the 31st day of July, 1993."

This prohibition against the registration of new members of a regulated profession is unique and unprecedented in Ontario. The Minister's referral letter has asked HPRAC to conduct *"an analysis of... whether the existing limitations on the podiatrist class of members should continue."*³¹

The podiatric cap originates from the Ontario government's decision in the late 1970s to adopt the UK chiropody model. Until 1993, however, the Board of Regents, Chiropody continued to register US-trained podiatrists to practise in Ontario and the Ministry of Health continued to issue OHIP registrations to them. US-trained podiatrists were also registered by the Ministry during this period to operate radiographic equipment and order x-rays under the *Healing Arts Radiation Protection Act* and were appointed as Radiation Protection Officers.

The Health Professions Legislation Review endorsed the implementation of the podiatric cap through legislation. Its official reason for doing so was that the podiatry profession had failed to fulfill the four criteria set by the HPLR to justify independent regulation under the new regulatory framework. The absence of an educational facility in Ontario also appeared to be a major consideration behind the cap. Podiatrists in Ontario had also developed something of an antagonistic relationship with physicians and had positioned podiatry as an alternative to mainstream medicine, while chiropody had positioned itself as being complementary to mainstream medicine. One explanation for the podiatric cap, therefore, was that those professions that directly challenged the medical monopoly were less likely to succeed with regulation than those who positioned themselves as complementing it.³²

In the workup to the *Regulated Health Professions Act* and the *Chiropody Act, 1991*, the Board of Regents and the chiropody profession advocated for a prohibition against the registration of US-trained podiatrists, who were the real target of the prohibition against the registration of new "podiatrists".^{33 34}

³¹ Health Professions Review Advisory Council. *Current Ministerial Referrals*. "Chiropody/Podiatry: The Minister's Question". HPRAC. Web. <http://www.hprac.org/en/projects/chiropody_podiatry.asp> December, 19 2013.

³² "Health Care Practitioners". 2000. 104.

³³ Kerbl, David, Chiropodist, President Ontario Society of Chiropodists. "Standing Committee on Social Development - August 12, 1991 - Bill 43, Regulated Health Professions Act, 1991, and Companion Legislation" *Edited Hansard*. Ontario. Legislative Assembly. 35th Assembly, 12 August, 1991. <http://www.ontla.on.ca/web/committee-proceedings/committee_transcripts_details.do?locale=en&Date=1991-08-12&ParlCommID=133&BillID=&Business=Bill+43%2C+Regulated+Health+Professions+Act%2C+1991%2C+and+Companion+Legislation&DocumentID=17037#P437_125878>.

Because of free trade obligations, a prohibition against US-trained podiatrists alone would almost certainly have been challenged as discriminatory treatment. Accordingly, the government decided to put a universal prohibition in place effective July 31, 1993 against the registration of any new members of the podiatrist class.

The College of Chiropodists believes it self-evident that the podiatric cap must disappear with the move to a North American podiatric model. The Ontario Society of Chiropodists, the Ontario Podiatric Medical Association, the Canadian Federation of Podiatric Medicine and the Canadian Podiatric Medical Association are all in agreement. No current College registrant has expressed opposition to removal of the cap. During the stakeholder consultations, no stakeholder has expressed opposition to removal of the podiatric cap. In fact, a number of stakeholders found the cap peculiar and counterintuitive in an environment of increasing scarcity of healthcare practitioners.

The cap has been the most obvious impediment to the natural evolution of the chiropody profession in Ontario in response to health system changes and health system demands. While other jurisdictions have evolved to a podiatry model, Ontario persists with a model of footcare delivery and regulation that was adopted in the late 1970s and has evolved in most comparable jurisdictions.

The cap is the only reason that a Mutual Recognition Agreement for chiropody and podiatry under the Agreement on Internal Trade has not been agreed to amongst the Canadian provinces and territories. Chiropody/podiatry is the only RHPA profession that does not have an interprovincial/territorial MRA in place and the only obstacle to doing so has been the cap. The cap is the principal reason that podiatrists are not recognized with other healthcare professions for purposes of mutual recognition under Chapter 16 (Appendix 1603 .D1) of the North American Free Trade Agreement (NAFTA) (See Part II, General Duty). The cap is also in conflict with the spirit, if not the letter, of the *Fair Access to Regulated Professions Act*.

As such, the existence of the cap has substantially complicated College operations, because the College has no option but to deny applications for registration as podiatrists from Ontario residents who are graduates of DPM programs in Québec and the United States and from podiatrists from other provinces and from foreign jurisdictions.

More importantly, in the College's view, the cap neither serves nor protects the public interest. Despite the growing gap between the demand for the footcare services provided by podiatrists, the supply of podiatrists cannot be increased. The most highly-qualified group of podiatrists in Ontario must practise as chiropodists and within the limited chiropody authorized acts (See Case Study 1). The waste or

³⁴ Springer, Andrew, on behalf of the Board of Regents of Chiropody. "Standing Committee on Social Development - August 12, 1991 - Bill 43, Regulated Health Professions Act, 1991, and Companion Legislation" 12 August, 1991.

misapplication of these competencies is difficult to justify, particularly in the current environment where the demand for footcare far outstrips the supply.

Case Study of an American trained DPM Practicing in Ontario

James Hill holds a B.Sc. in Biology from Wayne State University and a Doctor of Podiatric Medicine/DPM degree from the Dr. William M Scholl College of Podiatric Medicine in Chicago Illinois. From 1996 to 1998 he completed a podiatric surgical residency in the medical and surgical treatment of the forefoot, rear foot and ankle, including diabetic limb salvage and trauma at the Columbia North Houston Medical Center in Houston Texas. He is a fellow of the American College of Foot and Ankle Surgeons and is Board certified by the American Board of Podiatric Surgery (ABPS) in Foot Surgery. James is also Board certified by the ABPS in Reconstructive Rearfoot and Ankle Surgery.

He is licensed as a podiatric physician and surgeon in Michigan. Several days a week he performs complex surgical procedures on the foot and ankle at the Oakwood Southshore Medical Center, the Henry Ford Wyandotte Hospital and Beaumont Hospital in Michigan and at a community-based clinic in Troy, Michigan. Procedures he routinely performs as a licensed podiatric physician and surgeon in Michigan include surgeries for limb and life threatening diabetic foot infections, and traumatic injuries including calcaneal fractures and complex ankle fractures. He also performs elective procedures for complex forefoot, midfoot, rearfoot and ankle deformities including surgery involving diabetic Charcot reconstruction, rheumatoid forefoot reconstruction, flatfoot repair and ankle replacement.

In 1999 he was registered by the College of Chiropractors of Ontario to practise chiropractic in this province where he is resident. Like approximately 20 other DPM graduates, because of the "podiatric cap" and despite his education and training, the College could not admit him to the podiatrists class of members. Accordingly, his Ontario practice is restricted to the more limited chiropractic authorized acts and he is unable to perform any of the podiatric procedures for which he is trained and that he performs regularly in Michigan.

Case Study 1: James Hill, DPM.

The Applicant recommends the removal of the podiatric cap. In fact, achievement of the fundamental objective of this Application, namely transitioning to a podiatry model of footcare delivery and regulation, is premised on the removal of the podiatric cap.

Overview of the Recommendations by the College

As will be articulated in greater depth and detail in this Application, the College is recommending an adaptation of the North American podiatry model of care and regulation to better reflect Ontario's present healthcare delivery paradigm, the government's stated policy objectives and to implement a model that will better address the public interest by closing the gap between the demand for advanced footcare and the supply of competent practitioners. This gap exists primarily among seniors (who comprise about 58% of chiropractors' and podiatrists' patients) and among patients with chronic disease such as diabetes. There are multiple reasons for the gap. One is the increased incidence of chronic debilitating conditions of the foot and ankle associated with chronic systemic diseases such as diabetes, arthritis and cancer. Furthermore, and despite the government's intentions in adopting a chiropractic model three decades ago, orthopedic surgeons acknowledge that they cannot fill the gap for

higher-end medical care. There are no more than 25 orthopedic surgeons specializing in the foot and ankle in Ontario. According to a submission to the Ministry of Health and Long-Term Care funded by the Ontario and Canadian Orthopedic Associations, general orthopedic surgeons have stopped performing many foot and ankle surgeries and the number of foot and ankle surgeons has not increased enough to fulfill the needs of Ontario citizens.³⁵ The same report noted that some foot and ankle specialists are reducing the number of less specialized foot and ankle surgeries they perform, in some cases because operating time is limited for such procedures.³⁶ The report also notes that the performance of less complex foot and ankle surgeries is not an efficient use of highly-specialized orthopedic surgeons.³⁷ Adaptation of the North American podiatry model will allow podiatrists to provide a more seamless continuum of care to patients and some components of the North American podiatry model are essential for podiatrists and chiropractors to provide safe and effective care and the highest and best standards of care in the CURRENT scope of practice.

"Wait times data clearly demonstrates that the volumes of patients being treated within the health care system at the present time is not managing the surgical need for forefoot or ankle surgery within the province of Ontario. As many patients are currently unable to access care within the health care system the absolute volume of surgeries required is not known"

- (Daniels et al, 2009.20).

Chiropractic's evolution, coupled with changes in the healthcare delivery system, has already taken the practice of the profession towards the North American podiatry model. For example, whereas the government anticipated that chiropractors would practise primarily in hospitals, CHCs and public health units, in 2012 less than 20% of registrants reported that they practised full or part-time in a hospital or in an analogous healthcare delivery institution. The education programs at the Michener have gone through a series of enhancements and have equipped chiropractors with competencies far in excess of those required for the chiropractic scope of practice and authorized acts.

One of the reasons the government of the day may have had for the "clustering" of podiatrists with the chiropractic profession as a class of members was to "avoid public confusion".³⁸ If that in fact was an objective, it has clearly failed. Few members of the public -- and not many more members of other healthcare professions -- understand what a chiropractor is or does. Nor do they understand the differences between chiropractors and podiatrists. Because of international adoption of the podiatry

³⁵ Daniels, Dr. T, et al. "Proposal for the Development of a Provincial Foot and Ankle Program". Ontario Orthopaedic Association and the Canadian Orthopaedic Association, May 2009. 9

³⁶ "Proposal for the Development of a Provincial Foot and Ankle Program". May 2009. 12.

³⁷ "Proposal for the Development of a Provincial Foot and Ankle Program". May 2009. 11.

³⁸ "Striking a New Balance: a Blueprint for the Regulation of Ontario's Health Professions". 1989. 11.

nomenclature, in particular the close proximity to the US, the recognition of podiatry and the podiatry profession is substantially higher.

The adoption of a North American podiatry model will also allow practitioners, both chiropractors and podiatrists, to practise to the full extent of the competencies they have acquired. The conversion to a podiatry model is also consistent with practices elsewhere in Canada - namely British Columbia and Alberta - and in many comparable foreign jurisdictions.

This is not to say that the government's decision in 1980 to adopt the UK chiropody model was ill-advised. It is simply that Ontario's healthcare delivery paradigm and government policy have since moved in different directions. Furthermore the anachronisms and rigidities of the *Chiropody Act, 1991* have limited the professions' and the College's ability to adapt and evolve in response to changes in healthcare policy, funding and healthcare delivery, patient demand (due largely to the growth of the seniors demographic), inter-jurisdictional labour mobility requirements and education and to promote clinical best practices and interprofessional collaboration.

The College, therefore, applied for an HPRAC scope of practice review in 2006, recommending a conversion to a podiatry model that reflects the most extensive podiatry scopes of practice now existing in Canada, namely those of British Columbia and Alberta, and adapted to Ontario's health policy, regulatory and health system frameworks. The following is the College's submission to HPRAC, complete with supplementary documentation and materials.

College of Chiropodists' (Applicant's) Questionnaire

Q 1: "Does your current scope of practice accurately reflect your profession's current activities, functions, roles and responsibilities?"

Response: No. As will be explained in greater depth and detail in this Application, the history of the chiropody and podiatry professions in Ontario and the models of healthcare delivery and regulation selected by the Government of Ontario three decades ago led to regulatory and delivery models that have become seriously outdated and have resulted in a mismatch with Ontario's present healthcare delivery paradigm, government policy, patient demand, the competencies that podiatrists and chiropodists have acquired and the venues in which chiropodists and podiatrists now practise.

The current scope and authorized acts reflect an institution-based delivery model. At that time, the vast majority of chiropodists worked in hospitals and similar institutions as salaried employees within multidisciplinary teams. Less than 20% of chiropodists work full or part-time in institutional practice today and most work as sole practitioners in private practice. The scope of practice and authorized acts from members of the podiatrist class were never designed to support, accommodate or promote the podiatry practice model, which is a non-institutional, community-based, practice model.

Q 2: "Name the profession for which a change in scope of practice is being sought, and the professional Act that would require amendment."

Response: The chiropody and podiatry professions are currently regulated in Ontario under the *Regulated Health Professions Act (RHPA)* and the *Chiropody Act, 1991*. The College proposes the replacement of the *Chiropody Act* with a Podiatry Act.

This Application proposes the creation of a unitary "podiatry" profession that reflects the North American podiatry model in terms of scope of practice and practice model. The podiatry profession is currently regulated by the College of Chiropodists as a class of members of the chiropody profession. For purposes of this Application, the proposed expanded scope of practice and new or expanded authorized acts are built on the current podiatry authorized acts as stipulated in subsection 5. (2) of the *Chiropody Act, 1991* and on the authorities granted to podiatrists under other legislation.

Consistent with practices in other jurisdictions and in line with the scope of practice and authorized acts herein proposed and to avoid public and interprofessional confusion, the College proposes that the chiropody profession no longer be recognized for purposes of regulation under the *Regulated Health Professions Act (RHPA)*, although the "chiropodist" title would continue to be a protected title under the RHPA to avoid public confusion.

Q 3: "Describe the change in scope of practice being sought."

Response: The current scope of practice statement reads as follows:

"The practice of chiropody is the assessment of the foot and the treatment and prevention of diseases, disorders or dysfunctions of the foot by therapeutic, orthotic or palliative means."

The proposed scope of practice statement reads as follows (the changes from the current scope statement are underlined):

"The practice of podiatry is the assessment or diagnosis of the foot and ankle and the treatment and prevention of diseases, disorders or dysfunctions of the foot, ankle and structures affecting the foot or ankle by therapeutic, orthotic or palliative means."

As such, the College is seeking an anatomical expansion of the scope of practice to include the ankle and structures affecting the foot or ankle and additional controlled acts to enable qualified podiatrists to provide highest and best clinical treatment within the current and within a proposed expanded continuum of care.

Q 4: "Name the College/association/group making the request, or sponsoring the proposal for change."

Response: The Applicant is the College of Chiropodists of Ontario, established and operating under the *Chiropody Act, 1991*.

Q 5: "Address/website/e-mail."

Response:

College of Chiropodists of Ontario
180 Dundas Street West, Suite 2102
Toronto, Ontario
M5G 1Z8
General's Email - slefkowitz@cocoo.on.ca
Registrar's Email – Fsmith@cocoo.on.ca

Q 6: "Telephone and fax numbers."

Response: (416) 542-1333 or Toll Free in Ontario at 1-877-232-7653. Fax: (416) 542-1666

Q 7: “Contact person (including day telephone numbers).”

Response: Don Gracey: dgracey@cgroup.com; 905-946-1515 extension 227.

Q 8: “List other professions, organizations or individuals who could provide relevant information with respect to the requested change scope of practice of your profession.”

Response: The College prepared a list of identifiable stakeholders, including those organizations and colleges whose members' scopes of practice and authorized acts would overlap with those being proposed by the College. The College also identified other stakeholders that could be expected to have an interest in this review. That list grew incrementally as the stakeholder consultations proceeded.

Dear

As you may know, the Health Professions Regulatory Advisory Council (HPRAC) is scheduled to at least begin a review of the chiropody and podiatry professions this year. Specifically, the Minister has asked HPRAC “to review issues relating to the regulation of chiropody and podiatry and provide advice as to whether and how there should be changes to existing legislation regarding these related professions” and analyze “the current model of foot care in Ontario, issues regarding restricted titles, and whether the existing limitations on the podiatrist class of members should continue.”

The College of Chiropodists of Ontario will recommend to HPRAC that Ontario adopt a podiatry model of footcare, coincident with trends in other jurisdictions and to better address the growing and increasingly unmet demand for footcare across Ontario, particularly by seniors, diabetics and other populations. The scope of practice and new or expanded authorized acts that will be proposed by the College are attached to this letter. Additional information, including the College’s original letter to the Minister requesting the HPRAC review, is available through the College’s website at [URL].

We anticipate that [Name of Organization] will wish to be kept advised and consulted during the HPRAC process and may wish to be directly engaged in the HPRAC review itself. Accordingly, we would appreciate the opportunity to meet with you at your earliest opportunity to discuss the College’s position and to hear whatever comments and suggestions you would like to offer.

We will follow up with your office shortly.

Yours sincerely,

Figure 4. Template of the Stakeholder Letter sent to all Stakeholders

In February, 2013 the College began to send letters to the identified stakeholders informing them of the anticipated HPRAC review and what the College intends to recommend to HPRAC for purposes of the review. Each stakeholder was also offered the opportunity to be fully briefed by the College and was sent a letter to inform them of their opportunity to participate (See Figure 5 below).

The list below identifies those stakeholders who were contacted as well as those who expressed an interest in having a briefing and when such briefings occurred (Stakeholder Contact Information has been provided to HPRAC separately by letter.)

Stakeholders – Current as of January 28 2014	Letters Sent (Y/N)	Response Received (Y/N)	Interest Expressed (Y/N)	Meeting Arranged (Date)
Ontario Society of Chiropodists (OSC)	Y	Y	Y	Multiple, ongoing meetings
Ontario Podiatric Medical Association (OPMA)	Y	Y	Y	2013/11/21
Canadian Association of Foot Care Nurses	Y	Y	N	“I did forward your email request to the provincial advisor for Ontario and after further reflection realize that CAFCN although a nursing footcare association may not be your best source at this point in time. We are hopeful that CNO, RNAO or RPNAO might be able to assist in education and scope of practice questions.” -Pat MacDonald
Canadian Federation of Podiatric Medicine (CFPM)	Y	Y	Y	2013/05/24 -14:00
Canadian Podiatric Medical Association (CPMA)	Y	Y	Y	2013/05/24 –15:30
American Podiatric Medical Association (APMA)	Y	Y	Y	2013/05/07
American Association of Colleges of Podiatric Medicine (AACPMAS)	Y	N		
Council on Podiatric Medical Education (CPME)	Y	Y	Y	2013/05/07
The College of Physicians and Surgeons of Ontario (CPSO)	Y	Y	Y	2013/06/20 -10am
College of Medical Laboratory Technologists (CMLTO)*	Y	N		
Ontario Medical Association (OMA)	Y	Y	Y	2013/04/11

				There has been continuous follow-up with the OMA
Ontario Chiropractic Association (OCA)	Y	Y	Y	2013/06/13 – Teleconference + follow-ups.
The College of Kinesiologists of Ontario	Y	Y	Y	2014/04/15 + follow-ups
The College of Family Physicians of Canada (CFPC)	Y	N		
Ontario College of Pharmacists (OCP)	Y	Y	N	
College of Physiotherapists of Ontario	Y	Y	Y	2013/11/21 + follow-ups
Ontario Physiotherapy Association (OPA)*	Y	Y	Y	2013/10/29 + follow-ups
College of Nurses of Ontario (CNO)	Y	Y	N	
Ontario Nurses' Association (ONA)	Y	N		
Registered Nurses' Association of Ontario (RNAO)	Y	Y	N	
Registered Practical Nurses' Association of Ontario (RPNAO)	Y	Y	N	
Ontario Orthopedic Association (OOA)	Y	Y	Y	19/12/2013 – The meeting was not viewed as a consultation but a one-way briefing in which information was provided to them. They gave no comments or feedback. The Association has <u>not</u> responded to subsequent contacts by the College.
College of Optometrists	Y	Y	N	
LHINC Council (LHIN Collaborative)	Y	N		
Ontario Association of Community Care Access Centres (OACCAC)	Y	N		
Ontario Association of Non-Profit Homes & Services for Seniors (OANHSS)*	Y	Y	Y	2013/03/27 + follow-ups
Ontario Long-Term Care Association (OLTCA)	Y	Y	Y	2014/07/08

Ontario Hospital Association (OHA)	Y	N		
Ontario Retirement Communities Association (ORCA)	Y	Y	N	
Canadian Association of Retired Persons (CARP)	Y	Y	N	<p>“Although we will not be involved directly, it would be great to see the end results of your efforts. We wish you all the best.”</p> <p>–Sarah Park</p>
Canadian Diabetes Association	Y	Y	N	2014/05/22
Ontario Association of Medical Laboratories (OAML)	Y	Y	Y	2013/10/29
Ontario Society of Senior Citizens' Organizations (OSCO)	Y	N		
Canadian Life and Health Insurance Association (CLHIA)	Y	Y	Y	2013/06/06
Workplace Safety and Insurance Board (WSIB)	Y	Y	N	
The Michener Institute for Applied Health Sciences	Y	Y	Y	June 21, 2013 + follow-ups

Figure 5. HPRAC Stakeholder Response Chart

Q 9: "What are the exact changes that you propose to the profession's scope of practice (scope of practice statement, controlled acts, title protection, harm clause, regulations, exemptions or exceptions that may apply the profession, standards of practice, guidelines, policies and bylaws developed by the College, other legislation that may apply the profession and other relevant matters)? How are these proposed changes related to the profession and its current scope of practice?"

Response: The College is proposing the creation of a unitary podiatry profession in Ontario with a scope of practice and authorized acts that reflect the podiatry scopes of practice in British Columbia, Alberta and in other comparable jurisdictions; and that are adapted to Ontario's healthcare policy, regulatory and healthcare delivery frameworks. The current College of Chiropodists of Ontario would be replaced by a College of Podiatrists of Ontario. As such, the College is recommending the replacement or wholesale revision of the *Chiropody Act, 1991*, the regulations thereunder, plus all College policies, guidelines and By-Laws that are currently in force and effect, plus coincidental amendments to other statutes and regulations.

Protected Titles: Continuation of statutory protection for the titles "Podiatrist" and "Chiropodist", variations or abbreviations thereof, or equivalents in another language. In addition, statutory protection of the two titles (as per current practice in comparable jurisdictions):

"Podiatric Surgeon", a variation or abbreviation thereof, or an equivalent in another language.

"Foot Surgeon", a variation or abbreviation thereof, or an equivalent in another language.

Inter-jurisdictional Comparison: In Alberta, the protected titles for the podiatry profession are: a) "podiatrist"; (b) "podiatric medical practitioner"; (c) "podiatric surgeon"; (d) "podiatric orthopedist"; (e) "podiatric physician"; (f) "doctor of podiatric medicine"; (g) "doctor"; (h) "DPM"; and (i) "Dr".³⁹ In British Columbia, the protected titles for the podiatry profession are: (a) "podiatrist"; (b) "podiatric surgeon"; (c) "surgeon"; and (d) "doctor".⁴⁰ "Podiatric Surgeon" is a protected title in most US states and in jurisdictions such as the UK and Australia.

Proposed Scope of Practice for the Podiatry Act: "The practice of podiatry is the assessment or diagnosis of the foot and ankle and the treatment and prevention of diseases, disorders or dysfunctions of the foot, ankle and structures affecting the foot or ankle by therapeutic, orthotic or palliative means" (Additions to the current scope of practice statement are underlined for ease of reference).

Proposed New or Expanded Authorized Acts for the Podiatry Act:

1. Communicating a diagnosis identifying a disease or disorder of the foot or ankle as the cause of a person's symptoms (Currently authorized to members of the podiatrist class only).
2. Performing a procedure on tissues below the dermis to treat conditions of the ankle or foot (Currently authorized with respect only to the foot).
3. Setting or casting a fracture of a bone or dislocation of the joint, in the foot or ankle (Not currently authorized for either chiropodists or podiatrists).
4. Administering, by injection, a substance in the Regulations (Currently authorized for both chiropodists and podiatrists, but limited to injections into the foot).
5. Applying or ordering the application of a prescribed form of energy (Not currently authorized for either chiropodists or podiatrists).

³⁹ Canada. Ministry of Health. Province of Alberta. *Health Professions Act: Podiatrists Profession Regulation*. Province of Alberta, 2012. Web.

<http://www.qp.alberta.ca/1266.cfm?page=2012_060.cfm&leg_type=Regs&isbncIn=9780779764440>. 7-8.

⁴⁰ Canada. Ministry of Health. British Columbia. *Health Professions Act: Podiatrists Regulation*. Province of British Columbia, 1 February 2011. Web.

<http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/538573145>.

6. Prescribing, dispensing and selling a drug designated in the Regulations (Chiropodists and podiatrists are currently authorized to prescribe, but not to dispense or sell).

Proposed New or Expanded Authorities Under Other Acts:

7. Order prescribed laboratory tests (Not currently authorized for either chiropodists or podiatrists) under the *Laboratory and Specimen Collection Center Licensing Act and Regulation 682 thereunder* and the *Medical Laboratory Technology Act and regulations*.
8. Operate radiographic equipment, prescribe radiographs within the podiatry scope of practice and be designated as "radiation protection officers" under the *Healing Arts Radiation Protection Act* or its successor. (Currently authorized for members of the podiatrist class and for DPM chiropodists).

General Regulation 203/94: Major revisions are required to this Regulation in order to remove references to "members of the podiatrist class", "podiatry class", "chiropody class" and "chiropodist" in order to implement and reflect a unitary podiatry profession.

Additional revisions to other regulations will be required to reflect the new scope of practice statement and the new and expanded authorized acts.

The College also proposes changes to the list of drugs that may be prescribed and administered by podiatrists and the competencies required to do so in order to support several of the new and expanded authorized acts and also to reflect the New Classes of Practitioners Regulations (NCPR) under the (federal) *Controlled Drugs and Substances Act* (CDSA). The NCPR includes "podiatrists" within the definition of "practitioner" for purposes of that regulation.⁴¹

Q 10: "How does current legislation (profession-specific and/or other) prevent or limit members of the profession from performing to the full extent of the proposed scope of practice?"

Response: The current legislation does not allow practitioners to perform to the full extent of the proposed scope of practice. The current scope of practice also entails mismatches between what chiropodists and podiatrists are allowed and not allowed to do; for example the authority to perform a range of surgical procedures, but an inability to order laboratory tests to ensure those surgical procedures and the follow-up can be conducted safely. Furthermore, the current legislation does not

⁴¹ Note: for purposes of the NCPR, "podiatrist" is defined as "a person who is registered and entitled under the laws of a province to practise chiropody or podiatry and who is practising chiropody or podiatry in that province", SOR/2012-230. Web: <<http://laws-lois.justice.gc.ca/eng/regulations/SOR-2012-230/page-1.html>>.

allow many chiropodists and podiatrists to practise to the full extent of their acknowledged competencies. The competency of podiatrists to perform the proposed authorized acts has been amply demonstrated in other jurisdictions.

To begin with, the current scope of practice and authorized acts do not include the ankle and are limited to the foot for purposes of diagnosis, assessment, treatment and the performance of procedures such as injecting substances and ordering or taking radiographs. In the case of bone surgery, the current legislation limits podiatrists to the bones of the forefoot (i.e. the metatarsals and the phalanges of the toes).

More specifically, with respect to the individual proposed authorized acts (the proposed expansions of current authorized acts are underlined):

“Communicating a diagnosis identifying a disease or disorder of the foot or ankle as the cause of a person's symptoms ”:

Members of the podiatrist class may currently communicate a diagnosis identifying a disease or disorder of the foot as the cause of a person's symptoms.

It has long been acknowledged and documented that the selection of those professions authorized to "communicate a diagnosis" under the RHPA was arbitrary. Since then, a number of additional professions, such as physiotherapy, nurse practitioners and naturopathy, have been granted the controlled act within their respective scopes of practice.

Notwithstanding their competencies to do so, no chiropodist is authorized to perform the "communicating a diagnosis" controlled act, despite chiropodists' authority to perform surgical procedures below the dermis. The Ministry of Health and Long-Term Care maintains that chiropodists may formulate a diagnosis, but may not communicate that diagnosis to a patient or to the patient's representative. It is anomalous for any profession that is authorized to perform surgical procedures and to prescribe drugs not to be able to communicate a diagnosis to patients explaining the disease or disorder that the surgery or drugs are designed to address and to obtain informed consent to treatment. Extended health benefits insurers and other practitioners routinely ask chiropodists to provide a diagnosis of their patients, which they are technically not authorized to provide. It is particularly anomalous for DPM graduates who are limited to the chiropody authorized acts not to be able to communicate a diagnosis in Ontario when they are obviously as competent as members of the podiatrist class to do so and are authorized to do so when practising in other jurisdictions.

Inter-jurisdictional comparison: "Communicating a diagnosis" as defined by the RHPA is not a restricted act in either British Columbia or Alberta. In both provinces, the scope of practice for podiatry includes the ankle.^{42 43}

According to a survey conducted by the Applicant during the summer of 2013, 98% of registrants intend to perform this controlled act and 82% believe they already have the competencies to do so.

2. "Performing a procedure on tissues below the dermis to treat conditions of the ankle or foot":

Both chiropodists and podiatrists are currently authorized to perform the authorized act of "cutting into subcutaneous tissues of the foot". Podiatrists are authorized to cut into "subcutaneous tissues of the foot and bony tissue of the fore foot." The addition of the reference to the "ankle" is consistent with practice in comparable jurisdictions (i.e. 48 US States and the District of Columbia, Alberta and British Columbia) and is recommended in order to acknowledge the interconnectedness between the ankle and the foot and to reflect the expanded anatomical boundaries of the proposed scope of practice for all appropriately-qualified practitioners to perform bone surgery on the foot and ankle.

Inter-jurisdictional comparison: In British Columbia, Alberta, in 48 states, plus the District of Columbia and in several European countries podiatrists are authorized to perform surgical procedures on subcutaneous tissues of the ankle and foot (i.e. both soft and bony tissue).^{44 45} "Podiatric surgeons" in the United Kingdom and Australia are also authorized to perform surgical procedures on the foot and ankle.

According to a survey conducted by the Applicant during the summer of 2013, 63% of registrants already perform or intend to perform this controlled act and 34% believe they already have the competencies to do so.

3. "Setting or casting a fracture of the bone or dislocation of the joint, in the foot or ankle":

Currently, neither chiropodists nor podiatrists are authorized to perform this controlled act. This creates a severe impediment to performance of both the current and the proposed scopes of practice. In the current scope of practice podiatrists perform osteotomies and arthroplasties and would do so under the proposed scope of practice as well. In performing osteotomies (surgical cuts into bone) and arthroplasties (a joint remodeling surgical procedure), podiatrists surgically "fracture" bones and dislocate joints and need the companion authority to set or cast them in order to provide an appropriate continuum of care and to comply with the clinically-accepted standard of care for these procedures.

⁴² *Health Professions Act: Podiatrists Regulation*. 2011.

⁴³ *Health Professions Act: Podiatrists Profession Regulation*. 2012. 8.

⁴⁴ *Health Professions Act: Podiatrists Regulation*. 2011.

⁴⁵ *Health Professions Act: Podiatrists Profession Regulation*. 2012. 8.

Being authorized to set and cast fractures and dislocations in the foot or ankle will enable podiatrists to treat abnormalities of bony structures in both the acute and planned surgical reconstructive settings.

The inability to "set fractures" also prohibits podiatrists from responding to emergency situations, leaving an emergency room visit the most likely alternative.

Inter-jurisdictional comparison: In neither British Columbia nor Alberta is this defined as a restricted act. In both provinces, setting fractures is deemed to be part of the scope of practice of podiatry.^{46 47}

According to a survey conducted by the Applicant during the summer of 2013, 63% of registrants intend to perform this controlled act with respect to the foot (once they acquire or demonstrate the competencies necessary to do so) and 24% believe they already have the competencies to do so.

According to a survey conducted by the Applicant during the summer of 2013, 49% of registrants intend to perform this controlled act with respect to the ankle and 15% believe they have the competencies to do so.

Clinical Scenario: ARTHRITIS

A 55 year old woman with a history of "arthritis" presents to the Podiatrist's office complaining of bilateral forefoot deformity and pain. Her right foot hurts more than the left. This limits her daily activities and is diminishing her overall fitness level. She has tried a variety of pads, shoes and OTC insoles all without significant relief. Her primary care physician has prescribed Celebrex and she takes a daily 81mg ASA. She has no other medical problems or medications. She has no known drug allergies and has had no previous surgery. She does not smoke or drink alcohol other than an occasional glass of wine. Her Family History is positive for deep vein thrombosis (DVT) and subsequent pulmonary embolism (PE) which killed her mother in her fifties after a long flight to Europe.

Physical exam reveals a well-developed middle-aged woman in no apparent acute discomfort or distress. Pedal pulses are palpable. Capillary fill time is "within normal limits" (WNL). Mild diffuse non-pitting ankle edema is noted on both sides. Neurological exam is WNL with deep tendon reflexes, both Achilles and patellar 2/4 on both sides. Babinski and ankle clonus are normal. Pin prick, proprioception and vibratory sensations are normal on both lower extremities. Skin exam reveals that her skin is thin, warm and dry with hair growth present bilateral foot. Hyperkeratosis is noted at the plantar aspect of the second and fifth metatarsal heads on both feet and the dorsal aspect of the proximal interphalangeal joints of digits 2, 3, 4 and 5 bilateral foot. The lesser digits on both feet display pain on palpation, subluxation with dorsal contraction with fibular deviation. There is plantar bony prominence with pain on palpation and distal plantar fat pad atrophy at metatarsal heads one through five on both feet. Severe bunion deformity with pain on palpation and range of motion noted at the first MPJ on both feet. Hypermobility is noted at the first metatarsal cuneiform joint on both feet.

Radiographs were taken at the Podiatrist's office on the initial visit; three views weight-bearing of both feet, AP, oblique and lateral are negative for acute fracture or dislocation. Mild diffuse osteopenia is noted bilateral. There is fibular deviation and subluxation with peri-articular degenerative changes of the lesser metatarsal phalangeal joints on both feet. The lesser digits are dorsally contracted on both feet. There is an increase in the hallux abductus angle, first intermetatarsal angle and tibial sesamoid position on both feet.

Case Study 2. Clinical Scenario for an Arthritic Patient.

⁴⁶ Health Professions Act: Podiatrists Regulation. 2011.

⁴⁷ Health Professions Act: Podiatrists Profession Regulation. 2012. 8.

Clinical Scenario: ARTHRITIS Continued

This same patient returns several months later with a chronic discomfort with prolonged weight-bearing secondary to progressing deformity of both feet. She would like to discuss surgical treatment options.

CURRENT SCOPE:

A letter is written by the podiatrist/chiroprapist to the patient's primary care physician recommending surgical intervention. The patient returns to the primary physician resulting in a delay of care depending on local wait times.

PROPOSED/EXPANDED SCOPE:

The Podiatrist requests routine blood work, electrocardiogram, and urinalysis with medical clearance to be provided by her primary care physician. She discontinued taking ASA five days prior to her scheduled procedure.

Surgery is performed in the office or surgery centre by the Podiatrist utilizing sedation, local anesthetic and an ankle tourniquet. Procedures include pan-metatarsal head resection with correction of hammertoe deformity of digits 2, 3, 4 and 5 on the right foot with first MPJ fusion with internal fixation. An autograft bone graft was obtained by the Podiatrist from the right calcaneus at the same surgical sitting to be placed at the first MPJ fusion site and at the first metatarsal cuneiform fusion. The patient will be non-weight bearing in a below knee cast and crutches or a walker for 6-8 weeks. Serial x-rays to monitor healing will be provided in the Podiatrist's office. Blood work and ancillary testing will also be provided as needed by the Podiatrist during the post-operative course of treatment.

A prescription was given for acetaminophen with codeine for management of post-operative pain. A prescription was also given for Lovenox (enoxaparin) 30mg subcutaneously by self-injection into the abdomen every 12 hours for 10 days after surgery to decrease the chance of DVT and/or subsequent PE. A referral is made to a Physiotherapist to aid in return to ambulation and assistive daily living care is ordered for at home recovery.

The patient's past medical history, medications and allergies were reviewed as well as a complete review of systems. Her condition was evaluated and her x-rays and treatment options were discussed in detail. Organized blood work including CBC, Rheumatoid factor, Anti-nuclear antibodies (ANA), erythrocyte sedimentation rate (ESR) and C-reactive protein levels. Debrided hyperkeratotic tissue from both feet in the office and the patient was provided with a temporary pad for comfort. Recommendations were made for orthotics and more supportive shoes. Surgical treatment was recommended only if conservative options fail.

Case Study 2. Clinical Scenario for an Arthritic Patient continued

5. "Administering, by injection, a substance designated in the Regulations":

Currently, both chiroprapists and podiatrists are authorized to administer substances by injection, but only into the feet. To function properly and lawfully and in the best interests of patients within the current and proposed scopes of practice, podiatrists need the authority to administer substances by injection elsewhere in the body. For example, as per clinical best practices and for optimal effectiveness, appropriately-qualified podiatrists need to be authorized to perform sublingual, intradermal and subcutaneous IM and IV injections and intraosseous (IO) in the thigh, buttocks, shoulders, arm, abdomen, wrist or hand, as well as in the foot and ankle.

The drugs listed in Figure 6 elicit their actions within the central nervous system and not within the foot. These drugs reach the central nervous system via the systemic circulation. The parenteral routes of administration introduce drugs directly into the systemic circulation (IV) or almost directly into the systemic circulation (IM, SC). The accepted standard for parenteral administration of these drugs is outside of the foot. These parenteral routes of administration are preferred or mandated for the drugs in question as these drugs are either poorly absorbed or unstable in the GI tract (e.g. many of the opioid narcotics) and would not adequately reach the central nervous system. Parenteral administration also provides a rapid onset of action which is imperative for emergency medications such as naloxone and flumazenil.

6. "Applying or ordering the application of a prescribed form of energy":

The *Chiropody Act, 1991* does not grant this controlled act to either chiropodists or podiatrists. Nevertheless, section 2 of Ontario Regulation 107/96 authorizes (by exemption) members of the College of Chiropodists to apply electricity for electrocoagulation or fulguration. The College asserts that it is in the public interest to include this controlled act in the new scope of practise in order for podiatrists to be able to diagnose and treat patients safely, efficiently and effectively in both the current and proposed scopes of practice. In the College's view it is essential that appropriately qualified podiatrists have access to (i.e. authorized to order and/or perform) certain "forms of energy" such as Magnetic Resonance Imaging (MRIs) for bony and soft tissue pathology, diagnostic ultrasound of the foot, ankle and leg to evaluate and/or guide diagnostic procedures within arterial, venous, subcutaneous and musculoskeletal structures, plethysmography to assess vascular pathology, nerve conduction velocity studies and EMGs in order to identify and assess nerve damage.

Inter-jurisdictional comparison: Analogous authorities to ordering or applying prescribed forms of energy are not restricted in Alberta or B.C.

According to a survey conducted by the Applicant during the summer of 2013, 61% of registrants intend to perform an electromyography and 21% believe they have the competencies to do so. 77% of registrants intend to perform nerve conduction studies and 31% believe they have the competencies to do so. 78% of registrants intend to perform electromagnetism for MRI and 32% believe they have the competencies to do so. 79% of registrants intend to perform diagnostic ultrasound and 31% believe they have the competencies to do so.

7. "Prescribing, dispensing and selling a drug designated in the Regulations":

Both chiropodists and podiatrists are currently authorized to prescribe drugs designated in the Schedules in Ontario Regulation 203/94. The list of prescribed drugs would have to be consolidated and augmented to reflect the unitary and expanded scope of practice and authorized acts and also to authorize qualified podiatrists to prescribe, dispense and sell drugs and substances regulated under the *Controlled Drugs and Substances Act*. Proclamation of the (federal) New Classes of Practitioners

Regulations enables provincial legislation to authorize chiropractors and podiatrists to use such drugs. See Figure 6 for examples of controlled drugs and substances required to perform the proposed acts.

Name of Drug	Administration Method	Schedule
Codeine	PO	I
Hydrocodone	PO	I
Oxycodone	PO	I
Morphine	PO,IV	I
Meperidine (Demerol)	PO,SC,IM,IV	I
Nalbuphine (Nubain)	SC,IM,IV	I
Pentazocine (Talwin)	PO,SC,IM,IV	I
Butorphanol (Stadol)	IM,IV	I
Naloxone (Opioid Antagonist)	SC,IV,IM	I
Flumazenil (Benzodiazepine Antagonist)	IV	IV

Figure 6. Examples of Drugs and Substances Required to Perform the Proposed Acts

Some topical medicines and other drugs are fabricated by pharmaceutical companies and pharmacists specifically for conditions of the foot and ankle (Formula 3, FFN and Clear Nails to treat fungal toenails, Lamisil 2.5% in DMSO, 10 mL, Apply OD. Topical antifungal; 10% Ketoprofen PLO, 30g, Apply to affected area TID. Topical anti-inflammatory ; Verapamil 15%, Diclofenac 6%, Bupivacaine 1% in Lipoderm, 50g, Apply to affected area BID. Used for treatment of ganglions.) These drugs are rarely available over-the-counter and are provided directly by pharmaceutical companies to chiropractors and podiatrists for direct dispensing to their patients. Hence, the Applicant is asking for the addition of the "dispensing" authority to the current authorized act, as is currently the case in Ontario with physicians, dentists and dental hygienists.

Inter-jurisdictional comparisons: In Alberta, podiatrists are authorized to prescribe a Schedule 1 drug within the meaning of the *Pharmacy and Drug Act*. They have full prescribing privileges for drugs listed in Schedule F of the *Food and Drugs Act* and Regulations; they may prescribe and dispense the benzodiazepine class of drugs, as well as those specified in the *Controlled Drugs and Substances Act*; and may dispense, compound, provide for selling or sell a Schedule 1 drug or Schedule 2 drug within the meaning of the *Pharmacy and Drug Act* for the purpose of treating ailments, diseases, deformities and

injuries of the human foot and ankle.⁴⁸ In British Columbia, podiatrists are authorized to prescribe, compound, dispense or administer by any means a drug listed in Schedule I or II of the *Pharmacists, Pharmacy Operations and Drug Schedule Act*.⁴⁹

Authorities beyond the RHPA

The Laboratory and Specimen Collection Centre Licensing Act, Regulation 682:

Currently, podiatrists and chiropodists are not authorized to order any of the laboratory tests they need under the current scope of practice, including those to diagnose, plan and evaluate treatments and to monitor diseases and treatment outcomes. Chiropodists and podiatrists must refer patients back to family physicians to generate required laboratory tests, which delays diagnosis and treatment, inconveniences patients and unnecessarily adds costs for the healthcare system. In particular, podiatrists and chiropodists are not authorized to order laboratory tests or specimen collection for diagnostic pathology and microbiology that are integral to the effective and safe assessment and treatment of their patients. It is anomalous that chiropodists and podiatrists are authorized to perform surgical procedures on the subcutaneous tissues of the foot and podiatrists are also authorized to perform surgical procedures on the bones of the forefoot, yet neither chiropodists nor podiatrists are authorized to order any of the laboratory tests used to identify or quantify, for example, pathogens, viruses and blood clotting times and factors. Accordingly, in the patients' interests, the Applicant is urging amendments to Regulation 682 (and the regulations under the *Medical Laboratory Technology Act*) in order to allow qualified podiatrists to order directly laboratory tests within the proposed scope of practice, so that they may provide timely and appropriate diagnoses to patients without the need for circular referrals to family physicians. The laboratory tests that the Applicant recommends qualified podiatrists be able to order include but are not limited to:

- Laboratory evaluations, such as electrolytes, BUN, creatinine, INR/PTT, CBC, platelet count, nicotine, urinalysis, arterial blood gases, urine HCG (pregnancy testing), pulmonary function tests;
- Infection profiles, such as CBC with differential, blood cultures, antibiotic blood levels (for example Vancomycin peaks and troughs); and
- Arthritis panels, such as Rheumatoid factor, erythrocyte sedimentation rate, anti-nuclear antibody profile, HLA-B27 genetic marker, C-Reactive Protein and erythrocyte sedimentation rate.

⁴⁸ *Health Professions Act: Podiatrists Profession Regulation*. 2012. 8.

⁴⁹ *Health Professions Act: Podiatrists Regulation*. 2011.

- Podiatrists in British Columbia and Alberta are authorized to order these tests.

The *Healing Arts Radiation Protection Act* (HARP Act):

The HARP Act, as currently written, authorizes any graduate of a "four year course of instruction in chiropody" to order and take x-rays, operate radiographic equipment and to be designated as a radiation protection officer (RPO). As such, only 14% of current College registrants are eligible to perform any of the authorities under the HARP Act (i.e. members of the podiatrist class, DPMs practising as chiropodists and a very few chiropodists). Qualified podiatrists being able to order or take x-rays as part of the proposed scope of practice would obviate the need for circular referrals to family physicians and is also integral to timely and appropriate diagnosis and treatment. The HARP Act and any successor legislation should authorize all appropriately-qualified podiatrists to order and take x-rays of the lower limb, ankle and foot, to own radiographic equipment for that purpose and to be eligible for designation as radiation protection officers.

According to a survey conducted by the Applicant during the summer of 2013, 96% of registrants intend to prescribe x-rays and 73% believe they have the competencies to do so, while 59% of registrants intend to take x-rays and 29% believe they have the competencies to do so.

Q 11: *"Do members of your profession practice in a collaborative or team environment where change in scope of practice and the recognition of existing or new competencies will contribute to interprofessional health care delivery? Please describe any consultation process that has occurred with other professions."*

Response: In December, 2012, the College circulated a survey to its registrants as part of the registration renewal process for 2013. The survey "closed" on March 31, 2013. This survey was the second survey of this nature and the College intends to continue to conduct similar surveys coincident with registration renewal for the foreseeable future.

The survey results indicated that in 2012:

- 27% of registrants worked in multidisciplinary clinics;
- 12% of registrants worked full or part-time in multidisciplinary, primary care delivery groups, such as Family Health Teams (physician and nurse practitioner-led), or Community Health Centres;
- 10% of registrants worked full or part time in public hospitals; and
- 9% of registrants worked full or part-time in long-term care and retirement homes.

Another noteworthy outcome of the survey is that 20% of registrants provided footcare in patients' homes, other than in the long-term-care homes, retirement homes, assisted and supportive living centres. When providing footcare in patients' homes, registrants are on their own. It is particularly

important in this delivery venue, given that patients are not ambulatory, or their mobility is at least seriously compromised, that practitioners be able to practise the widest possible scope and provide the most extensive and seamless continuum of care that their competencies allow. Doing this will enable them to provide homebound patients with the full continuum of footcare they require and to minimize the necessity for circular referrals to family physicians, or relying on hospital emergency departments. It is noteworthy, in this regard, that Dr. Sinha's report recommends increased access for seniors to home care by primary care practitioners.⁵⁰

A further noteworthy outcome of the survey is that only 10% of registrants (entirely chiropodists) worked, full or part-time, in hospitals. Why is this noteworthy? Because when the chiropody program was launched it was the government's expressed intention that chiropody be provided primarily in hospitals by practitioners employed as salaried personnel.⁵¹ The small number of chiropodists currently practising in hospitals demonstrates how far the current chiropody practice model has changed and evolved from the original model in response to patient demand and changes in Ontario's healthcare delivery system.

“Put another way, the natural progression or evolution of the chiropody profession in Ontario has been towards the North American podiatry model.”

In terms of the interprofessional consultation process on which the College embarked:

- The College prepared a list of Colleges and professional associations where the scopes of practice intersected with that being proposed to HPRAC, or whose members refer their patients to or otherwise work with chiropodists and podiatrists.
- The College included in this list stakeholders who might be impacted in other ways by the scope of practice changes being recommended, or who might otherwise be expected to have an interest in the scope of practice changes.
- Organizations were added to this "stakeholder list" as the College's consultation process unfolded.

⁵⁰ Sinha, Samir. “Living Longer, Living Well”. Ministry of Health and Long-Term Care. December 20, 2012. Digitalized Publication.

<http://www.health.gov.on.ca/en/common/ministry/publications/reports/seniors_strategy/docs/seniors_strategy_report.pdf>.

⁵¹ “Foot-Care Services”. 13 March, 1980.

- The College sent a letter to each identified stakeholder setting out the changes the College intends to recommend to the scope of practice, authorized acts and other authorities and offered a briefing to each.
- 27 stakeholders responded. 19 asked for a briefing and 19 such briefings have been completed.

In some cases, absent a response from the stakeholder, the College proactively reached out to the stakeholder in order to address known or anticipated matters (e.g. Ontario Orthopedic Association, Ontario Long-Term Care Association).

Q 12: *"Describe how the proposed changes to the scope of practice of the profession are in the public interest. Please consider describe the influence of any the following factors:"*

Response:

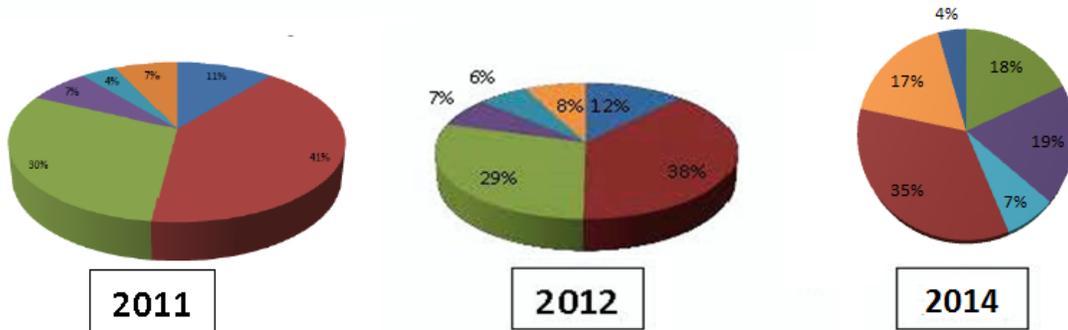
- a. *Gaps in professional services:* As explained elsewhere in this Application, primarily because of the growth of the seniors population and the incidence of chronicity associated with that population, there is an expanding gap between the demand for services within the proposed podiatric scope and the supply of practitioners who are authorized and competent to provide those services. One indicator of this gap is the increase in wait times for chiropodists and podiatrists in Ontario (See Figure 7). The gap is caused by a combination of an inadequate number of practitioners and scope of practice restrictions. The fact is that there is no regulated profession in Ontario, other than the 25 or so orthopedic surgeons specializing in footcare, whose scope of practice focuses exclusively on the diagnosis and treatment of diseases, disorders and dysfunctions of the foot and ankle. These gaps are particularly evident in areas of the province that are underserved in terms of access to primary care practitioners. The gaps are concerning because individuals, primarily seniors, who are caught in that gap are unable to get timely diagnosis and treatment of their foot and ankle ailments. Given the critical role that foot and ankle health plays in mobility, delayed diagnosis and treatment leads to increased levels of chronicity, plus loss of mobility, independence and one's ability to work and perform activities of daily living.

"...limb amputation is largely preventable in people with diabetes. Routine screening for vascular risk factors, foot examination at least annually to assess for peripheral neuropathy or PAD, patient education regarding footcare and referral to a podiatrist or vascular surgeon when needed, are important steps toward lowering the risk of this major diabetes complication."

- Sarah E Capes, M.D., MSc, FRCPC, Diana Sherifali, RN, PhD, CDE, "Assessment and Management of the Diabetic Foot" in Canadian Diabetes, Winter 2010/volume 23/ Number 4.

Over the past year, has the average wait time for patients to obtain treatment changed?(Measuring the time elapsed between scheduling and having their first consultation)

Average Wait Times for Patients



<u>2012 Results</u>	
No Wait Times	56
Less than 1 week	175
1-2 Weeks	135
2-3 Weeks	32
3-4 Weeks	28
More than 4	34
Total Responses	460
Total Average Wait Time	1.53

- No Wait Times
- Less than 1 week
- 1-2 Weeks
- 2-3 Weeks
- 3-4 Weeks
- More than 4

<u>2014 Results</u>	
No Wait Times	7
Less than 1 week	56
1-2 Weeks	29
2-3 Weeks	30
3-4 Weeks	12
More than 4	28
Total Responses	162
Total Average Wait Time	1.85

Figure 7. Average Wait Times for Patients seeking a Chiroprapist

Another facet of the supply/demand gap is the limited number of venues where foot and ankle services are available. Notwithstanding the small size of the professions in both relative and absolute terms, both chiroprapists and podiatrists practise in multiple healthcare delivery venues, including nursing homes, retirement homes, home care and primary healthcare delivery venues such as Family Health Teams (See Figure 8).

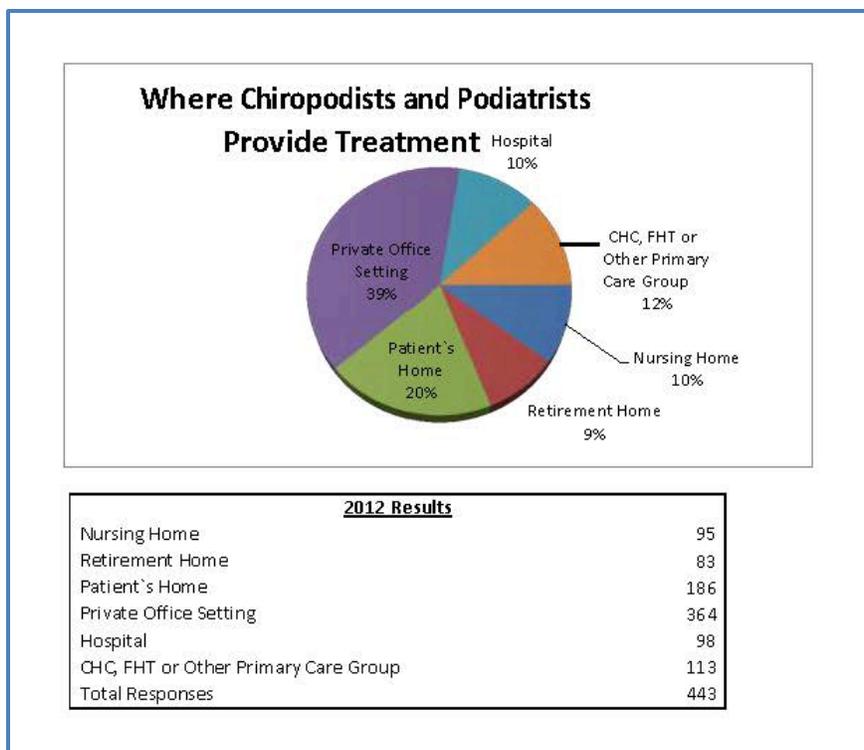


Figure 8. Where Chiropodists and Podiatrists Provide Treatment

The North American "podiatry model" is more than scope of practice and relevant competencies. It also entails a different model of healthcare delivery. A number of podiatrists do practise in hospitals and in analogous healthcare institutions. Nevertheless, the podiatric model of practice is decentralized and revolves around community-based clinics and surgical centres. As such, the North American podiatry model of practice helps to de-stress institutional models of care by draining off those patients whose conditions can be safely and effectively treated elsewhere. The North American podiatry model of practice is also more accessible and convenient to patients and there is also abundant evidence that it is more cost-effective than institutional models of care (See Appendix B).

- b. *Epidemiological trends in illness and disease:* The increased incidence of and morbidity and mortality associated with chronic diseases such as diabetes, arthritis and cancer that often manifest themselves in the foot and ankle are documented elsewhere.

Diabetes: The Canadian Association of Wound Care claims that there are currently 2.3 million Canadians living with diabetes of whom approximately 345,000 will develop a foot ulcer.⁵² A significant minority of diabetic foot ulcers fail to heal and will require limb amputation. Limb amputation is associated with a significant risk of mortality: 30% will die within one year of amputation and 69% will not survive beyond

⁵² <http://CWC.net/index.php/public/fax-stats-and-tools/statistics/>

five years.⁵³ According to a 2013 Report by the OECD ("Health at a Glance"), Canada's prevalence of Type I and Type 2 Diabetes at 8.7 exceeds the OECD's average of 6.9. There is a particularly substantial body of scientific evidence relating the importance and efficacy of podiatric care for diabetic patients, viz:

- Patients who received simultaneous vascular surgery and podiatric care are much more likely to avoid amputations.⁵⁴
- Patients treated by podiatrists have a higher awareness and knowledge of diabetic foot care and self-care that reduce the incidence of foot problems.⁵⁵
- Podiatric treatment of diabetic patients with foot ulcers in the multidisciplinary system reduces treatment costs.⁵⁶
- The American Diabetes Association recommends that diabetic treatment teams consist of a family physician, an ophthalmologist and a podiatrist.
- Podiatric treatment provided to diabetics is a significant element in preventing foot amputation, thus reducing the heavy cost of hospitalization and other types of treatments.⁵⁷
- In its clinical practice guidelines for General Practitioners, the Canadian Diabetes Association recommends that General Practitioners "Look at your patient's feet and know the signs". Among other recommendations, the CDA recommends referral for professional nail and skin care and for professionally fitted footwear if patients present with numb, painful or tingling feet, or present with signs of bony changes or deformities. If patients present with dry, cracked blistered or ulcerated feet, the CDA recommends referral for professional skincare to manage calluses and referral for non-weightbearing footwear. If a patient's feet display dependent rubor, signs of ischemia and/or gangrenous ulcers, the CDA recommends referral for professional skincare to manage calluses.

⁵³ Ibid.

⁵⁴ Brinton, EA et al. "Amputation prevention by vascular surgery and podiatry collaboration in high-risk diabetic and nondiabetic patients: The Operation Desert Foot Experience". *Diabetes Care*. 22 (5), 1999: 678-83.

⁵⁵ Hamalainen, H, Liukkonen, I, Ronnema, T and T Toikka. "Evaluation of the Impact of Podiatrist Care in the Primary Prevention of Foot Problems in Diabetic Subjects". *Diabetic Care*. 20 (12), 1997: 1833-7.

⁵⁶ Apelgvist, J, Larsson, J, Persson, U and G, Ragnarson-Tennvall. "Diabetic Foot Ulcers in a Multidisciplinary Setting. An Economic Analysis of Primary Healing and Healing with Amputation". *Journal of Internal Medicine*. 235 (5), 1994: 463-71.

⁵⁷ "Evaluation of the Impact of Podiatrist Care in the Primary Prevention of Foot Problems in Diabetic Subjects". 1997:1833-7.

Arthritis: According to the Arthritis Alliance of Canada.⁵⁸ 4.6 million Canadians suffer from some form of arthritis. Arthritis is the most common cause of disability in Canada, resulting in poor quality of life and workforce limitations. Osteoarthritis, Rheumatoid Arthritis and Post-Traumatic Arthritis often manifest themselves in the foot. Arthritis cannot be cured. A 2008 study by T. Daniels et al. concludes that patients with advanced-stage ankle arthritis are as disabled as patients with end-stage hip arthritis.⁵⁹ For arthritic conditions that are posttraumatic, the majority of patients are in the prime of their lives and require effective treatment outcomes in order to return to productive and enjoyable lifestyles. The treatment objectives are controlling inflammation and preserving joint function, or restoring joint function if it has been lost. Because the foot is a frequent target, chiropodists and podiatrists are often the first practitioners to encounter some of the complaints that identify arthritic conditions— inflammation, pain, stiffness, excessive warmth or injuries. Even bunions can be manifestations of arthritis.

According to the Canadian Arthritis Association,

Four out of five people experience a foot problem sometime in their lives; some of those problems are the result of arthritic complaints. Most minor foot problems — such as calluses and corns, high and low arches and exotic — sounding (but common) ills like plantar fasciitis — are easily treatable, particularly by podiatrists, chiropodists and occupational therapists. For more serious problems, especially those related to arthritis, you'll need the services of a podiatrist or medical doctor, particularly if you require surgery. Any major procedure requiring general anesthetic must be performed by an orthopedic surgeon, dermatologist or plastic surgeon, but most minor surgery — and a great deal of non-surgical care — can be done by a foot specialist known as a podiatrist (or, for minor problems, a chiropodist).⁶⁰

Cancer: Foot melanoma is the deadliest form of cancer. Bob Marley, the noted Jamaican singer-songwriter, died at the age of 36 from an untreated malignant melanoma under his toenail. Early diagnosis and treatment of foot melanomas can avoid their spread throughout the body. Effective diagnosis of foot melanoma requires regular clinical examinations, particularly for patients over 50 and, when a melanoma is suspected, skin biopsies (i.e. laboratory tests).

c. *Changing public needs for services and increased public awareness of available services:* As discussed elsewhere in this Application Ontario's aging population and chronicity associated therewith prompt increased demand for foot and ankle care that is not being adequately addressed within Ontario's existing health delivery system.

⁵⁸ Arthritis Alliance of Canada. "Impacts of Arthritis in Canada: Today and Over the Thirty Years". AAC. Fall 2011.

⁵⁹ Daniels, T et al. "Comparison of Health-Related Quality of Life Between Patients with End-Stage Ankle and Hip Arthrosis". *Journal of Bone and Joint Surgery of America*. 90 (3), 2008: 499-505.

⁶⁰ The Arthritis Society. "Your Treatment Team: Podiatrists and Chiropodists". The Arthritis Society, 2014. Web. <<http://www.arthritis.ca/page.aspx?pid=1277>>.

- d. *Waiting times for healthcare services:* Ontario's wait times for orthopedic surgery of the foot and ankle persistently exceed clinical guidelines and best practices. The Canadian and Ontario orthopedic associations have acknowledged that the current number of orthopedic surgeons specializing in foot and ankle care is limited and that changes have to be made.⁶¹ Converting to a podiatric scope of practice would help alleviate wait times for orthopedic surgery in two ways: First, members of the College of Podiatrists could diagnose and treat more patients and provide additional procedures, thereby reducing the demand and wait times for orthopedic surgeons. Second, orthopedic surgeons could utilize more of their time and expertise to concentrate on the more complex procedures and diagnoses and reduce wait times for them.

Current wait times for chiropodists and podiatrists also often exceed clinical guidelines. The proposals made in this Application with respect to enhanced scope of practice and removal of the podiatric cap can be expected to increase the number of podiatric practitioners and, thereby, reduce wait times for their services.

- e. *Geographic variation in availability and diversity of healthcare providers across the province:* The current chiropody framework has led to huge disparities in practitioner distribution across the Province. This is particularly the case for podiatrist members. Figure 3 on page 16 illustrates the current distribution of chiropodists and podiatrists among the 14 LHINs. Statistically adjusted rates of foot and ankle surgery conducted by orthopedic surgeons also varies widely across the 14 LHINs. The Ontario-wide statistically adjusted rates of orthopedic surgery were 49 per 100,000 population for foot surgery and 16.7 per 100,000 population for ankle surgery (Subject to updating from WHIS). The lowest adjusted rates of foot and ankle surgery were in the North West, North Simcoe Muskoka and Central West LHINs. The highest rates for foot surgery occurred in the Erie St. Clair, Toronto Central and North East LHINs and the highest adjusted rates for ankle surgery occurred in the Toronto Central, South West and Erie St. Clair LHINs. According to the Canadian and Ontario Orthopedic Associations, these differences can be attributed to the availability, or lack thereof, of practitioners to perform foot and ankle surgery.⁶²
- f. *Changing technology:* There has been a number of innovations that enable podiatrists to obtain good outcomes from procedures that were historically limited to orthopedic surgeons and to hospitals and similar institutions. Advances in surgical and anesthetic techniques, fixation options, portable/outpatient intra-operative imaging technologies, portable/outpatient emergency equipment and crash cart technologies have become available in healthcare delivery in general. More specific to podiatry, technological advances include:

⁶¹ Ontario Orthopaedic Association, Canadian Orthopaedic Association. "Proposal for the Development of a Provincial Foot and Ankle Program". OOA/COA, 2009.

⁶² "Proposal for the Development of a Provincial Foot and Ankle Program". 2009. 12.

- Shock wave therapy for heel spurs and plantar fasciitis and Achilles tendinopathy (Requires local anesthetic and diagnostic ultrasound);
- Endoscopy plantar fasciotomy for plantar fasciitis; and
- Endoscopic intermetatarsal nerve decompression for Morton's neuroma.

g. *Demographic trends:* Statistics and projections pertaining to Ontario's aging population are well known (See Following Text Box). Nearly 60% of Ontario's podiatrists' and chiropodists' patients are 55 years of age or older. This figure will likely increase as the percentage of seniors in the population increases --- assuming there is a parallel growth in the profession. A major public benefit of conversion to a podiatric model of care is to enhance seniors' access to more timely, convenient and cost-effective foot and ankle care and to enable a more extensive and seamless continuum of care.

- 1.9 million Ontarians are 65 years of age or older.
- 14.6% of Ontarians are 65 years of age or older.
- The proportion of seniors to the general population is projected to double over the next 20 years.
- Seniors account for nearly half of total healthcare expenditures.
- The vast majority of seniors have at least one chronic disease or condition.

-Dr. S. K. Sinha. "Living longer Living Well". MHLTC, 2012. 10.

h. *Promotion of collaborative scopes of practice:* Although much of the current and proposed scopes of practice involve public domain activities that can be performed and are being performed by members of multiple regulated and unregulated professions, except for the 25 or so orthopedic surgeons specializing in the foot and ankle, podiatrists and chiropodists are the only regulated professions trained to specialize in the foot and ankle and are the only professions authorized to perform subcutaneous surgical procedures on the foot and ankle. Nevertheless, nurses, physiotherapists, chiropractors and massage therapists do provide important non-invasive treatments of the foot and ankle and will continue to do so, often in collaboration with podiatrists. The advent of a unitary profession with the podiatric scope will facilitate interprofessional collaboration and the College and the professional associations intend to promote enhanced interprofessional collaboration once the new scope of practice and authorized acts are in place. Creating a unitary profession under the single and better-known title "podiatrist" will facilitate interprofessional collaboration by addressing confusion around the "chiropodist" title. (See Response to Question # 5 in HPRAC's "Additional Questions".)

- i. *Patient safety:* The College is confident that current and prospective registrants will practise safely and effectively and have, or will acquire, the knowledge, skill and judgment to do so. The College will be amending its Standards of Practice to ensure safe and effective performance of the new and expanded authorized acts, by those who have demonstrated the competencies to do so. A concern to the College is the increasing number of unregulated "footcare specialists", "cosmetologists", "aestheticians" and the like who are practising within the current chiropody scope. These practitioners are performing often risky procedures without appropriate training and safeguards and on patients who may not be aware of the risk to which they are being exposed. Expanding the scope of practice and removing the podiatric cap as recommended in this Application will begin to close the supply/demand gap and, thereby, begin to make these practitioners redundant.

"The Ministry needs to build the continuum of care in the community, so there are more options for seniors to get the care they need outside of hospitals and long-term care homes".

-Ministry of Health, Results-Based Plan Briefing Book 2012-2013.

There is no evidence from other jurisdictions in which the podiatric scope has been in operation for substantial periods of time to apprehend an increased risk of harm to patients as a consequence of implementation of either the scope or the podiatric model of care. Nevertheless, the College will be asking for authority to regulate surgery centres and other venues that are owned by podiatrists and in which podiatric surgery is conducted and will devise and implement Quality Assurance requirements and mechanisms analogous to those for Independent Health Facilities administered by the College of Physicians and Surgeons of Ontario.

- j. *Wellness and health promotion:* There is a large volume of evidence and advice that maintaining good foot health is instrumental to overall health and is also necessary for mobility, independence, productivity and the normal conduct of activities of daily living. There is also a large volume of evidence that many diseases, disorders and dysfunctions manifest themselves first, or at some point, in the foot. Chiropodists and Podiatrists play an important role in promoting and preserving foot health and wellness. What chiropodist and podiatrist do in foot wellness and health promotion can, however, be accomplished fully and effectively within the current scope of practice and authorized acts.
- k. *Health human resources issues:* The Minister's referral asked HPRAC not only to conduct a scope of practice review, but to review and make recommendations on other or related matters such as the podiatric cap. As indicated in the Forward to this Application, in the College's view any cap on the registration of qualified, healthcare practitioners cannot be justified in Ontario's current and

projected health human resources environment. Removal of the cap will facilitate the profession's ability to grow naturally and to respond to patient and healthcare system demands.

Expanding the scope of practice is projected to have beneficial HHR impacts in two respects discussed in more detail elsewhere in this Application and in the College's response to HPRAC's Additional 18 Questions:

1. By allowing podiatrists to perform the more advanced surgical procedures for which they are qualified, reducing the demand and wait times for orthopedic and other surgeons (particularly the 25 or so orthopedic surgeons who specialize in the foot and ankle). This would hopefully have the effect of reducing wait times for the more complex foot and ankle surgical procedures that require the attention of orthopedic and other surgeons.
 2. By filling the gaps in the scope of practice, pertaining particularly to diagnostic tests, reducing demand and wait times for general practice physicians.
- l. *Professional competencies not currently recognized:* Chiropodists' scope of practice and authorized acts have not changed, in Ontario, to reflect changes in the chiropody educational program and the podiatric cap keeps them from performing any of the controlled acts authorized for podiatrists, regardless of competencies.

There are about 75 Doctors of Podiatric Medicine --three times the number of orthopedic surgeons certified as foot and ankle specialists ---registered to practise in Ontario who are competent to and whose peers in other jurisdictions currently:

- Perform surgical procedures on the foot and ankle;
 - Set and cast fractures of bones or dislocations of joints in the foot and ankle;
 - Order or apply "forms of energy" such as MRIs;
 - Prescribe, dispense, or sell drugs, including controlled drugs and substances, consistent with the podiatric scope of practice;
 - Administer substances by injection were clinically indicated in the body; and
 - Order laboratory tests.
- m. *Access to services in remote, rural or under services areas:* The distribution of chiropodists and particularly podiatrists throughout Ontario is very uneven. Figure 3 on page 16 illustrates the distribution of chiropodists and podiatrists by LHIN District. The lowest ratios of chiropodists and podiatrists to population occur in urban areas of the Province.

As discussed elsewhere in this Submission and in the response to HPRAC's 18 Additional Questions, access to footcare services, especially advanced footcare services, are particularly compromised in Northern Ontario. The Provider in Sioux Lookout characterized footcare services in the area as "more or less nonexistent and desperately required". The College also hears anecdotal evidence about individuals in Northern Ontario who require advanced footcare having to travel to Manitoba to get it. Impaired access to footcare in Northern Ontario is almost certainly a major factor in the relatively high number of diabetic toe and foot amputations and partial amputations compared to the rest of the Province.

Footcare in Ontario's Aboriginal , First Nations, Métis and Inuit communities is particularly challenged, despite the alarmingly high incidence of diabetes among members of those communities. The incidence of Type 2 Diabetes in such communities is 3 to 5 times higher than the general population. The Sandy Lake First Nations have the third highest incidence of diabetes recorded in the world. One result is a substantially and unacceptably higher occurrence of lower limb amputation and foot abnormalities.

To respond to the supply/demand gap in rural, remote and underserved areas, some chiropractors and podiatrists have established satellite clinics. Some chiropractors and podiatrists serve on the staffs of clinics that focus on aboriginal health. But such initiatives fall far short of need.

Removal of the podiatric cap will prompt growth of the profession. With additional numbers, market forces will attract podiatrists to underserved areas. The proposed expanded scope of practice will relieve demand for orthopedic surgeons providing footcare surgery that podiatrists can competently and safely perform and will create a more seamless continuum of care that will reduce the number of circular referrals to general and other practitioners.

Q 13: *"How would this proposed change in scope of practice affect the public's access to health professions of choice?"*

Response: The principal motivation behind the College's proposal is to enhance the public's access to, and choice among, regulated footcare practitioners and to create an expanded and seamless continuum of footcare. As stated elsewhere in this Application, the gap between the demand for advanced footcare services and the supply of regulated, qualified practitioners continues to grow, primarily (but not exclusively) as a consequence of the growth of the seniors demographic. Individuals 55 years of age and older constitute approximately 58% of chiropractors' and podiatrists' patients. The supply/demand gap is, in part, manifested by long wait lists for diagnosis and treatment by orthopedic surgeons specializing in the foot (of which there are about 25 in Ontario).

"We also learned that there still are older Ontarians who cannot easily find a primary care provider. This is especially the case for those who are homebound and would benefit from house calls. We need to do more to improve primary care for older Ontarians by building models of care that deliver high quality care and best serve their needs, while ensuring that every older Ontarian who wants a primary care provider can get one."

-Dr. S. K. Sinha. "Living longer Living Well". MHLTC, 2012. 10.

The gap in the supply of and demand for chiropodists' and podiatrists' services in Ontario is a function of several factors:

The gap in the supply of and demand for advanced footcare in Ontario is a function of several factors:

Gaps or mismatches in the current authorized acts that prompt circular referrals that delay diagnosis and treatment and compound wait lists and wait times

- The limited scope of practice and authorized acts for chiropody and podiatry in Ontario for which most chiropodists and podiatrists are overqualified and that, thereby, discourage practitioners from entering or staying in the profession in Ontario;
- The limited scope of practice and authorized acts that restrict chiropodists' and podiatrists' ability to respond to patient and health system demand; and
- The "podiatric cap" that prohibits the migration of podiatrists to Ontario from other jurisdictions regardless of demand and prohibits Ontario residents who have graduated from US or Québec podiatry schools from practising podiatry in Ontario.

Furthermore, orthopedic surgeons have not been able to fulfill the role envisaged for them by the government in the early 1980s. That was a critical part of the rationale for converting to a chiropody model. To begin with there are no more than 25 orthopedic surgeons in Ontario specializing in the foot and ankle. A submission by orthopedic surgeons to the Ministry of Health and Long-Term Care in March 2009 acknowledges that "the numbers of orthopedic surgeons in Ontario with a specific interest in foot and ankle surgery are few and the demand far exceeds the ability of the few to fulfill the needs of Ontario citizens". The same submission notes that "Some foot and ankle specialists are reducing the number of less specialized foot and ankle surgeries they will perform, in some cases because operating room (OR) time is limited for these types of procedures." The submission also notes that

"... most orthopedic residents graduate from programs with insufficient exposure to foot and ankle pathologies and thus do not manage these problems unless they have received additional training in the form of a foot and ankle fellowship".⁶³

The pie chart at Figure 3, page 16 illustrates the current distribution of chiropodists and podiatrists across Ontario. Substantial portions of the Province are unserved or substantially underserved by podiatrists and chiropodists. The near absence of chiropodists and podiatrists in North-Western Ontario, for example, is arguably at least a major factor in the high amputation rate for feet and lower limbs due to the lack of timely and effective diagnosis and treatment of diabetes and other diseases and disorders of the foot.

Nurses and others are already performing many of the routine, non-surgical aspects of the legislated scope of practice of chiropody and podiatry. The transformation the College proposes recognizes that trend and its inevitable and appropriate continuation. The proposed transformation also recognizes the acknowledged and important role for orthopedic surgeons to continue to perform the more complex surgical procedures on the foot and ankle that require, in the main, access to hospital operating rooms. "In the middle" so to speak, will be podiatrists providing a wider range of diagnoses and treatment, to the full extent of their competencies and in response to public demand, primarily in more accessible, non-institutional, community-based settings within a seamless continuum of care.

⁶³ "Proposal for the Development of a Provincial Foot and Ankle Program". May 2009. 9.

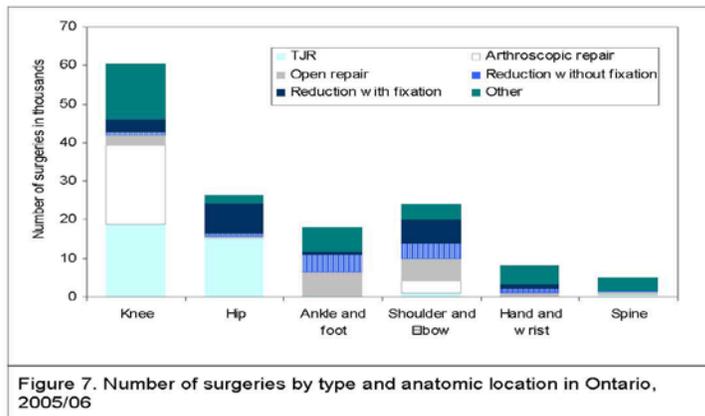


Figure 7. Number of surgeries by type and anatomic location in Ontario, 2005/06

Data Source: DAD, NACRS, SDS

The distribution of surgeries according to anatomic location is displayed in Figure 7. Surgeries on the knee were most common, accounting for over 40% of all surgeries, followed by the hip (18%), the shoulder and elbow (17%) and foot and ankle (12%). The number of knee replacements was 24% higher than the number of hip replacements. In addition, the number of knee arthroscopic surgeries was 8% higher than the number of total knee replacements. Arthroscopic surgeries were most commonly performed on the knee (87%) and the shoulder and elbow (13%). Reductions with fixations were most commonly carried out on the hip (41%), and shoulder and elbow (31%). Reductions without fixations were performed more often on the ankle and foot (38%), shoulder and elbow (33%) and hand and wrist (11%).

The number of surgeries performed by orthopaedic surgeons varied according to patient's age and sex (Figure 8). The total number of surgeries increased with age among women; however, among men, the number of surgeries increased with age up to the age of 54 and then showed a considerable decline. Among people 44 years or younger the number of surgeries was higher in men than women and among people 55 years or older the opposite was observed.

The pattern of surgery with age varied according to underlying condition. The volume of surgeries for arthritis and related conditions increased with age for men and women until age 64 years and then declined for those 65 years or older (Figure 9). The number of surgeries was higher in men less than age 55 years and in women 55 years or older. The volume of surgeries related to traumatic conditions was higher in younger men (less than age 55) and in older women (64 years or older). The number of surgeries for this diagnosis group was particularly high in older women (75 years or older) where the number of surgeries was almost triple the number in men the same age, and in younger men (24 years or younger) where the number of surgeries was almost double the number of surgeries in women the same age group.

Case Study 3. Number of Surgeries Performed by Orthopedic Surgeons in Ontario.

Q 14: "How would the proposed change in scope of practice affect current members of the profession? Other health professions? The public? Describe the effect of the proposed change in scope of practice might have on:"

Response:

- a. *Practitioner Availability:* The Labour Market Information Division of Employment and Social Development Canada maintains a National Occupational Standard for chiropractors and podiatrists, but does not track either profession in terms of employment growth or demand. This is perhaps because of the relatively small size of the professions in Canada and their varied status with respect to scope and titles across the provinces and territories. Figure 3 compares the ratios of podiatrists and chiropractors to population in the other Canadian provinces where the profession is recognized and in comparable

foreign jurisdictions. The ratio of chiropodists to population in Ontario has reached --- in fact exceeded -- -- the target set by the government circa 1980. Nevertheless, that target was based on a different delivery model than the one that characterizes the chiropody profession today. Although the practitioner/population ratio set circa 1980 has been achieved, there are huge variations in the supply of chiropodists and/or podiatrists across the Province. (See Figure3; Page17.) Furthermore, although the numbers of chiropodists and podiatrists are small relative to other primary care professions, they are sufficient to have a meaningful and positive impact on healthcare delivery, particularly for patients who do not have access to a family physician. Despite having achieved the practitioner/population target, as stated and explained elsewhere in this Application, the College believes that the growth of the podiatry and chiropody professions in Ontario has been seriously stunted by the podiatric cap and by the limited scope of practice that does *not* allow many practitioners to perform to the full extent of their competencies, nor to fulfill their patients' expectations or the demands of Ontario's healthcare delivery system. The College is convinced that revocation of the podiatric cap (coupled with an indigenous podiatry education program) will remove huge obstacles to practitioner number growth. As evidence, the College cites the fact that it has received an unprecedented number of inquiries over the past several months from DPM graduates about the prospects of registration as podiatrists in Ontario in light of the HPRAC review. The College is also convinced that an enhanced scope of practice will be attractive and act as an incentive for individuals to follow a career in podiatry in Ontario.

The current numbers of podiatrists and chiropodists have led to their very uneven distribution across Ontario. Chiropodists and particularly podiatrists tend to be concentrated in Ontario's large urban centres. The College anticipates that an increase in the number of practitioners will be particularly felt in enhanced practitioner availability by those areas of the province that are currently unserved or underserved.

About one quarter of podiatrists' and chiropodists' patients report not having a family physician. As primary care and primary access practitioners, therefore, chiropodist provide many patients with access to the healthcare system that they would not otherwise have except through emergency departments and walk-in clinics.

Podiatry care not only reduces amputation risk, but also dramatically impacts the rate of hospitalization and reulceration.

- Gibson, et al, Int Wound Journal, 2013

Increased availability of podiatrists can logically be projected to decrease the demand for footcare services delivered by orthopedic surgeons. Nevertheless, evidence also clearly suggests that there is more than enough demand for footcare especially for routine, non-invasive cases to keep everyone busy. That situation will persist for the foreseeable future because of population growth and

demographic trends. Accordingly, increased availability of podiatrists is unlikely to displace any existing practitioners. The College does hope, however, that increased availability of podiatrists will reduce the utilization of unregulated practitioners who are performing sometimes risky procedures without appropriate training, safeguards or supervision; and are doing so primarily with vulnerable populations, such as seniors.

- b. *Education and training programs, including continuing education:* The College has committed to existing registrants to expend best efforts to ensure that refresher and bridging programs pertaining to the proposed scope of practice are reasonably available in Ontario. The College is also operating on the premise that the Government of Ontario would insist, or at least prefer, that a podiatry program that generates the competencies required to perform all of the proposed authorized acts would be established in Ontario as soon as possible. To that end, the College has initiated discussions with a number of academic institutions in Ontario with a view to their launching either or both the refresher and bridging programs and the full-time podiatry program. In the absence of a clear and reliable signal that the podiatric cap will be revoked and the proposed scope of practice implemented, these communications have not progressed beyond the discussion stage.

It should be emphasized that the decision to perform any or all of the new or expanded authorized acts will be left entirely to individual grand-parented practitioners. Based on the College's survey of registrants, the intention to perform and the perceived competency to perform vary widely among the proposed authorized acts.

- c. *Enhancement of quality of services:* Enhancement of services will result largely from podiatrists being able to provide a more extensive and seamless continuum of care, thus significantly reducing the need for time wasting and expensive referrals and circular referrals for diagnostic tests. The more extensive continuum of care leads to greater continuity of care that has been demonstrated to improve quality of service and patient outcomes. The result will be substantially enhanced convenience for patients; more timely diagnosis and treatment; and healthcare system efficiencies. Enhancement of services will also occur by the provision of care in more accessible and patient-friendly community-based clinics, rather than in acute or chronic care institutions and emergency departments.

Podiatric medical care in people with a history of diabetic foot ulcers can reduce high level amputation from between 65% and 80%.

- Gibson, et al, Int Wound Journal, 2013

- d. *Costs to Patients or clients:* As discussed elsewhere in this Application, the advent of a podiatry scope of practice in Ontario can be expected to generate net healthcare system savings. Currently, services rendered by chiropodists are paid for by most extended health benefits insurers, the WSIB, auto insurers

(under the Statutory Accidents Benefits Schedule) and patients themselves. OHIP partially covers podiatrists' services up to a maximum of \$135/year (plus up to \$15 for x-rays). Most extended health benefits insurers, the WSIB, auto insurers and patients themselves also pay for podiatrists' services. According to a recent study conducted in Arizona, net system costs increased and outcomes decreased as a consequence of the delisting of podiatry from the State's Medicare Plan.

Discussions with the Provider Services Branch of the Ministry of Health and Long-Term Care, the Canadian Life and Health Insurance Association and the WSIB give no reason to believe that implementation of the proposed podiatry model will change the status quo and, thereby, have a material impact on the costs to patients or clients.

- e. *Access to services:* As explained in a. and elsewhere in this Application, the College believes that access to services will be significantly enhanced by converting to a podiatry model as proposed. Patients' reliance on hospitals, where wait times for foot surgery are characteristically longer than clinical guidelines, will be reduced and access in areas of the province that are currently unserved or underserved will be improved. Conversion to the proposed podiatry model is also expected to have a ripple effect on other professions, for example helping to reduce wait times for orthopedic surgeons for complex foot and ankle surgeries and for other types of orthopedic surgery.

Each \$1 invested in care by a podiatrist for people with diabetes results in \$27 to \$51 of healthcare savings.

- JAPMA, 101(2), 2011

- f. *Service efficiency:* The principal service efficiency that will be realized is to reduce the need for referrals for diagnosis and treatment within the proposed podiatry scope of practice and circular referrals for diagnostic tests, which are time-consuming for patients and delay timely diagnosis and treatment.
- g. *Interprofessional healthcare delivery:* Please see the response to Question Five in the Submission on HPRAC's 18 Additional Questions.
- h. *Economic issues:* The Applicant foresees no material economic impacts. Studies referenced elsewhere in this Application give reason to project net health system efficiencies and cost reductions. The clinical evidence identified in other parts of this Application clearly suggests that the adoption of a podiatry model will lead to better health outcomes. The economic literature clearly indicates that better health outcomes have a positive impact on employment, productivity and economic growth. Clinical evidence also indicates that the proposed podiatry model will improve health outcomes particularly from the management of chronic diseases such as diabetes, arthritis and cancer. These in turn lead to cost savings through a reduction in hospital stays, emergency room visits and also improved productivity. Better

continuity of care lowers resource utilization and reduces systemic healthcare costs. Accordingly, the proposed podiatry model can be expected to generate positive micro and macroeconomic outcomes, but the College acknowledges that those outcomes are unlikely to be material in the Ontario context, at least in the short-term, in light of the small size of the profession and its economic impact.⁶⁴

Q 15: *"Are members of your profession in favour of this change in scope of practice? Please describe any consultation process and the response achieved."*

Response: The following chiropody and podiatry professional associations are on record as supporting the conversion to a podiatry scope of practice, model of footcare delivery and regulation as put forward in this Application: The Ontario Society of Chiropractors (OSC); the Ontario Podiatric Medical Association (OPMA); and the Canadian Podiatric Medical Association (CPMA) that is the national association for podiatrists. The Canadian Federation of Podiatric Medicine (CFPM) is a national association primarily representing those who currently practise in the UK model. In its submission to HPRAC during the Ontario footcare model review, the CFPM came out strongly against the North American podiatry model and in favour of the UK model. For the reasons indicated in the response to Question 30, the College believes that adoption of the UK model would represent a serious backward step for Ontario and not be in the public interest.

In December, 2012, the College convened a number of working groups for the HPRAC review, including a Working Group on Member Consultations & Communications. The Working Group on Member Consultations & Communications consists of chiropractors and podiatrists registered with the College. Its role is to design and implement a communications strategy with the College membership on every aspect of the HPRAC review. The Working Group will continue in operation at least until the end of the HPRAC review.

In March of 2013, the College launched a website, (called the "HPRAC Portal"), that is accessible to all registrants through the members-only section of the College of Chiropractors' official website. The HPRAC Portal provides an abundance of information on all aspects of the HPRAC review, including the details of, background to, rationale for and implications for members of the recommendations being made to HPRAC to convert to a full scope podiatry model of footcare and regulation. The content of the Portal is continuously updated. One of the features of the HPRAC Portal is an interactive capability whereby registrants may make comments, ask questions and offer suggestions to which the College responds. One third of College registrants have accessed the Portal at least once and most of them have accessed the Portal multiple times.

⁶⁴ Coyle, Doug et al. "Economic Impact of Improvements in Primary Healthcare Performance". Ottawa: Canadian Health Services Research Foundation. 2012. 17-19.

The College also launched an HPRAC-specific electronic newsletter called "SCOPE". SCOPE editions are sent to all registrants by electronic E-Blast. As of the date of this Application, 15 SCOPES have been published. Each addresses, or calls registrants' attention to, a specific HPRAC review-related topic --- and also reminds registrants to access the HPRAC portal.

Updates on the project to convert to a full scope podiatry model of regulation and footcare are also provided at each College Council meeting during the public sessions.

The College also offered town hall meetings and webinars to registrants in order to keep them informed on all aspects of the HPRAC review. The College also expended best efforts to identify any areas of concern or opposition within the membership.

Historically, there have been many frictions and divisions within and between the chiropody and podiatry professions in Ontario. In that context, the consensus in support of the conversion to a full scope podiatry model is a truly remarkable achievement for all concerned and bodes well for the future of the profession.

Q 16: *"Describe any consultative process with other professions that might be impacted by these proposed changes."*

Response: In early 2013, the College began to assemble an "HPRAC Review Stakeholder List". That list included professional associations representing, and RHPA Colleges responsible for regulating, professions that would be impacted, or might perceive themselves as being impacted, by the changes being proposed. The professions encompassed within the List included medicine, chiropractic, pedorthics, pharmacy, physiotherapy, nursing and optometry, including specializations and classes of members thereof.

Beginning in February, 2013, the College sent individualized letters to each College and Association on the List. The letter conveyed a high-level description of what the College intended to propose to HPRAC, including the proposed wording of the expanded scope of practice and new and expanded authorized acts, plus the proposed new or expanded authorities under the *Healing Arts Radiation Protection Act* and the *Laboratory and Specimen Collection Centre Licensing Act*. Each letter offered a follow-up briefing session by the College.

Follow-up briefing sessions were subsequently convened with the College of Physicians and Surgeons of Ontario, the Ontario Medical Association, the Ontario Chiropractic Association, the College of Physiotherapists of Ontario, the Ontario Physiotherapy Association, the Canadian Federation of Podiatric Medicine, the Canadian Podiatric Medical Association, the American Podiatric Medical Association, the Council on Podiatric Medical Education, the Ontario Association of Non-Profit Homes & Services for Seniors, the Canadian Life and Health Insurance Association, the Ontario Society of Chiropodists, the

Ontario Podiatric Medical Association, the Ontario Orthopedic Association, the Ontario Association of Medical Laboratories and the The Michener Institute for Applied Health Sciences.

Thematic subjects raised by the associations and Colleges in these sessions included:

Will all current registrants of the College of Chiropodists be automatically grand-parented to perform all of the new or expanded authorized acts, or alternatively will all registrants have to acquire the requisite competencies to perform all of the new or expanded authorized acts?

Answer: The College proposes that the performance of any the new and expanded authorized acts will not be mandatory by current College registrants and by students who are in-stream at the Michener chiropody program, but will be mandatory for all other first-time registrants. Using the PES Analysis as a foundation, grand-parented registrants and Michener graduates will have to demonstrate to the College's satisfaction that they have acquired the requisite knowledge, skill and judgment to perform whatever new or expanded authorized acts they elect to perform.

Grand-parented registrants and Michener graduates who choose not to perform any or all of the new or expanded authorized acts, or who do not demonstrate the competencies to do so, will have terms, conditions and limitations applied to their registrations by the College.

How will other healthcare practitioners and members of the public distinguish between those who have been authorized by the College to perform any or all of the new or expanded authorized acts and those who have not?

Answer: Following the precedent of other Colleges that have gone through analogous scope of practice changes, such as the College of Dental Hygienists of Ontario and the College of Physiotherapists, the intention is that the College of Podiatrists will make a roster publicly available on the College's official website listing each registrant and the authorized acts he/she has been deemed competent by the College to perform.

Will podiatrists seek hospital privileges?

Answer: The College's proposal does not include hospital privileges for podiatrists.

Where and how will new podiatrists be educated?

Answer: The College has determined that a university-based, post baccalaureate podiatry program is required to provide the competencies necessary to practise the proposed scope of practice and authorized acts safely and effectively. The College's preference is to have the podiatry program affiliated with an Ontario medical school. To that end, the College has initiated exploratory discussions with seven Ontario universities that have medical schools and two that do not have medical schools, but have health sciences faculties that could be expanded to include a podiatry program.

Will the College impose a post-graduation residency or internship requirement and, if so, what are the College's plans to have teaching hospitals open up sufficient places?

Answer: New registrants and grand-parented registrants wishing to perform the more complex surgical procedures authorized within the proposed scope of practice will be expected to complete or have completed surgical residencies in accredited hospitals. The residency stream in Ontario is expected to be separate and apart from that for orthopedic surgeons and therefore, would not impact on the availability of residency spaces available for them.

Clinical Scenario FRACTURE

19 year old healthy female injured playing soccer on a weekend. Telephones the Podiatrist at the office and directed to the on call practitioner who instructs the patient to meet at the office (No referral or ER visit required).

Exam reveals swelling and discomfort to the lateral left foot and ankle with some tenderness to the proximal left fibula. Exam is otherwise normal. A letter is written by the podiatrist/chiropractors to the patient's primary care physician recommending an x-ray. The patient returns to the primary care physician for further treatment.

PROPOSED/EXPANDED SCOPE:

A weight-bearing x-ray is taken immediately in the office and interpreted by the Podiatrist revealing a non-displaced spiral oblique fracture of the distal left fibula and a displaced fracture of the proximal metaphysis of the fifth metatarsal left foot.

A compression dressing is applied along with a removable fracture boot. The patient is instructed to be non-WB with crutches. A prescription for a non-steroidal anti-inflammatory (NSAID) and pain medication was dispensed along with a prescription for crutches which can be picked up at the pharmacy. An x-ray at an outpatient imaging facility was ordered by the Podiatrist of the left knee to rule out fracture of the proximal left fibula (Treatment for a proximal fibula fracture actually occurs distally at the ankle joint.).

Surgical consultation was provided for open reduction with internal screw fixation (ORIF) of the left fifth metatarsal fracture to be performed within a week by the Podiatrist in the office surgical suite (or outpatient surgery center?) utilizing IV sedation or nitrous oxide, mid-calf tourniquet and local anesthetic. An order for pre-operative CBC, platelet count, PT/PTT, HCG and urinalysis was given for the local outpatient laboratory. Pre-operative IV antibiotic, prophylaxis was administered 30 minutes prior to surgery. A post-op intramuscular injection of Toradol (NSAID) was administered prior to discharge.

Routine post-operative care was performed with the involvement of CCAC wound care Registered Nurses. Serial dressing changes and x-rays to assess healing. Local redness and swelling occurs along the incision at 10 days after surgery. A small amount of local purulent drainage is noted. A culture and sensitivity is obtained from a swab of the wound. CBC with differential, erythrocyte sedimentation rate and C-reactive protein levels are obtained from blood work ordered by the Podiatrist at the outpatient laboratory. A prescription is given for an empiric antibiotic and then changed to a more specific antibiotic after the culture and sensitivity results are returned and the local infection has not completely resolved when the patient is subsequently examined. The infection completely resolves with specific antibiotic therapy and the surgical wound heals without further complication. The patient fell one week after surgery. An x-ray was taken in the Podiatrist's office which displayed loosening of the internal hardware. The patient was taken back to the outpatient surgical suite by the Podiatrist and the internal fixation was replaced and reduction of the fracture was maintained. Cast immobilization of the foot and ankle fractures continue via strict non-WB and crutches for 4-6 weeks. Outpatient physical therapy begins at 4 weeks. The patient returns to full activity within 2 months after the initial injury. The Podiatrist fits the patient for an ankle brace and an orthotic.

Case Study 4. Clinical Scenario for a Patient Experiencing a Fracture

Q 17: "How will the risk of harm to the patient or client be affected by the proposed change in scope of practice?"

Response: As discussed elsewhere in this Application, the College will ensure that only those grand-parented members who demonstrate the competencies to do so will be allowed to perform whatever new or expanded authorized acts they elect to perform. Terms, conditions and limitations will be applied to all grand-parented registrants to prohibit them from performing any of the new or expanded authorized acts for which they do not have the required competencies. From the proclamation date forward, new applicants for registration to the College, except for those graduating from the chiropody program at The Michener, will have to demonstrate that they have obtained the competencies to perform all of the controlled acts authorized to the profession. Michener graduates will be treated the same as grand-parented registrants.

There is no reason to fear that patients' safety will be in any way compromised by the implementation of the proposed model. The College's Code of Ethics stipulates that:

"The public is entitled to safe, effective and ethical care performed by knowledgeable, skilled, accountable practitioners in accordance with the professional standards of the College."

"Each member will provide individualized comprehensive and safe care, recognizing the patient's particular needs, and respecting their cultural background."

Any College registrant doing something for which he or she is not competent would be liable to prosecution for professional misconduct.

The College believes that the risk of harm to patients will actually be reduced as a consequence of the system-wide impacts of the proposed reforms. The current limited scope prompts circular referrals to order diagnostic tests and to perform treatment modalities that are actually within the competencies of many registrants, but beyond their legislated scope of practice. Those circular referrals tend to increase patient risk by delaying diagnosis and treatment. The College is convinced that the proposed model will enhance patient safety by providing a more extensive continuum of care and by facilitating more timely diagnosis and treatment. It is also at least an arguable proposition that the community-based delivery model will not only be more convenient and accessible to patients and families in clinically-appropriate instances, but will also reduce the risk of patient infections and other complications, compared to hospital inpatient care.

For example, adverse events are a serious cause of concern to the healthcare system. Adverse effects are defined as anything that causes injury to a patient as the result of a medical intervention rather than the underlying medical condition. A study published in 2004 randomly selected 20 hospitals across five provinces, examined 2.5 million annual hospital admissions and found that the overall incidence rate of

adverse events was 7.5%.⁶⁵ Conversely a study on the rate of adverse events in outpatient care in Canada from 2013 found outpatient rates to be only 4.2%.⁶⁶

Likewise, in Canada there are an estimated 220,000 healthcare associated infections acquired in healthcare facilities, with 8,000 deaths attributable to these infections annually.⁶⁷ In acute care in-hospital settings, the average infection rates range from 6.3/1000 patient days in the Gyn. & Orthopedic setting, to 20.3/1000 patient days in the ICU.⁶⁸ This number is drastically reduced in the outpatient setting with infection rates of 5-6/1000 resident days in long-term care settings and surgical site infection rates of 1.4-3.1% in ambulatory settings.⁶⁹

Podiatrists and chiropractors have the knowledge, skill and judgment to determine when care by another practitioner, or in a hospital, or other delivery venue, is in the best interest on the patient. They will refer whenever it is in the patient's best interests and are required by the College to do so.

The College believes that the community-based delivery model of which the podiatric model is a part, will ensure enhanced public safety by reducing the number of patients required to be admitted to a hospital for treatment, thereby reducing infection rates and other complications. The College notes, in this regard, the Ontario government's "key commitment" to move low risk, OHIP-covered surgical procedures to community-based specialty clinics to help more patients receive the most appropriate care in the most appropriate place.⁷⁰

Q 18: "What other regulated and unregulated professions are currently providing care with the competencies proposed as an expansion to your scope of practice? By what means are they providing this care (e.g. under delegation, supervision or on their own initiative)?"

⁶⁵ Baker, G. Ross, Blais, Regis et al. "The Canadian Adverse Events Study: the incidence of adverse events among hospital patients in Canada". *Canadian Medical Association Journal (CMAJ)*, May 2004 vol. 170 no. 11. Web <<http://www.cmaj.ca/content/170/11/1678.short>>.

⁶⁶ Baker, G. Ross, Blais, Regis et al. "Assessing adverse events among home care clients in three Canadian provinces using chart review". *British Medical Journal (BMJ)*, July 2013 vol. 22 no. 12. Web <<http://qualitysafety.bmj.com/content/22/12/989.abstract>>.

⁶⁷ Johnston, Lynn, Simor, Andrew and Taylor, Geoff. "Public Reporting and Inter-hospital Comparison of Health Care-Acquired Infections". *Association of Medical Microbiology and Infectious Diseases-Canada*, May 2006. CHICA: Publication. <<http://www.chica.org/pdf/AMMIposition.pdf>>.

⁶⁸ Canada. Public Health Agency of Canada. *Essential Resources for Effective Infection Prevention and Control Programs: A Matter of Patient Safety: A Discussion Paper*. Ottawa: Queen's Printer, 2010. Digitalized Report: <<http://www.phac-aspc.gc.ca/nois-sinp/guide/ps-sp/pdf/ps-sp-eng.pdf>>. 8.

⁶⁹ *Essential Resources for Effective Infection Prevention and Control Programs: A Matter of Patient Safety: A Discussion Paper*. 2010. 12.

⁷⁰ Ontario. Ministry of Health and Long-Term Care. *A Policy Guide for Creating Community-based Specialty Clinics*. Queen's Printer, December 17, 2013. Publication. 1.

Response: Please see the Response to Question # 1 in the Submission in the Submission in response to HPRAC's 18 Additional Questions.

Q 19: *"Specify the circumstances (if any) under which a member of the profession should be required to refer a patient/client to another health professional, both currently and in the context of the proposed change in scope of practice."*

Response: Subsection 1.15 of the College's Professional Misconduct Regulation (Ontario Regulation 750/93) stipulates that professional misconduct by a member includes:

"Failing to advise the patient to consult with a physician or other regulated health professional where the member recognizes, or ought to recognize, a condition that is beyond the competence or experience of the chiropractor or that requires such a consultation to ensure the proper care of the patient."

A Standard of Practice of the profession is that each member must practise within his or her scope of practice, education and competency.

In sum, the College requires each member to refer patients to, or consult with, another health professional whenever the patient's condition or the treatment required is, or may be, beyond the member's individual knowledge, skill and judgment, or is beyond the legislated scope of practice of the profession, or the controlled acts authorized to the profession. It is the College's clear expectation that these requirements would persist under the proposed changes in scope of practice and authorized acts.

Clinical Scenario: WOUND CARE & DIABETES

A 45 y/o insulin dependent diabetic gentleman comes into the office with a red and swollen left foot. He does not recall any trauma and has no pain. He says that he has been diabetic since he was a teenager and he is taking injectable insulin on a daily basis. He says that he only checks his blood sugar every few days and he has not checked his blood glucose today. He says that he saw a doctor at the clinic last week because he was sick to his stomach and felt feverish but the doctor did not check his feet. He was told to take OTC Tylenol for his fever by the clinic. He states that he still does not feel well with fever, chills and some nausea.

Past medical history is positive for insulin dependent diabetes mellitus, hypercholesterolemia and high blood pressure. Past surgical history includes tonsillectomy and appendectomy. He denies smoking or alcohol use. He is employed on the line in the local factory and stands all day in steel-toed shoes. Family history is positive for cardiac disease and diabetes. Review of systems reveals some left knee pain from limping on his left foot, kidney trouble and diabetic retinopathy, but otherwise ROS is non-contributory.

Physical exam reveals his blood pressure, heart rate and respirations are all wnl. Blood glucose accu-check taken in the office reveals his blood sugar is elevated 4x normal. His body temperature is wnl.

This is a slightly overweight appearing gentleman sitting comfortably in the exam room chair in no apparent acute discomfort or distress.

Lower extremity vascular examination reveals that popliteal pulses (behind the knee) are palpable on both sides. Posterior tibial (behind the ankle) and dorsalis pedis (top of the foot) pulses are normal on the right side and bounding on the left foot. Capillary refill time is two seconds on both feet. Diffuse non-pitting left foot and ankle edema noted on the left foot. No edema noted to the right lower extremity. There is edema and pain at the back of the left knee with palpable lymph nodes.

Neurological exam reveals deep tendon reflexes, Achilles and patellar are normal. Reduced vibratory sensation and reduced proprioception (position sense) on both lower extremities. Protective sensation is absent to the distal aspect of both feet as measured by the 5.07 Semmes-Weinstein monofilament.

Skin exam reveals diffuse redness with cellulitis and lymphangitis with proximal streaking to the dorsal lateral left foot and plantar left arch. Otherwise skin is warm and dry with hair growth present on both feet. Mild maceration with hyperkeratosis noted to the fourth interdigital space left foot. Hyperkeratosis and underlying ulceration noted to the tip of the fourth toe left foot. Upon debridement of the fourth interdigital space left foot approximately 5ml of thick purulent drainage and foul odor is noted with deep tracking and penetration to the fourth and fifth MPJ level with deep tissue necrosis. The lesion at the distal tip of fourth toe left foot probes to bone with purulent drainage. There are no other open lesions or signs of infection on either foot.

Musculoskeletal exam reveals no pain on palpation or range of motion to either lower extremity. The fourth digit on the left foot is contracted plantarly at the proximal interphalangeal joint but it is reducible. (FLEXIBLE HAMMERTOE) There is collapse of the medial plantar arch on the left foot with abduction of the left forefoot noted and medial bony prominence noted to the left instep and dorsal left midfoot. Crepitus is noted upon palpation and range of motion of the joints throughout the left midfoot. Muscle strength is within normal limits. He limps when he walks and he is unable to perform single limb heel raise on the left side.

Clinical Scenario: WOUND CARE & DIABETES – Cont'd

Current Scope:

The patient is unable to receive help and therefore they must go to Emergency. Unfortunately as this scenario presents, the patient appears “fine” even though medically unwell. Thus the patient will likely have to wait at the bottom of the ER waiting room lineup. Upon receiving treatment the patient will have to deal with a Triage Nurse, an ER Nurse, an ER MD, a Porter to the x-ray room, an X-ray Technician, a Phlebotomist to draw blood for lab testing plus swab for culture, a Lab Tech to analyze and enter the data into the computer, a Radiologist to review the x-rays and an ER MD to page an Orthopedic Surgeon to attend and treat the patient.

Proposed/Expanded Scope:

Weight bearing x-rays of both feet and ankles would be taken in the Podiatrist's office, 3 views of both ankles, AP, mortise and lateral and two views of both feet, AP and oblique are negative for acute fracture or dislocation on the right side. There is emphysema and gas in the soft tissue of the distal fourth intermetatarsal space left foot (indicative of a severe anaerobic bacterial infection which produced the foul odor). Multiple displaced fractures and gross dislocation at the left midtarsal joint with diffuse osteopenia. (Poor bone stock because of hyperemic/increased blood flow washing out density of bone leading to multiple fractures and dislocations consistent with neurogenic osteoarthropathy, i.e. Charcot foot).

The wound at the tip of the fourth toe left foot was debrided in the office. Culture and sensitivity obtained along with empiric oral antibiotic therapy. An accommodative pad was dispensed and recommendations given for an orthotic and proper shoes.

If wound care fails and the culture returns, the Podiatrist orders a bone scan to rule out bone infection of the fourth digit. X-rays repeated to evaluate for bony destruction from infection. Prescription is given for IV antibiotics and PICC (peripherally inserted central catheter). A simple flexor tenotomy is performed in the office on the fourth toe clearing up the ulcer. The infection heals and the patient is cured.

[Case Study 5. Clinical Scenario for a Patient Experiencing Wound Care and Diabetes Continued](#)

More specifically, by way of illustration, and without limiting the generality of the foregoing, under the proposed scope of practice podiatrists would:

- Refer to an orthopedic surgeon, infectious disease specialist or general practice physician any patient with a condition for which safe and effective treatment would require, or best be conducted in, a hospital operating facility;
- Refer to an orthopedic surgeon or general practice physician any patient with a condition whose treatment requires general anesthesia or inpatient hospital care;

- Refer to a vascular surgeon or general practice physician any patient with a condition for which safe and effective treatment would require, or best be conducted in, a hospital operating facility;
- Refer to or consult with an oncologist any patient requiring the evaluation and/or treatment of any cancer as it pertains to the foot and ankle;
- Refer to or consult with a rheumatologist or a general practitioner any patient for evaluation and treatment of rheumatologic conditions (such as sero negative, sero positive, etc.);
- Consult with a neurologist or a general practitioner any patient requiring evaluation and treatment of neurological conditions (such as Charcot-Marie Tooth, mono and poly neuropathy, drop foot and weakness) and testing (such as NCVs and EMGs);
- Refer to a physiotherapist or other regulated rehabilitation professional patients requiring post-surgical rehabilitation;
- Refer to an occupational therapist any patient requiring professional advice and assistance with respect to the patient's activities of daily living (ADL);
- Refer to an Infectious Disease Centre or a general practitioner any patient with a condition for which safe and effective treatment would require, or best be conducted in, a hospital operating facility;
- Refer to or consult with a pain management specialist any patient needing evaluation and treatment of a complex regional pain syndrome, fibromyalgia and/or radiculopathy;
- Consult with a radiologist any patient requiring an MRI, CT scans, diagnostic ultrasound and/or bone scans;
- Refer to or consult with a dermatologist any patient needing evaluation and treatment of skin cancer;
- Refer to or consult with an endocrinologist any patient for the evaluation and treatment of diabetes management and/or osteoporosis;
- Refer to or consult with a wound care specialist any patient for the evaluation and treatment of chronic wounds;

- Refer to or consult with a plastic surgeon any patient requiring a skin graft, tissue defect and/or skin flap procedure;
- Refer to or consult with a hyperbaric oxygen treatment centre any patient for the evaluation and treatment of chronic wounds, PVD and/or diabetic wound management;
- Refer to or consult with a designated ADP assessor in all circumstances where a patient requires an assistive device under the Ministry of Health and Long-Term Care's ADP Program;
- Refer to or consult with a medical doctor (i.e. ER Dr.) or appropriate medical specialist any patient with a condition that would benefit from such a referral and/or consultation or for which safe and effective treatment would require, or best be conducted, in a hospital facility; and
- Refer to or consult with an emergency facility whenever the patient's condition requires.

[In the above list, "refer" is understood to mean sending a patient to another practitioner to assume ongoing management of the patient's condition. "Consult" is understood to mean sending a patient to another practitioner for advice and assistance for the referring podiatrist about the diagnosis and proposed treatment of a particular case, but case management is expected to remain with the practitioner. "Consult" may or may not require the referred practitioner to conduct a physical examination of the patient.]

It is important to add, however, that access to diagnostic testing and a broader scope of practice more reflective of podiatrists' competencies will reduce the need for circular referrals to other healthcare practitioners and thereby improve patient convenience, expedite diagnosis and treatment and reduce wait times and system-wide costs.

Q 20: *"If this proposal is in relation to the current supervisory relationship with another regulated health profession, please explain why this relationship is no longer in the public interest. Please describe the profession's need for independent/autonomy in practice."*

Response: Podiatrists have always practised independently primarily in sole practitioner clinics, but also in multiple healthcare delivery venues such as long-term-care homes, hospitals and in privately-funded multidisciplinary clinics. Chiropractors and podiatrists are recognized as primary healthcare practitioners who have the knowledge, skill and judgment to deliver footcare autonomously within their legislated scope of practice and authorized acts. As explained elsewhere in this Application, the original (circa 1980) concept for the chiropody model in Ontario was for chiropractors to work, by and large, as salaried personnel in hospitals and analogous institutions under a supervisory relationship with physicians. That model is now passé. Because of hospital cost-cutting and other changes in Ontario's healthcare delivery

framework, less than 20% of chiropractors work full or part-time in hospitals or in analogous institutions today. Although chiropractors have made some penetration into multidisciplinary primary care delivery organizations such as Family Health Teams and the like, most chiropractors' practice venues are identical or very similar to those of podiatrists.

The podiatry model of care being proposed is essentially a community clinic-based model, with podiatrists working independently or as parts of multidisciplinary health teams in a range of clinical settings. This model is actually an alternative to the hospital-centric model of healthcare delivery and derives its benefits from being so. Furthermore, addressing the growing supply/demand gap for safe and effective footcare, particularly in areas of the province that are currently chronically underserved or not serviced at all, requires podiatrists to be able to practise independently within a scope of practice that reflects their competencies.

The proposed model is founded on the continuation of podiatrists being primary healthcare practitioners and being able to practise independently (but not necessarily independently) in multiple, noninstitutional venues. In this context, a delegation system would constitute a step backwards and be incompatible with the objectives being sought. A delegation system would not be in the best interests of patients, for the healthcare system generally.

Q 21: *“Does the proposed change in scope of practice require the creation of a new controlled act or an extension of or change to an existing controlled act? Does it require delegation or authority to perform an existing controlled acts or a subset of existing controlled act?”*

Response: This Application does not contemplate the creation of a new controlled act, or an extension of or change to an existing controlled act. The Application does propose:

- a) Expanding the anatomical boundaries of the scope of practice and existing and proposed authorized acts to include the ankle and structures affecting the foot or ankle;

Extending the controlled acts and non-RHPA authorities currently authorized to members of the podiatrist class to include appropriately-qualified chiropractors (who would be grand-parented as podiatrists in the new College) and podiatrists who opt to perform any or all of those authorized acts; and

- b) Adding the controlled acts of i) "setting or casting a fracture of a bone or dislocation of the joint in the foot or ankle; ii) "applying or ordering the application of a prescribed form of energy"; and the authority to iii) order certain laboratory tests within the proposed scope of practice and authorized acts.

The Applicant proposes that these controlled acts be legislatively authorized to the profession, rather than requiring delegations from members of another profession. Very few chiropractors or podiatrists

currently perform any controlled acts pursuant to delegations. The practice venues and practice situations of the majority of registrants make a delegation system problematic.

Q 22: *"If the proposed changes scope of practice involves an additional controlled act being authorized to the profession, specify the circumstances (if any) under which a member of the profession should be permitted to delegate that act. In addition, please describe any consultation process that has occurred with other regulatory bodies that have authority to perform and delegate this controlled act."*

Response: The College of Chiropodists currently has in place a policy that authorizes registrants to assign public domain acts, but prohibits the delegation of authorized acts. There is no intention to change this approach.

While the College proposes controlled acts being authorized for the profession, the College wishes to emphasize that grand-parented registrants would have to demonstrate to the College their competencies to perform any of those controlled acts before being authorized to do so. Those authorized practitioners would then be identified by a public roster on the College's website. Terms, conditions and limitations would apply to all other grand-parented registrants.

Under the *Nursing Act, 1991* (subsection 5. (1) (b)), registered nurses may perform controlled acts authorized to chiropodists and podiatrists pursuant to an "order" from a chiropodist or podiatrist to do so. By letter dated February 21, 2013 the Applicant approached the College of Nurses of Ontario to discuss the subject-matter of this Application and these provisions of the *Nursing Act* in particular. The College of Nurses indicated it does not intend to engage in HPRAC's review and has no basis on which to judge the competencies of College of Chiropodists' registrants to perform the proposed expanded scope of practice and the proposed new or expanded authorized acts.

The Applicant reached out to each College whose members are currently authorized to perform any of the proposed new or expanded authorized acts. The College met with the College of Physicians and Surgeons of Ontario on June 20, 2013 and the College of Physiotherapists of Ontario on November 21, 2013. No other College indicated interest in what the Applicant is proposing, or any intention to engage in the HPRAC review. As of the date of this Application, neither the CPSO nor the College of Physiotherapists has registered any opposition with the Applicant.

Q 23: *"Are the entry-to-practise (didactic and clinical) education training requirements of the profession sufficient to support the proposed change in scope of practice? What methods are used to determine the sufficiency? What additional qualifications might be necessary?"*

Response: The current entry-to-practice requirements are geared to the chiropody scope of practice and authorized acts listed in subsection 5 (1) of the *Chiropody Act, 1991*. These requirements are not sufficient to support the proposed change in scope of practice. The College aspires to an Ontario-based university podiatry program that, once fully operational, would graduate in the range of 25 podiatrists

per year who would be fully competent to perform the proposed scope of practice and enable performance of all of the proposed authorized acts. In this regard, the Kent State University College of Podiatric Medicine has written to the College offering to assist an Ontario University to set up and launch a podiatry program and to provide upgrading, bridging and refresher courses for grand-parented registrants who wish to acquire the competencies to provide some or all of the new or expanded authorized acts.

In order to determine the sufficiency of the training and education programs from which current registrants graduated vis-à-vis the proposed scope of practice expansion, the College retained Professional Examination Services (PES) to conduct a comprehensive review. PES determined that the following cohorts of registrants are competent to perform any and all of the new or expanded authorized acts:

- Graduates of US DPM programs who are practising in Ontario as chiropodists.
- Graduates of the podiatry program offered by the Université de Québec.
- All current or future graduates from podiatry programs in the United States or the Université de Québec.
- Registrants in the podiatrist class of members, albeit in many cases requiring "refresher" courses.

Q 24: *"Do members of the profession currently have the competencies to perform the proposed scope of practice? Does this extend to some or all of the members of the profession?"*

Response: About 15% of current registrants are judged to currently possess the competencies to perform all of the proposed new or expanded authorized acts. This compares very favourably to the percentage of dental hygienists currently performing "scaling, root planing and curettage" without a dentist's order and the percentage of physiotherapists who have registered to perform "expanded practice physiotherapy" roles under the scope of practice expansion that came into effect in 2010. As averred elsewhere in this Application, the education and training of current registrants now spans a wide range. Following the precedent of other professions that have gone through scope of practice expansions, the College proposes that the performance of any of the new or expanded authorized acts not be mandatory for existing registrants who would be grand-parented into the proposed new College. The same would apply to graduates of the Michener chiropody program who registered in the program prior to the proposed scope of practice changes coming into effect. Grand-parented practitioners who wish to perform any or all of the proposed new or expanded authorized acts would have to demonstrate to the College that they have the competencies to do so safely and effectively. Again, following the precedent of other professions that have gone through scope of practice expansions, the College will

create a publicly-available roster of those practitioners who have been deemed by the College as competent to perform the authorized acts . The roster would list those practitioners on an authorized act-by-authorized act basis.

For purposes of the “Gap Analysis” conducted by PES, current registrants were divided by PES into six cohorts and PES determined the competencies of members of each cohort to perform the proposed additional and expanded authorized acts. The full PES report is reproduced at Appendix A. In summary PES made the following determinations:

- The 85 College registrants who graduated from US DPM programs are assumed to have received the training necessary to perform the expanded scope of practice. Nevertheless, although they may have acquired these competencies as part of their DPM education, some have not exercised those competencies for a considerable period of time because of the limited scope of practice in Ontario. Those individuals, including those who have graduated since 1995, will require refresher or upgrading programs should they choose to perform any or all of the proposed authorized acts.
- The 20 practitioners who graduated from DPM programs since 1993 but practise as chiropodists have the competencies to perform all of the proposed new and expanded authorized acts.
- The single practitioner who graduated from the DPM program at the Université de Québec has the competencies to perform all of the proposed new and expanded authorized acts.
- The George Brown/Michener programs have gone through many changes in terms of curriculum length and content over the past 30 years. Any of the graduates of those programs who are current registrants of the College and who wish to perform any or all of the proposed expanded or new authorized acts will require some bridging programs.
- There are currently 43 registrants who are graduates of education programs outside of North America (i.e. the UK, Australia and South Africa). The multiplicity of programs from which these registrants graduated made it impossible for PES to reach any uniform or general conclusions. In order to practise any or all of the proposed authorized acts the College will evaluate each practitioner individually and practitioners may require at least refresher programs and perhaps a bridging program as well.

As indicated elsewhere, there is a substantial number of Ontario residents, or former Ontario residents, who have obtained DPM degrees and are practising podiatry elsewhere than Ontario. There are also roughly seven Ontario residents currently enrolled in DPM programs in Québec or the US. The currently-limited scope of practice discourages many from contemplating a return to Ontario to practise. Should

the scope of practice be expanded as proposed in this Application, however, the College anticipates that a significant number of these practitioners and graduates will return to Ontario. Those returnees will be fully competent to perform all of the proposed new and expanded authorized acts. Perhaps as validation, the College notes that 18 DPM graduates have applied for registration in Ontario over the last six months, likely in anticipation of removal of the podiatric cap and the launch of a scope of practice more reflective of their competencies and practice aspirations.

The PES report provides the foundation for the design of refresher and competency programs. It is the College's clear preference that any refresher or bridging programs be reasonably available to grand-parented registrants in Ontario. To that end, the College has initiated discussions with a number of universities. Those discussions have been somewhat hampered by, and no conclusions have been reached because of, the podiatric cap. Unless and until there is a reasonably clear signal that the podiatric cap is to be revoked, educational institutions are very reticent to engage in such discussions, let alone provide any commitments.

Q 25: *"What effect will the proposed change in scope of practice have on members of your profession who are already in practice? How will they be made current with the changes, and how will their competency be assessed? What quality improvement/quality measurement programs should or will be put into place? What educational bridging programs will be necessary for current members to practise with the proposed scope?"*

Response: The College proposes that current registrants not be obligated to acquire the competencies to perform any or all of the proposed authorized acts. Those grand-parented registrants who elect to perform any or all of the authorized acts would have to demonstrate to the College that they have, or have acquired, the competencies to do so safely and effectively. Nonetheless, the College anticipates that patient expectations, clinical best practices and competitive considerations will prompt practitioners to acquire those competencies in order to provide a more extensive and seamless continuum of care. Each individual registrant will continue to be governed by the College's professional misconduct regulation obliging them to have the knowledge, skill and judgment to perform any controlled act safely and effectively. As it has already done with its drug regulation, the College will be vigilant in its communications and in its quality assurance mechanisms to ensure that only fully competent practitioners are performing the podiatry authorized acts.

As indicated elsewhere, many of those practitioners currently practising as chiropodists (except for those who have DPM degrees) would require bridging courses before practising any of the new authorized acts. Many members of the podiatrist class would require some form of refresher courses. Also, as indicated elsewhere in this Application, the College has initiated discussions with academic institutions in Ontario to provide the requisite bridging/refresher courses and to make those programs reasonably available to those grand-parented registrants who wish to take them.

Q 26: *"How should the College ensure that members maintain competence in this area? How should the College evaluate the membership's competence in this area? What additional demands might be put on the profession?"*

Response: The College intends to benefit from the experience of other Colleges that have recently gone through analogous scope of practice changes and has already initiated discussions with Colleges to that end. As explained elsewhere in this Application, the approach being recommended by the College is for current members of the College of Chiropodists to be automatically grand-parented into the College of Podiatrists, but their performance of any of the new or expanded authorized acts will not be mandatory. The same would apply to students of the Michener Institute who are in train at the time the new legislation is proclaimed. The College would attach terms, conditions and limitations to grand-parented registrants' registrations prohibiting them from performing any of the new or expanded authorized acts for which they had not demonstrated requisite competencies to the College's satisfaction. Otherwise, applicants for new registration would have to satisfy the competency criteria to perform all of the authorized acts.

The College believes that its long history of effective regulation, which the Ministry has endorsed, demonstrates the College's ability and commitment to ensuring that its members are fully competent to practise safely and effectively.⁷¹ Much can be learned and adapted from the many podiatry professional regulators in Canada and the United States that have regulated similar podiatry scopes of practice for considerable periods of time. The Professional Examination Services' Report provides a good start in terms of defining the competency gap and the bridging or refresher requirements for current registrants. Other Ontario Colleges have gone through similar scope of practice enhancements (e.g. College of Physiotherapists) and the College has reached out to them to learn from their experience. Furthermore, the College will expend best efforts to have upgrading and refresher courses launched in Ontario, along with a full-time, university-level podiatry program that is accredited by the CPME.

Q 27: *"Describe any obligations or agreements on trade and mobility that may be affected by the proposed change in scope of practice for the profession. What are your plans to address any trade/mobility issues?"*

Response: The chiropody model as it currently exists in Ontario and the "podiatric cap" in the *Chiropody Act*, create insurmountable impediments to inter-jurisdictional mobility for both podiatrists and chiropodists. Primarily because of the podiatric cap, but also because of the chiropody curriculum at the Michener Institute, chiropody and podiatry are the only regulated healthcare professions in Canada that have been unable to sign a Mutual Recognition Agreement (MRA) under the Agreement on Internal Trade (AIT) with other provinces and territories. Ontario residents who have graduated from DPM programs since 1993 have also been prohibited from returning to practise in Ontario as podiatrists.

⁷¹ Letter from the Minister of Health and Long-Term Care (Ms. Mathews) to HPRAC, June 24, 2011.

The podiatric cap has also been the principal impediment to listing podiatrists (or chiropodists) in the Medical/Allied Professions category of Appendix 1603.D. 1 pursuant to Section D of Annex 1603 of the North American Free Trade Agreement.

The podiatric cap is also in conflict with the Government of Canada's policies and commitments with respect to foreign credential recognition.

The College's legal advice, furthermore, is that the podiatric cap contravenes at least the spirit of the *Fair Access to Regulated Professions Act*.

Accordingly, conversion to a podiatry model as proposed by the Applicant will remove these impediments, bring the profession into compliance with the *Fair Access to Regulated Professions Act*, open the way to the execution of an MRA under the AIT and facilitate the inter-jurisdictional mobility of practitioners.

Foreign Credential Recognition

"Internationally-trained workers help fill skills shortages in key occupations and make important contributions to Canada's economy. That's why attracting and recruiting the best international talent is critical to Canada's long-term success..."

The Government of Canada is committed to streamlining foreign credential recognition so that skilled workers are able to find meaningful work that contributes to Canada's economy and overall prosperity".

-Employment and Social Development Canada

Q 28: "How do you propose to educate or advise the public of this change in scope of practice?"

Response: The College would have a multifaceted communications plan ready to launch when the necessary legislation is close to Proclamation. Part of the communications plan would consist of a five-pronged external communications strategy:

- 1. Prong #I:** Intra-Professional Communication to advise foot health professionals, chiropodists and podiatrists plus peer groups such as orthopaedic surgeons, vascular surgeons, rheumatologists, family physicians, nurses, etc. of the changes and their implications.
- 2. Prong #II:** Healthcare sector Advocacy Groups that have been part of driving the demand for the scope changes to improve access, efficacy and outcomes of foot health for seniors, diabetics, arthritis sufferers, sport and occupational injuries, etc. will be advised promptly of the implications of the scope changes and what they will mean to the groups of healthcare consumers they represent.

3. **Prong #III:** The general public needs to learn about the changes and benefits as quickly as possible and over a sustained period to ensure the messages are received. This will allow members of the public to take full advantage of the improved quality of care, improved choice and access and improved continuum of outcomes experienced as tools to managing chronic conditions such as diabetes, arthritis, circulatory challenges from heart and other conditions while gaining mobility.
4. **Prong #IV:** Message champions and communication channels such as media, family practice and physician offices, hospital and healthcare waiting rooms, health centres, walk-in clinics and a variety of social media portals linked to stakeholder groups will be provided with the news of the changes and the impacts.
5. **Prong # V:** Leading up to proclamation of the new legislation, the College will communicate the new entry to practice requirements to podiatry and chiropody educational programs in other countries and advise chiropody and podiatry regulators and professional associations of the scope of practice and entry to practice requirements. The resources and networks of organizations such as the International Federation of Podiatrists/Fédération Internationale des Podologues (FIP) would be used to whatever extent can be negotiated.

The communication tactics to be applied throughout the implementation of the five-phased plan will include:

- Use of the College website and public information section;
- Partnering with interested groups, such as CARP/Zoomer, the Canadian Diabetes Association, the Ontario Association of Non-Profit Homes and Services for Seniors and the Arthritis Association to get the message out;
- Use of the College's portal for chiropodists and podiatrists on the HPRAC Review and scope of practice topics to provide tools to registrants to communicate the changes and their implications to their patients;
- Information flyer for posting on community billboards in libraries and community centres;
- Digital posting through Rogers and Shaw electronic community information boards via regional community cable TV;
- Information packages to healthcare reporters, editors, publishers;
- Public awareness campaign using print and broadcast ads to major outlets across Ontario;

- PSAs (Public Service Announcements) to community newspapers and other outreach;
- Brochures for distribution to College registrants for use in their practice settings;
- Information to other healthcare professional groups;
- Information to long-term care facilities, retirement homes, CCACs, providers of supports and services for seniors, school boards and institutional channels; and,
- Dialogue and follow-up with specific risk population groups such as provincial not-for-profit organizations dedicated to diabetes and other key conditions in which good foot health promotes better overall health outcomes.

Q 29: *"What is the experience in other Canadian jurisdictions? Please provide copies of relevant statutes and regulations."*

Response: Podiatry and/or chiropody are statutorily regulated in all Canadian provinces except Nova Scotia, Prince Edward Island and Newfoundland and Labrador. In New Brunswick (no more than 15 practitioners) the legislation delegates regulation of the profession to the professional association. In the remaining provinces "colleges" analogous to RHPA Colleges exist, although the structure and terminology pertaining to scopes of practice and authorized acts and the legislative frameworks vary materially.

Over the last 20 years or so, the "podiatrist/podiatry" title and professional designations have been adopted by all provinces except Ontario. Alberta and British Columbia manifest the North American podiatry model. Québec is somewhere between the UK chiropody model and the North American podiatry model. Saskatchewan and Manitoba manifest the UK chiropody model, although the College has been given to understand that Manitoba would like to adopt the North American podiatry model.

DPM graduates are eligible to practice the profession in all regulated provinces. Only graduates of DPM programs are eligible to register to practise the profession in British Columbia, Alberta and Québec. Graduates of DPM programs and baccalaureate and diploma-level programs in chiropody and podiatry accredited by the respective regulatory bodies are eligible to practise the profession in Saskatchewan, Manitoba and New Brunswick.

Alberta

Titles: "Podiatrist", "podiatric surgeon", "doctor of podiatric medicine", "podiatric physician", "DPM", "Dr." "doctor" (Section 14 of the *Podiatrist Profession Regulation*, Alberta Regulation 60/2012)

Regulation/Registration for Podiatrists: College of Podiatric Physicians of Alberta

Scope of Practice:

- Diagnose and treat ailments, diseases, deformities and injuries of the human foot and ankle, including the articulation of the tibia and fibula and those muscles and tendons directly affecting foot function, including the employment of preventive measures and the use of medical, physical or surgical methods but not including treatment of systemic disease, except the local manifestations in the foot,
- Engage in research, education and administration with respect to health, and
- Provide restricted activities authorized by the regulations.

"Restricted" Acts (Section 15):

Bone and soft tissue surgery;

- Set or reset a bone fracture;
- Reduce a dislocation of a joint;
- Administer vaccine;
- Prescribe or administer nitrous oxide for anesthesia or sedation;
- Order or apply any form of ionizing radiation in medical radiography nuclear medicine;
- Order or apply forms of nonionizing radiation (e.g. MRI, ultrasound).

Health Professions Act PODIATRIST PROFESSION REGULATION Alberta Regulation 60/2012

Authorization to use titles

14(1) A regulated member registered on the general register or courtesy register may use the following titles, abbreviations and initials:

- (a) podiatrist;
- (b) podiatric surgeon;
- (c) doctor of podiatric medicine;
- (d) podiatric physician;
- (e) D.P.M.;
- (f) doctor;
- (g) Dr.

(2) A regulated member registered on the provisional register may use the following titles, abbreviations and initials:

- (a) podiatrist;
- (b) doctor of podiatric medicine;
- (c) podiatric physician;
- (d) D.P.M.;
- (e) doctor;
- (f) Dr.

(3) A regulated member registered on the general register or courtesy register may use the title "specialist" if the regulated member

(a) meets the requirements established by the Council for the use of the title specialist, and

(b) is authorized by the Registrar to use that title.

Restricted activities

15(1) A regulated member registered on the general register, courtesy register or provisional register may, in the practice of podiatry and in accordance with the standards of practice, perform the following restricted activities for the purpose of diagnosing and treating ailments, diseases, deformities and injuries of the human foot and ankle:

(a) to cut a body tissue, to administer anything by an invasive procedure on body tissue or to perform surgical or other invasive procedures on body tissue;

(b) to set or reset a fracture of a bone;

(c) to reduce a dislocation of a joint;

(d) to prescribe a Schedule 1 drug within the meaning of the *Pharmacy and Drug Act*;

(e) to dispense, compound, provide for selling or sell, incidentally to the practice of podiatry, a Schedule 1 drug or Schedule 2 drug within the meaning of the *Pharmacy and Drug Act*;

Authorized Drugs:

- Subject to the *Controlled Drugs and Substances Act*, a podiatrist may purchase and supply to the podiatrist's patients only those drugs, chemicals and compounds that are authorized by the Lieutenant Governor in Council and may prescribe those authorized drugs, chemicals or compounds for compounding under the direction of a pharmacist or restricted practitioner under the *Pharmaceutical Profession Act*.

For a complete list of Schedule I and II Drugs see <http://cocoohprac.wildapricot.org/resources/Fo%20Links%20ONLY%20-%20No%20Portal%20Access/Provincial%20Drug%20Lists.pdf>.

British Columbia

Titles: "Podiatrist, Podiatric Surgeon", "surgeon", "doctor". (Subsection 3 (1) Podiatrists Regulation, BC Regulation 2014 2010)

Regulation/Registration Podiatrists: College of Podiatric Surgeons of British Columbia.

Scope of Practice: A registrant may practise podiatric medicine.

Authorized Acts/Restricted Activities:

A registrant in the course of practising podiatric medicine may do any of the following:

- make a diagnosis identifying, as the cause of signs or symptoms of the individual, a disease, disorder or condition of the foot or lower leg;
- perform a procedure on tissue below the dermis of the foot or lower leg;

Health Professions Act PODIATRIST PROFESSION REGULATION Alberta Regulation 60/2012 – CONT'D

(f) to administer a vaccine;

(g) to prescribe or administer nitrous oxide gas for the purposes of anaesthesia or sedation;

(h) to order any form of ionizing radiation in medical radiography and nuclear medicine;

(i) to apply any form of ionizing radiation in medical radiography;

(j) to order any form of non-ionizing radiation in magnetic resonance imaging or ultrasound imaging;

(k) subject to subsection (2), to apply any form of non-ionizing radiation in ultrasound imaging.

(2) No regulated member shall perform the restricted activity described in subsection (1)(k) in respect of a fetus.

For the complete Act please visit:

http://www.qp.alberta.ca/documents/Regs/2012_060.pdf

B.C. Reg. 214/2010 M195/2010 (British Columbia)

Health Professions Act PODIATRISTS REGULATION

Definitions

1 In this regulation:

"**Act**" means the *Health Professions Act*;

"**compound**" means to mix with one or more other ingredients;

"**dispense**" has the same meaning as in the *Pharmacy Operations and Drug Scheduling Act*, but excludes a sale, as defined in that Act;

"**podiatric medicine**" means the health profession in which a person provides the services of prevention, treatment and palliation of diseases, disorders and conditions of

(a) the foot, and

(b) the bones, muscles, tendons, ligaments and other tissues of the lower leg that affect the foot or foot function,

but does not include any treatment of the foot or lower leg that may affect the course of treatment of a systemic disease unless the treatment of the foot or lower leg is provided in collaboration with a medical practitioner;

"**prescribe**" means to issue a "prescription" as defined in the *Pharmacy Operations and Drug Scheduling Act*.

- set or cast a fracture of a bone of the foot or lower leg;
- reduce a dislocation of a joint of the foot or lower leg;
- administer intravenous fluids by injection;
- for the purpose of arthroscopic surgery of the ankle, put an instrument or a device, hand or finger into an artificial opening into the body;
- apply
 - (i) laser, for the purpose of cutting or destroying tissue, or
 - (ii) X-rays, for diagnostic or imaging purposes, excluding X-rays for the purpose of computerized axial tomography;
- issue an instruction or authorization for another person to apply, to a named individual,
 - (i) ultrasound for diagnostic or imaging purposes, excluding any application of ultrasound to a fetus,
 - (ii) electromagnetism for the purpose of magnetic resonance imaging, or
 - (iii) X-rays for diagnostic or imaging purposes, including X-rays for the purpose of computerized axial tomography;
- in respect of a drug specified in Schedule I or II of the Drug Schedules Regulation, B.C. Reg. 9/98,
 - (i) prescribe the drug,
 - (ii) compound the drug,

**B.C. Reg. 214/2010
M195/2010 (British Columbia) – CONT'D**

College name

2 The name "College of Podiatric Surgeons of British Columbia" is the name of the college established under section 15 (1) of the Act for podiatric medicine.

Reserved titles

3 (1) The following titles are reserved for exclusive use by registrants:

- (a) podiatrist;
- (b) podiatric surgeon;
- (c) surgeon;
- (d) doctor.

(2) This section does not prevent a person from using

- (a) the title "doctor" or "surgeon" in a manner authorized by another enactment that regulates a health profession, or
- (b) an academic or educational designation that the person is entitled to use.

Scope of practice

4 A registrant may practise podiatric medicine.

Restricted activities

5 (1) A registrant in the course of practising podiatric medicine may do any of the following:

- (a) make a diagnosis identifying, as the cause of signs or symptoms of the individual, a disease, disorder or condition of the foot or lower leg;
- (b) perform a procedure on tissue below the dermis of the foot or lower leg;
- (c) set or cast a fracture of a bone of the foot or lower leg;
- (d) reduce a dislocation of a joint of the foot or lower leg;
- (e) administer intravenous fluids by injection;
- (f) for the purpose of arthroscopic surgery of the ankle, put an instrument or a device, hand or finger into an artificial opening into the body;
- (g) apply
 - (i) laser, for the purpose of cutting or destroying tissue, or
 - (ii) X-rays, for diagnostic or imaging purposes, excluding X-rays for the purpose of computerized axial tomography;
- (h) issue an instruction or authorization for another person to apply, to a named individual,
 - (i) ultrasound for diagnostic or imaging purposes, excluding any application of ultrasound to a fetus;
 - (ii) electromagnetism for the purpose of magnetic resonance imaging, or
 - (iii) X-rays for diagnostic or imaging purposes, including X-rays for the purpose of computerized axial tomography;

- (iii) dispense the drug, or
- (iv) administer the drug by any method;
- conduct challenge testing for allergies
 - (i) that involves injection, scratch tests or inhalation, if the individual being tested has not had a previous anaphylactic reaction, or
 - (ii) by any method, if the individual being tested has had a previous anaphylactic reaction.

Authorized Drugs:

In respect of a drug specified in Schedule I or II of the *Drug Schedules Regulation, B.C. Reg. 9/98*, a Podiatrist may;

- (i) prescribe the drug,
- (ii) compound the drug,
- (iii) dispense the drug, or
- (iv) administer the drug by any method.

For a complete list of Schedule I and II Drugs see <http://cocoohprac.wildapricot.org/resources/For%20Links%20ONLY%20-%20No%20Portal%20Access/Provincial%20Drug%20Lists.pdf>.

Saskatchewan**

Titles: “Podiatrist” and “Podiatric Surgeon”

Regulation/Registration for Chiropodists/Podiatrists:

Saskatchewan College of Podiatrists (SCOP)

Scope of Practice: Podiatry is defined as the primary healthcare discipline concerned with the diagnosis

**B.C. Reg. 214/2010
M195/2010 (British Columbia) – CONT’D**

(i) in respect of a drug specified in Schedule I or II of the Drug Schedules Regulation, B.C. Reg. 9/98,

- (i) prescribe the drug,
- (ii) compound the drug,
- (iii) dispense the drug, or
- (iv) administer the drug by any method;

(j) conduct challenge testing for allergies

(i) that involves injection, scratch tests or inhalation, if the individual being tested has not had a previous anaphylactic reaction, or

(ii) by any method, if the individual being tested has had a previous anaphylactic reaction.

(2) Only a registrant may provide a service of podiatric medicine as set out in this regulation if, on the day before this section comes into force, the provision of the same service by anyone other than a person authorized under the *Podiatrists Act* was prohibited.

For the complete Act please visit:

<http://www.bclaws.ca/civix/document/id/complete/statreg/538573145>

The Podiatry Act (Saskatchewan)

COLLEGE

Association continued as college

3 The Saskatchewan Association of Chiropodists is continued as a corporation to be known as the Saskatchewan College of Podiatrists.

PROHIBITION

Protection of title

21(1) Subject to subsection (2), no person other than a member shall use the title “Podiatrist” or “Chiropodist” or any word, title or designation, abbreviated or otherwise, to imply that the person is a member.

(2) A podiatric surgeon who is registered pursuant to section 42.1 of The Medical Profession Act, 1981 may use the title “Podiatrist”.

Use of title “Doctor”

22(1) A member may use the title “Doctor” but only in conjunction with the word “podiatrist”, “podiatry”, “chiropodist” or “chiropody” to indicate clearly that the member is not a physician or podiatric surgeon within the meaning of The Medical Profession Act, 1981.

(2) Clause 80(1)(c) of The Medical Profession Act, 1981 does not apply to a member who uses the title “Doctor” in accordance with subsection (1).

and treatment of disorders and injuries and anatomic defects of the human foot.

Authorized Acts: Podiatry primarily concerns itself with the diagnosis and treatment of diseases and disorders of the skin and nails of the human foot, local manifestations of systemic diseases in the human foot and underlying foot pathomechanics and gait anomalies. "Podiatric Surgeons" may be authorized by the Saskatchewan College of Physicians and Surgeons to be registered as Podiatric Surgeons by the College of Podiatrists and authorized to perform within a scope of practice defined by the College of Physicians and Surgeons. [Subsection 42. 1, *Medical Profession Act*, 1981, as amended.] It is the College's understanding that no member of the College of Podiatrists has, in fact, registered as a "Podiatric Surgeon".

Authorized Drugs: Currently no prescribing or diagnostic rights exist for Podiatrists within this province as those authorities in the *Podiatry Act* have not yet been proclaimed.

**Note: The Saskatchewan Government decided not to embed scopes or "controlled acts" in individual professions' acts. It was determined that the overlaps in professional scopes obviated the need for statutory definition. All of the definitions provided in this section are from the Saskatchewan College of Podiatrists' Regulatory By-Laws.

Manitoba

Titles: "Podiatrist", "Chiroprapist"

Regulation/Registration for Chiroprapists/Podiatrists: College of Podiatrists of Manitoba

Scope of Practice:

- The practice of podiatry is the use of medical, physical or surgical methods to prevent, diagnose and treat ailments, diseases, deformities and injuries of the human foot, but does not include treatment of systemic disease, except for the local manifestations in the foot.

For purposes of the *Podiatrists Act*, the foot is described as including the articulation of the tibia and fibula with the bones of

The Podiatry Act (Saskatchewan) – Cont'd

SASKATCHEWAN COLLEGE OF
PODIATRISTS — REGULATORY BYLAWS
INTERPRETATION

Section 19 Interpretation
In these bylaws,

(1) Act means *The Podiatry Act*

(2) Podiatry is defined as the primary health care discipline concerned with the diagnosis and treatment of disorders and injuries and anatomic defects of the human foot.

(3) Podiatry primarily concerns itself with the diagnosis and treatment of diseases and disorders of the skin and nails of the human foot, local manifestations of systemic diseases in the human foot and underlying foot pathomechanics and gait anomalies.

For the complete Act please visit:

<http://www.qp.gov.sk.ca/documents/English/Statutes/Statutes/P14-1.pdf>

For the complete Bylaw please visit:

<http://www.qp.gov.sk.ca/documents/Bylaws/SCOP/February9,2007.pdf>

C.C.S.M. c. P93 The Podiatrists Act (Manitoba)

Practice of podiatry

2(1) The practice of podiatry is the use of medical, physical or surgical methods to prevent, diagnose and treat ailments, diseases, deformities and injuries of the human foot, but does not include treatment of systemic disease, except for the local manifestations in the foot.

Foot includes articulation and muscles and tendons

2(2) For the purpose of this Act, the human foot includes the articulation of the tibia and fibula with the bones of the foot and the muscles and tendons directly affecting foot function.

Included practices

2(3) Subject to the regulations, in the course of practising podiatry, a podiatrist may
(a) cut into the subcutaneous, ligamentous, and bony tissues of the foot and the tendons directly affecting the function of the foot;
(b) inject substances into the foot; and
(c) prescribe drugs.

Representation as a podiatrist

3(1) No person except a podiatrist shall
(a) represent or hold out, expressly or by implication, that he or she is a podiatrist or is entitled to engage in the practice of podiatry as a podiatrist; or
(b) use any sign, display, title or advertisement implying that he or she is a podiatrist.

the foot and the muscles and tendons directly affecting foot function.

Authorized Acts:

- Subject to the regulations, in the course of practising podiatry, a podiatrist may:
 - a) Cut into the subcutaneous, ligamentous, and bony tissues of the foot and the tendons directly affecting the function of the foot;
 - b) Inject substances into the foot; and
 - c) Prescribe drugs.

Podiatrists authorized to perform surgical procedures must be listed in a separate College register.

Authorized Drugs:

- Under *the Podiatrists Act* of Manitoba, podiatrists have prescribing rights, subject to regulations. At this time no such regulations exist and, accordingly, podiatrists in Manitoba may not prescribe.

Québec

Titles: "Podiatrist"

Regulation/Registration for Podiatrists: Ordre des Podiatres du Québec

Scope of Practice:

- Every act which has as its object the treatment of local disorders of the foot which are not systemic diseases constitutes the practice of podiatry.

C.C.S.M. c. P93 The Podiatrists Act (Manitoba) – Cont'd

Use of title

3(2) No person except a podiatrist shall use the title "podiatrist" or "chiroprapist", a variation or abbreviation of that title, or an equivalent in another language.

Use of title "Doctor"

3(3) A podiatrist registered under this Act may display or make use of the title "Doctor" or the abbreviation "Dr.", provided it is used in connection with the word "podiatrist", clearly indicating that he or she is not a physician within the meaning of *The Medical Act*.

PART 3

COLLEGE OF PODIATRISTS OF MANITOBA

College established

4(1) The Association of Chiroprapists is continued as a body corporate under the name College of Podiatrists of Manitoba.

For the complete Act please visit:

<http://web2.gov.mb.ca/laws/statutes/ccsm/p093e.php>

PODIATRY ACT (QUEBEC)

DIVISION II

THE ORDRE DES PODIATRES DU QUÉBEC

2. All the persons qualified to practise podiatry in Québec constitute a professional order called the "Ordre professionnel des podiatres du Québec" or the "Ordre des podiatres du Québec".

1973, c. 55, s. 2; 1977, c. 5, s. 229; 1994, c. 40, s. 438.

3. Subject to this Act, the Order and its members shall be governed by the Professional Code.

DIVISION IV

PRACTICE OF PODIATRY

7. Every act which has as its object the treatment of local disorders of the foot which are not systemic diseases constitutes the practice of podiatry.

1973, c. 55, s. 7.

8. A podiatrist may determine the podiatric treatment indicated, by clinical and radiological examination of the feet.

However, a podiatrist shall not make radiological examinations unless he holds a radiology permit issued in accordance with section 187 of the Professional Code.

1973, c. 55, s. 8.

11. Every podiatrist is authorized to use the medications which he may need in the practice of his profession, and to administer and prescribe medications to his patients, provided that they are medications contemplated by the regulations made under section 12.

He may also issue attestations relating to the supplying of such medications.

1973, c. 55, s. 11.

Authorized Acts:

- A podiatrist may determine the podiatric treatment indicated, by clinical and radiological examination of the feet. However, a podiatrist shall not make radiological examinations unless he holds a radiology permit issued in accordance with section 187 of the Professional Code. Podiatrists are authorized to prescribe and use the medications which they may need in the practice of their profession and to administer and prescribe medications to their patients, provided that they are medications contemplated by the regulations.

Authorized Drugs:

- Podiatrists may use in the practice of their profession or administer or prescribe to their patients the medications listed in Schedule I and II of the *Regulation on Medicines a Podiatrist may use in the Exercise of his Profession or Administer or Prescribe to his Patients*.

For a complete list of Schedule I and II Drugs see <http://cocoohprac.wildapricot.org/resources/For%20Links%20ONLY%20-%20No%20Portal%20Access/Provincial%20Drug%20Lists.pdf>.

New Brunswick

[The College admits to experiencing some difficulty in obtaining information pertaining to the practise of podiatry in New Brunswick and despite expending best efforts to do so, cannot guarantee the accuracy of the information provided below.]

Titles: "Podiatrist", "Chiropodist", "Dr.", "Doctor"

Regulation/Registration for Chiropodists/Podiatrists:

New Brunswick Podiatry Association.

PODIATRY ACT (QUEBEC) – CONT'D

12. The Office des professions du Québec shall prepare periodically, by regulation, after consultation with the Institut national d'excellence en santé et en services sociaux, the Ordre des podiatres du Québec, the Ordre des médecins du Québec and the Ordre des pharmaciens du Québec, a list of the medications which a podiatrist may use in the practice of his profession or which he may administer or prescribe to his patients, and determine, where required, the conditions subject to which a podiatrist may administer and prescribe such medications.

1973, c. 55, s. 12; 1974, c. 65, s. 109; 1977, c. 5, s. 14, s. 229; 1989, c. 30, s. 2; 2002, c. 27, s. 41; 2010, c. 15, s. 74.

13. No podiatrist may sell orthopaedic shoes or prostheses.

Nor may a podiatrist have a direct or indirect interest in an undertaking for the manufacture or sale of orthopaedic shoes or prostheses. If an interest in such an undertaking devolves to him by succession or otherwise, he shall dispose of it immediately.

However, a podiatrist is authorized to manufacture, transform, alter or sell podiatric orthoses even if the podiatrist does not hold a permit issued under the Act respecting medical laboratories, organ and tissue conservation and the disposal of human bodies (chapter L-0.2).

For the complete Act please visit:

http://www2.publicationsduquebec.gouv.qc.ca/dynameSearch/telecharge.php?type=2&file=/P_12/P12_A.html

ACTS OF NEW BRUNSWICK 2005

CHAPTER 35

An Act to Amend An Act Respecting Podiatry

"podiatrist" means a person who holds a current certificate of membership in the association and is certified to practice podiatry, chiropody, acupuncture of the foot and massage in connection therewith.

(b) by repealing subsection (2) and substituting the following:

2(2) The practice of podiatry does not include amputation of, or treatment of, or injuries to, or infection of the hands or fingers.

For the complete Act please visit:

<http://www.gnb.ca/0062/acts/BBA-2005/Chap-35.pdf>

Scope of Practice:

"Podiatrists" is defined as a person who holds a current certificate of membership in the Association and is certified to practice podiatry, chiropody, acupuncture the foot and massage in connection there with. The practice of podiatry does not include amputation of or treatment of or injuries to or infections of the hands or fingers.

Indications from the New Brunswick Department Health indicate that New Brunswick podiatrists are very limited in the surgical procedures they may perform, are not authorized to prescribe, dispense or administer drugs nor to order diagnostic tests.

Q 30: *"What is the experience in other International jurisdictions?"*

Response: In most developed nations there exists a health profession specifically concerned with or specializing in pedal health. At the risk of oversimplification, the UK's chiropody model was the original model and many jurisdictions' pedal health model (including Ontario's) reflect a direct lineage from that model. The US' pedal health was originally based on the UK chiropody model, but in the latter half of the 20th century the US model changed significantly into what became known as a podiatry model. That podiatry model now predominates in North American jurisdictions and for that reason it is referred to as the "North American podiatry model". Nevertheless, many countries in Europe and elsewhere have adopted the North American podiatry model, or have moved or are moving towards it.

Nomenclature, however, can be very confusing. For several decades, the pronounced trend worldwide has been to adopt the "podiatry" and "podiatrist" descriptors and titles, but a "podiatry" designation doesn't necessarily equate with a North American-style podiatry scope of practice and competencies. For example, the professions in Manitoba and Saskatchewan are called "podiatry" and the practitioners are called "podiatrists", but the scope of practice is more reflective of the UK chiropody model. Since circa 1994, "chiropody" and "podiatry" and "chiropodist" and "podiatrist" have been used interchangeably in the UK for what is really the traditional chiropody scope of practice.

Comparing and Contrasting the UK Chiropody/Podiatry and North American Podiatry Models

As related in the FORWARD to this Application, the essential differences between the two models can be characterized as follows:

- The North American podiatry model emphasizes the advanced medical diagnostic, non-surgical and surgical components of the footcare scope of practice. The UK chiropody model includes limited surgical procedures below the dermis and focuses on the nonsurgical treatment of conditions.

- The UK chiropody model focuses largely on the foot. The North American podiatry model includes the ankle, as well as the foot, and in some jurisdictions podiatrists are authorized to diagnose and treat conditions of the lower leg and other parts of the anatomy as well.
- The UK chiropody model does not include bone surgery; the North American podiatry model does.
- The practice venue for the UK chiropody model tends to be multidisciplinary and institution-based, although many chiropodists practise in other delivery streams. The practice venue for the North American podiatry model tends to be non-institutional podiatry or multidisciplinary clinics, surgical centres and wound care clinics and many podiatrists also have hospital privileges.
- The UK chiropody model does not include the ability to prescribe drugs or order diagnostic tests independently. The North American podiatry model includes the independent prescription of drugs, including narcotics and other controlled substances and the ordering of a full range of diagnostic tests commensurate with the scope of practice.
- The education programs under the UK chiropody model tend to be three-year diploma or baccalaureate programs, reflecting the chiropody scope of practice. The educational programs for the North American podiatry model tend to be four-year, post baccalaureate programs, followed by one year of hospital-based general residency, perhaps followed by another year or more of surgical residency.

Over the last several decades the titles and professional descriptors, "podiatrist" and "podiatry" have replaced, or are replacing, "chiropodist" and "chiropody". (Since 1994, the chiropody and podiatry titles have been interchangeable in the UK, but the podiatry title has become predominant. In the UK, the "chiropodist" title tends to be used by the older cohort of practitioners.) As indicated earlier, jurisdictions' adoption of the "podiatry" professional title and descriptor has not necessarily been accompanied by scope of practice changes. Sometimes the "podiatry" title has simply been superimposed on a chiropody scope of practice. More frequently, the adoption of the "podiatry" title has coincided with or has been prompted by some expansion in scope of practice beyond the traditional UK chiropody model and towards the North American podiatry model. While the North American podiatry model has spread largely in its "pure" form in terms of the scope of practice and related competencies (Québec being a notable exception), the spread of the UK chiropody model has tended to include components of the North American podiatry scope of practice.⁷²The "pure" North American

⁷² McNevin, Anthony. "Report of the International Education and Research Subcommittee" *Federation Internationale Des Podologues (FIPS)*, May 2008. International Federation of Podiatrists: Publication.

model manifests the most extensive scope of practice in pedal health extant anywhere. 48 US States and the District of Columbia, the 31 Mexican states, Alberta and British Columbia have in place scopes of practice analogous to that being proposed for Ontario in this Application.

The Current State of Podiatry in the US

With roughly 15,000 practising Podiatrists, graduating primarily from nine US academic institutions, the US podiatrist to general population ratio is roughly 1:20,928.^{73, 74} The total student population in podiatry programs in the US is roughly 1,700 with an average annual intake between 550 and 600 students.⁷⁵ These students are full-time for four years, followed by a year's general residency, often followed by one or more years of surgical residency taken in both hospitals and private practices. Upon completion of the academic program, graduates are awarded the degree of Doctor of Podiatric Medicine/DPM. Podiatrists in the US may generally diagnose, assess and treat conditions of the foot and ankle through, among other things, both soft and bony tissue surgery. Nonetheless, the podiatry scope of practice often excludes amputations. This description is largely applicable for all American states, as podiatrists are licensed to practise in all 50 states, the District of Columbia and Puerto Rico. However, since rights are ascribed to them under the regulatory or credentialing body of their respective states, the scopes of practice vary somewhat among these jurisdictions. In all states, diagnosis and treatment of the foot are authorized, as is the prescription of drugs, including narcotics. Treating the ankle in addition to the foot is permitted in 44 states plus the District of Columbia, with two additional states, New York and Massachusetts, currently putting forward legislation to include the ankle.

The work of American podiatrists is primarily carried out in private practices, surgical centres and wound care clinics; however they also serve on staff in hospitals and long-term care facilities, in municipal health departments and as commissioned officers in the Armed Forces.⁷⁶ Podiatrists in the US are often

⁷³ "Public Data: Population." *Google: Search Public Data*. Google, US Census Bureau, 25 September 2013. Web. <https://www.google.ca/publicdata/explore?ds=kf7tgg1uo9ude_&met_y=population&hl=en&dl=en&idim=country:US#!ctype=l&strail=false&bcs=d&nslm=h&met_y=population&scale_y=lin&ind_y=false&rdim=country&idim=country:US&ifdim=country&hl=en_US&dl=en&ind=false>.

⁷⁴ "Profile of Podiatric Medicine Throughout the World: United States" International Federation of Podiatrists, May 2007. Web. <http://www.fip-ifp.org/index.php?option=com_content&view=article&id=90&Itemid=224>

⁷⁵ "Profile of Podiatric Medicine Throughout the World: United States" May, 2007.

⁷⁶ "What is Podiatry?" Virginia Podiatric Medical Association. Web. <<http://vpma.org/displaycommon.cfm?an=1&subarticlenbr=11>>

members of group practices in which they work alongside members of other professions. American podiatrists have independent prescribing rights and as such may prescribe on their own initiative. Furthermore, podiatrists are also able to set fractures, take and interpret x-rays and order laboratory and other diagnostic tests consistent with the scope of practice.

The UK Model

Because Ontario adopted the UK chiropody model in the late 1970s and that model persists under the *Chiropody Act, 1991*, the College spent considerable time analyzing the UK model as it currently exists and whether its continuance in Ontario would serve and protect the public interest.

FEETfirst Report 1994

The foundation for today's UK chiropody/podiatry model in part springs from a 1994 Report of the joint Department of Health and the National Health Service Chiropody Task Force, entitled "FEETfirst" (sic). Remarkably, that report deals with many of the issues with which HPRAC is currently grappling in the chiropody and podiatry review. For that reason, the College has provided a copy of the complete Report in Appendix C.

Among the particularly noteworthy components of the Report in the context of HPRAC's review are the following:

- The Task Force recognized that the terms "podiatrist" and "podiatry" are increasingly being used within the profession and parts of the National Health Service in preference to the older and more familiar terms of "chiropodist" and "chiropody" (Page 5)
- In assessing the need for footcare, the Task Force found, inter alia, that
"The aging of the population is the main factor increasing need for all healthcare, but this is particularly relevant for footcare services because such a high proportion of the service is provided for older people.

There is no evidence that the diseases which cause major foot problems--namely osteoarthritis, diabetes and peripheral vascular disease--will change significantly in the forthcoming decades, or that there will be any marked change in the age-specific incidence and prevalence of these conditions. However, need will increase not only because of population aging, but also because of technological developments, that are poised to increase the range of effective interventions for people with foot problems. If need is defined as a problem for which there is an effective intervention, the need for footcare will increase to a greater degree than would be predicted by population aging alone.

It can be expected that alongside an increase in need, demand for footcare services will increase as expectations rise. Those who will be elderly in the future will have higher expectations than those who are elderly today.

Furthermore, certain populations have a higher level of need--such as the homeless whose conditions may also be complicated by alcoholism--and the need for chiropody may be high in inner-city areas." (Page 8).

- There should be an increased emphasis on "closed loop" treatment, by ensuring that patients' footcare conditions are effectively treated within an "episode of care", which requires the engagement of all providers having the requisite expertise. This is instead of continuous, long-term (and expensive) footcare, where patients' symptoms are more or less effectively treated, but the causes, systemic or otherwise, are not resolved.
- The Task Force urged a reorientation and reorganization of the chiropody profession. The growth of "Surgical Podiatry" should be encouraged to address the growing demand for what the Task Force called "operative footcare". The Task Force recommended that surgical podiatrists "should work in close association with orthopedic surgeons, but have their own distinct professional contribution" (Page 11). Footcare assistants should be trained by chiropodists/podiatrists and should assist chiropodists/podiatrists in basic footcare in order to enhance chiropodists'/podiatrists' productivity.
- Chiropody/podiatry should be more integrated with other professions and in multidisciplinary treatment centres.

(i) Difficulties in Comparing the UK and Ontario Models

Before getting to its analysis of the UK model in its current state of development and the conclusions the College drew therefrom, it is important to emphasize that an "apples to apples" comparison proved to be very difficult for a number of reasons:

- The UK professional regulatory model administered by the Health and Care Professions Council (HCPC) is quite different from the RHPA model. There is equivalent title protection and the titles "chiropodist" and "podiatrist" are protected titles reserved for members of the profession who are in good standing with the HCPC. What we understand in Ontario as legislated "scopes of practice", however, are not prescribed, although there are "restricted acts" that are analogous to RHPA controlled acts. Instead, the HCPC approves educational programs and requires its registrants to practise within the limits of the knowledge, skills, training and experience they have acquired through those programs and through their clinical experience. Practitioners'

scopes of practice will, therefore, change over their careers due to additional clinical and didactic training, specializing and clinical experience.⁷⁷

- The UK chiropody/podiatry model is also in the process of evolution and has been for some time. The current status of the profession is somewhat short of the status recommended by "FEETfirst", for reasons that the College has been unable to discover. It is not possible to project where the UK model may end up in terms of what we understand to be the profession's scope of practice and authorized acts.
- Finally, accurate, consistent and up-to-date information about the practise and regulation of chiropody/ podiatry in the UK proved very difficult to come by. This was a cause of considerable frustration for the College. Even Professional Examination Service encountered difficulties in this regard.⁷⁸

Why the College Chose not to Pursue the UK Model

From the information and documentation the College was able to retrieve, cross-reference and verify from multiple sources in the UK, the College concluded that adoption of the UK chiropody/podiatry model, as currently practised in the UK, would constitute a very substantial backward step and would do nothing to address the service gaps and access issues in footcare the College and others have identified. More specifically:

- UK chiropodists/podiatrists as a profession may not yet independently order or take laboratory tests or diagnostic imaging, unless authorized by the policy of the service provider for which they are working. According to the HCPC "*... it would be unusual for chiropodists/podiatrists to be independently involved in making decisions about these kinds of diagnostic tests. They are decisions made by other members of the healthcare team (i.e. doctors, nurse practitioners)*".⁷⁹
- The situation with respect to chiropodists'/podiatrists' prescriber status is complicated. In 2003 chiropodists/podiatrists were granted "supplementary prescriber" status. As such, they may (if employed within the National Health Service) independently prescribe any medicine from the British national formulary (BNF), except controlled drugs, for any condition within their competence under an agreed clinical management plan. Clinical management plans are usually

⁷⁷ E-mail to Don Gracey, The CG Group, from Nicole Casey, Policy Manager, HCPC, November 5, 2014.

⁷⁸ Professional Examination Service, Final Report of the Competency Assessment Project for the College of Chiropodists of Ontario, February 19, 2013, page 20.

⁷⁹ E-mail to Don Gracey, The CG Group, from Michael Guthrie, Director of Policy and Standards, HCPC, October 29, 2014.

devised by General Practice physicians and dentists who have independent prescriber status.⁸⁰ In 2012, the applicable law was amended to authorize chiropodists/podiatrists who have successfully completed a post-graduate pharmacology course approved by the HCPC to be "independent prescribers"^{81 82}

- The "scope of practice" of UK chiropodists/podiatrists does not include bone surgery.
- UK chiropodists/podiatrists "may perform procedures on the foot under local anesthetic, some of which may be considered surgical in nature. This includes removal of toe nails and removal of neurovascular corns/verrucae via electrosurgery/radiolase. They are not allowed to undertake deep tissue/bone surgery such as correcting various toe deformities".⁸³ (These procedures are within the scope of practice and authorized acts of podiatrists in Ontario and some are within the scope of practice of chiropodists.)
- Graduates of the UK chiropody/podiatry diploma, baccalaureate and even Masters programs experience a great deal of difficulty passing the College of Chiropodists of Ontario's registration exams that include pharmacology. In fact, many are unsuccessful even after many attempts at taking the examination. This would suggest that the competencies deemed necessary to practise within the UK scope are not geared to those required to practise chiropody in Ontario.
- Acupuncture is not deemed to be within the scope of practice of UK chiropodists/podiatrists, as a profession.

⁸⁰ NHS Choices: "Who can write a prescription?", January 24, 2013.

⁸¹ The additional education is at the Level 6 (baccalaureate) or Level VII (Masters) and includes didactic and supervised clinical work. E-mail to Suzanne Sterling, The CG Group, from Dr. Paul Chadwick, FFM, RCPS, October 30, 2014.) Chiropodists/podiatrists who complete this additional training have their names "annotated" in the HCPC Register. As of September 1, 2014, 26 chiropodists/podiatrists had qualified as independent prescribers.

⁸² *"(Chiropodist/podiatrists with independent prescriber status may only) prescribe medicines for those conditions where they have the knowledge, understanding, training and skills to do so safely and effectively. Independent prescribing means that qualified podiatrists would be able to make their own independent decisions about whether an individual patient needs to have a particular medicine. They would be able to write a prescription script. They could administer having prescribed, or delegate the administration to someone else (for example, this is the same way in which a doctor might decide a patient needs a medicine and a delegated administration to another member of the healthcare team). So, someone who is an independent prescriber may also "sell" or "administer" those medicines they are authorized to prescribe".* E-mail to Don Gracey, The CG Group, from Michael Guthrie, Director of Policy and Standards, HCPC, October 28, 2014.

⁸³ E-mail from Kim Bryan, UK Society of Chiropodists and Podiatrists, to Don Gracey, The CG Group, September 15, 2014.

Clearly, the UK chiropody/podiatry scope of practice is more limited and limiting than the chiropody scope of practice and authorized acts that currently exist under the *Chiropody Act*, 1991. That is why the College concluded that adoption of the UK model would actually represent a step backwards for footcare in Ontario. As the submissions to HPRAC in the "current footcare model review" clearly demonstrated, there are many professions in Ontario that currently provide footcare that would be deemed to be within the UK chiropody/podiatry scope of practice. The gaps in Ontario's footcare delivery exist in the specialized medical diagnostic and surgical continuum of foot and ankle care. Those gaps are beyond the scope of UK chiropodists/podiatrists, but are within the Alberta and British Columbia scopes that the College wishes to emulate.

In addition, adoption of the UK chiropody/podiatry model, or a facsimile thereof, would do nothing to address the inter-jurisdictional mobility issues that chiropodists and podiatrists face in Ontario. Ontario's chiropodists would continue to be very restricted as to where they could practise in Canada. Québec, British Columbia and Alberta would continue to be closed to them. The same would be the case with Manitoba if it is successful in its quest to adopt a podiatry model emulating the British Columbia and Alberta models. Likewise, there would be no incentive for DPM podiatrists from other provinces or graduates of DPM schools to register to practise in Ontario in order to help address the footcare HR deficits in this Province.

It is also our understanding that Saskatchewan is experiencing challenges with its "podiatry" model which is very much cast in the UK form. There has been a substantial net decline in the number of registrants, due to some practitioners leaving to practise elsewhere and other practitioners leaving the profession entirely. (In one year alone, the net number of registrants is reported to have declined by 25%.) The Saskatchewan College of Podiatrists is concerned that patients are not able to access the right practitioners at the right time for their foot conditions as a consequence. Attempts to expand the scope of practice to include diagnostic tests and prescribing rights are in limbo.⁸⁴

All this is not to say that the College rejects the UK model in its entirety. As in British Columbia, an "add-on" to the UK chiropody/podiatry model is developing called "Podiatric Surgeons". These practitioners have completed approximately seven years of didactic and clinical education set or approved by the UK College of Podiatric Surgeons,⁸⁵ after having been registered with the HCPC.⁸⁶ Their scope of practice and competencies are very similar to the scope of practice and competencies that the College recommends be adopted in Ontario. The HCPC has mounted a public consultation around a proposal to annotate the HCPC register of chiropodists/podiatrists to identify certified Podiatric Surgeons. The public consultation is scheduled to end in January, 2015. One of the principal issues with which the HCPC

⁸⁴ Telephone interview with Axel Rohrmann, Registrar of the College of Podiatry of Saskatchewan, October 8, 2014.] The relevant authorities in the Saskatchewan Podiatry Act have not been proclaimed.

⁸⁵ The College is a division or an affiliate of the UK Society of Chiropodists and Podiatrists.

⁸⁶ That UK College of Podiatry <http://www.scpod.org/podiatric-surgery/about-podiatric-surgeons/>

is grappling is the recognition or accreditation of the clinical and didactic courses necessary for practitioners to be "annotated" in the HCPC register as podiatric surgeons.

The podiatric surgeon "class" is still in the developmental process for regulatory purposes.⁸⁷ Furthermore, the UK Health and Care Professions Council indicates that the situation is "not straightforward". Accordingly, the College has reproduced verbatim the explanation provided by the HCPC via e-mail dated November 26, 2014 at Figure 9.

" What is commonly referred to as podiatric surgery however, is significantly different from the scope of practice of a chiropodist/podiatrist at entry to the profession. Podiatric surgery incorporates interventions beneath the skin and can include work with the bone.

Podiatrists who have at least one year's post-registration practice can undertake further study of about 3 years, culminating in the FCPodS (Fellowship of the Faculty of Podiatric Surgery). Graduates are considered qualified to undertake podiatric surgery, though typically FCPodS holders continue to receive supervision whilst carrying out surgery. There are about 180 holders of the FCPodS. After a further three years of training and supervised surgical practice, they can achieve the Certificate for the Completion of Podiatric Surgery Training (CCPST). Such surgery may include mid- and rear-foot work. There are about 100 holders of the CCPST. They perform surgery without supervision.

I should also note that there is work underway in Scotland to develop another route to qualification in podiatric surgery. Neither of these routes lead to annotation of podiatric surgery qualification on the HCPC Register, as discussed. At the moment we do not have information about the number of podiatrists / chiropodists practising podiatric surgery. However it is our intention in future to begin to annotate for podiatric surgery, and part of that will be to conduct approval processes for all of the relevant training programmes with reference to a new set of standards....."

Nicole Casey

Policy Manager

The Health and Care Professions Council

Park House, 184 Kennington Park Road, London, SE11 4BU www.hcpc-uk.org

Figure 9: Email dated November 26, 2014 from the Health and Care Professions Council (HCPC)

⁸⁷ The College made numerous attempts by e-mail and telephone to connect with the UK Society of Chiropodists and Podiatrists and the UK College of Podiatrists for information about the chiropody and podiatry profession as it is practised and regulated in the UK and the number, training and certification of podiatric surgeons in the UK. In a few instances, we were referred to the regulatory body, the Health and Care Professions Council. Otherwise, the UK Society and College were not as responsive as the College expected or required.

AUSTRALASIA

The "podiatry" model in Australasia appears to be very similar to the UK chiropody/podiatry model with some notable variations. The regulatory framework for healthcare professions also appears to be very similar to that in the UK.

Australia

Like Canada, Australia is a federation and the regulation of healthcare professionals is within state jurisdiction. "Podiatrists" are registered in each state and the Australian Capital Territory and regulated by a statutory professional regulatory body in each of Queensland, New South Wales, Tasmania, Victoria, South Australia, Western Australia and the Australian Capital Territory (ACT). In some States there is a specific Podiatry Act. In other states (e.g. South Australia and the ACT) podiatrist regulation is included within a single, omnibus statute applying to a number of health professions. The scopes of practice are materially the same among all the states and the ACT.

In 1977 the official nomenclature changed from "chiropodist/chiropody" to "podiatrist/podiatry", ostensibly to reflect an expanded scope of practice and upgraded education.

Unlike the UK, however, the anatomical scope of practice includes the "lower limb" as well as the foot and the role of podiatric surgeons as a specialization within the profession appears to be more established and advanced.

Currently in Australia there are 4,034 podiatrists in active practice, including 27 podiatric surgeons; a practitioner: population ratio of 1:5100. A three-year baccalaureate degree in one of the eight podiatry programs approved by the Podiatry Board of Australia is required to be eligible for registration.⁸⁸

According to the Podiatrists' Association of Australia, the podiatry scope of practice is

"..... the prevention, diagnosis, treatment and rehabilitation of medical and surgical conditions of the feet and lower limbs. The conditions podiatrists treat include those resulting from bone and joint disorders such as arthritis and soft-tissue and muscular pathologies, as well as neurological and circulatory disease. Podiatrists are also able to diagnose and treat any complications of the above which

⁸⁸ The Podiatry Board exercises authorities delegated by the Australian Health Practitioners Regulation Agency (AHPRA) and all Board members are appointed by the AHPRA. Qualification to register as a podiatric surgeon requires additional clinical training and didactic training at the postgraduate level.

*affect the lower limb, including skin and nail disorders, corns, calluses and ingrown toenails. Foot injuries and infections gained through sport or other activities are also diagnosed and treated by podiatrists."*⁸⁹

Except for podiatric surgeons, bone surgery is beyond the scope of practice and soft tissue surgery appears to be limited to procedures such as the surgical correction of chronically ingrown toenails and treating corns and calluses. Podiatrists are authorized to dispense or administer OTC pharmaceutical agents, apply specialist wound dressings, provide physical therapies and prescribe and dispense foot orthoses. The Podiatry Board determined that acupuncture should not be included within the podiatry scope of practice, although a number of podiatrists are cross-registered with the Chinese Medicine Board of Australia to do so.

Podiatrists who have successfully completed additional education may prescribe and dispense what are referred to as "Section 2, 3, 4 and 8 Medicines".

Multidisciplinary practice appears to be the preferred venue for podiatrists' employment.

New Zealand

New Zealand presents a reasonable facsimile of the UK chiropody model.

"Podiatrists" in New Zealand are regulated by the Podiatrists Board of New Zealand under the *Healthcare Practitioners Competence Assurance Act, 2003*. The Act came into legal force and effect on September 18, 2004. (Those who practised as chiropodists prior to 2003 were grandparented into the Board as "podiatrists" on that date.) The Act was subject to a statutory sunset review in 2012, but the College has been unable to ascertain whether the review actually took place and if it did, the outcome.

Under the Act, entry-level podiatrists are described as

"A registered primary health care practitioner who utilizes medical, physical, palliative and surgical means other than those prescribed in the Podiatric Surgeon Scope of Practice, to provide diagnostic, preventive and rehabilitative treatment of conditions affecting the feet and lower limbs."

To be eligible for registration with the Board an individual must have successfully completed a baccalaureate-level degree in podiatry from an accredited New Zealand University, or complete an overseas qualification deemed to be equivalent by the Podiatrists Board. All accredited Australian podiatry programs are recognized by the Board.

Podiatrists are authorized to administer local anesthesia in order to conduct surgical procedures within their scope of practice.

⁸⁹ <http://www.podiatryvic.com.au/Podiatrists/Scope.htm>

Podiatrists who have obtained additional education are eligible to be granted prescribing rights by the New Prescribers Advisory Committee and, as such, are authorized to prescribe medications designated by the Podiatry Board. Such practitioners are referred to as "Podiatric Prescribers".

Podiatric Surgeons' scope of practice is defined as

*"(The performance of) foot surgery by way of sharp toe nail wedge resection; surgical correction of lesser digital deformities affecting the phalanges, metatarsals and associated structures; surgical corrections of deformities affecting the first toe, first metatarsal and associated structures; surgical correction of osseous deformities of the metatarsus, mid-tarsus, rearfoot and associated structures; surgical correction and removal of pathological subcutaneous structures such as tendinous and nervous tissues and other connective soft tissue masses of the foot."*⁹⁰

Podiatric Surgeons must have successfully completed a postgraduate program in podiatric surgery approved by the Podiatrist Board.

There is a further class of podiatrists prescribed by the Board, "Podiatric Radiographic Imager", defined as a podiatrist who has obtained post-graduate qualifications and

*".....who is qualified to use radiological equipment, and is licensed by the National Radiation Laboratory, to obtain plain radiographic images of the foot, ankle and lower leg."*⁹¹

Chiropody and Podiatry in Continental Europe

In Europe the "podiatry" nomenclature has been almost universally adopted, but scopes of practice differ and often fall substantially short of the North American podiatry model. It is probably more accurate to describe these models as blends of the US and UK models and, therefore, for purposes of this description we use the "chiropody/podiatry" nomenclature.

Outside of the UK, countries such as Spain, Sweden, France, Germany, Italy and Finland have all adopted a chiropody/podiatry model, though the scopes of practice vary from country to country. Spain most closely approximates the US model with one of the most extensive scopes of practice. It also has one of the highest numbers of podiatry educational institutions and one of the highest numbers of podiatrists (known locally as "Podologists,") in Europe. There are roughly 5000 podiatrists in active practice in Spain and an estimated annual intake of 500 new students.⁹² Spanish podiatrists are authorized to perform

⁹⁰ "New Zealand Podiatrist Board Notice of Scopes of Practice and Related Qualifications", New Zealand Gazette, September 18, 2004.

⁹¹ "New Zealand Podiatrist Board Notice" Ibid.

⁹² "Profile of Podiatric Medicine Throughout the World: Spain" *International Federation of Podiatrists*. May 2007. Web. <http://www.fip-ifp.org/index.php?option=com_content&view=article&id=90&Itemid=224>

most surgical procedures on soft or bony tissue – rearfoot and forefoot – but they are not authorized to perform amputations.

The authority of practitioners to perform surgery is one of the major variables in scopes of practice across jurisdictions on the European Continent. "Podiatrists" in countries such as Finland, France, Germany and Sweden are not authorized to perform any type of subcutaneous surgery as part of their scopes. Conversely, podiatrists in Italy are allowed to perform both soft tissue and bone surgery on the foot and ankle.

Similarly the prescribing rights of podiatrists in European nations vary significantly. In Sweden, Italy, Germany and Finland podiatrists have no prescribing rights as of 2007.^{93 94 95} For the most part this coincides with the lack of authority to perform subcutaneous surgical operations. In other European countries such as France, podiatrists have prescribing rights for topical medicines. Spanish podiatrists have more extensive prescribing rights, although they are not clear-cut. In Spain Podiatrists are neither explicitly allowed to, nor are they forbidden from, prescribing drugs. As such, access is governed by Pharmacists' willingness to supply.

Other Jurisdictions

Outside the US and Europe, there are a number of countries that have adopted the UK chiropody/podiatry model. In Hong Kong, Singapore, Cyprus and Israel the traditional British model of chiropody exists, although in Israel (like Ontario), a North American-style podiatry model exists in parallel. These countries have no schools of their own. Students attend United Kingdom, United States, Australasian or South African schools. These countries generally follow the prescribing rights of the UK model and allow for the performance of soft tissue surgery as part of their scopes of practice, as well as bone surgery on the foot and ankle for podiatrists in Israel.

The legal authority to perform surgery is an indicator of the extent to which a podiatry model has been adopted. Podiatrists in many jurisdictions are authorized to perform soft tissue surgery (e.g. South Africa, Hong Kong, Singapore). The prescription of drugs, at the very least analgesics, is often included within the scope of practice for Podiatrists internationally. Prescribing rights are understandably usually linked to the extent to which the performance of surgical procedures are authorized.

⁹³ "Profile of Podiatric Medicine Throughout the World: Sweden" *International Federation of Podiatrists*. May 2007. Web. <http://www.fip-ifp.org/index.php?option=com_content&view=article&id=90&Itemid=224>

⁹⁴ "Profile of Podiatric Medicine Throughout the World: Italy" *International Federation of Podiatrists*. May 2007. Web. <http://www.fip-ifp.org/index.php?option=com_content&view=article&id=90&Itemid=224>

⁹⁵ "Profile of Podiatric Medicine Throughout the World: Finland" *International Federation of Podiatrists*. May 2007. Web. <http://www.fip-ifp.org/index.php?option=com_content&view=article&id=90&Itemid=224>

Q 31: "What are the potential costs and benefits to the public and the profession in allowing this change in scope of practice? Please consider and describe the impact of any of the following economic factors:"

Response:

Economic Assessment of Podiatric and Orthopedic Surgery Costs in Australia

"A recent report by *Access Economics* describes the results of an economic impact analysis estimating the potential impact of improving access to podiatric surgeons in the Australian health sector. The report assesses the cost effectiveness and cost benefit of using podiatric surgeons to perform foot and ankle surgery compared with using orthopaedic surgeons.

Key findings of the report are that:

- podiatric surgery is less costly than orthopaedic surgery across all categories of procedures on average by \$3,635 per procedure; and
- in addition to the \$3,635 per procedure saved in financial costs, there is a relative gain in well-being calculated at \$5,016 per procedure for podiatric surgery relative to orthopaedic surgery.

The report's conclusions support the greater utilisation of podiatric surgeons in the Australian health system. Specifically the report cites benefits including:

- substantial financial savings associated with reduced lengths of stay;
- decreased waiting times for elective foot and ankle surgery;
- increased productivity;
- improved prevention of co-morbidities associated with decreased waiting times; and
- a quicker return to an improved quality of life" (AHWI, 2008. 12).

Case Study 6. Caption from Australian Department of Human Services, "Foot and Ankle Surgery Project Literature Review".

System-wide benefits will be generated as a consequence of the following factors:

- The more extensive scope of practice and authorized acts will allow podiatrists to provide a more complete continuum of care, reducing the number of circular referrals and the costs and delays in timely diagnosis and treatment that circular referrals prompt;
- Attracting more podiatrists to practise in Ontario by a scope of practice that better reflects the competencies they have acquired and reduces the frustrations inherent in the current limited scope of practice, thus reducing wait-times for podiatrists, physicians/orthopedic surgeons through the displacement effect;
- Reducing the demand on hospital beds and hospital operating rooms, by siphoning off to podiatric clinics those surgical foot and ankle surgical procedures that can be safely and effectively conducted by podiatrists in other settings.

- Reducing the utilization of hospital ERs for foot and ankle conditions that can be safely and effectively treated by podiatrists in their clinics (e.g. setting or casting a fracture or dislocation).⁹⁶
- Reducing the demand on orthopedic surgeons for less complex foot and ankle surgeries. In this regard, a March, 2009 submission to the Ministry of Health and Long-Term Care by orthopedic surgeons stated that:

*"Performing a high proportion of less complex foot and ankle surgeries is not an efficient use of highly specialized foot and ankle surgeons. Because so many cases are being referred to these specialist, many referrals, where it is clear there is no need for specialized care, are simply returned to the referring physician and patients are not seen within the health care system"*⁹⁷;

- Providing enhanced access to foot and ankle care, especially in rural, remote, northern and other underserved areas of Ontario and for those who do not have access to a family physician;
- Reducing the number of foot and ankle cases handled in hospital emergency departments;
- Reducing the incidence (and cost) of foot and ankle ailments and systemic and chronic diseases that manifest themselves in the feet and ankles. For example, reducing the number of foot amputations caused by diabetic conditions; and
- Enhancing access to podiatric care in home care, long-term-care homes, retirement homes and in other seniors' congregate living centres and community-based programs. Seniors, by far, are the largest consumers of footcare services even though proper footcare for seniors is chronically neglected, notwithstanding the fact that proper footcare helps to keep seniors ambulatory, active and independent.

1. *Direct patient benefits/costs*

(Appendix B catalogs the costs/benefits of podiatric procedures on a procedure-by-procedure basis). The patient benefits and costs have been enumerated elsewhere in this Application.

⁹⁶ According to an internal study by the Institute for Clinical Evaluative Studies, the number of visits to Ontario hospital ERs has increased by 14% over eight years. When population growth is factored in, the rise in ER utilization has been 5.5%. "The prevailing theory is that the increase is a reflection of the difficulty patients have in accessing primary care. When patients have easy access to family doctors and other primary care providers they are less likely to visit ERs". "Health care, the forgotten issue Ontario's election", the Toronto Star, November 12, 2014.

⁹⁷ "Proposal for the Development of a Provincial Foot and Ankle Program". May 2009. 11.

Benefits of Reducing Circular Referrals: A Case Study

Clinical Scenario CANCER

A 50 y/o otherwise healthy woman comes into the clinic with a painful "wart" on the side of her left ankle. This has increased in size and has increased her discomfort over the last several months. She has seen her primary care doctor who told her that it was "probably a wart" and "don't worry about it". She is concerned because it occasionally bleeds when putting on her stockings or socks. She is on no medications and has no known drug allergies.

Physical examination performed in the office reveals a healthy well-developed middle-aged woman in no apparent acute discomfort or distress. Her pedal pulses are palpable. No edema is noted to either lower extremity. Pin prick, proprioception and vibratory sensations are within normal limits. Deep tendon reflexes, Achilles and patellar are equal and symmetrical on both sides. Muscle strength is within normal limits. Her gait is within normal limits.

Skin examination reveals toenails on both feet are normal. There are no open lesions or signs of infection to the right lower extremity. The dorsal lateral aspect of the left foot has a raised hyperkeratotic lesion with tenderness on palpation. This lesion has irregular borders and is raised and bleeds easily with light debridement. There is no purulent drainage, odor, deep tracking, ascending cellulitis and no signs of infection.

Radiographs of the left ankle, three views weight bearing, anterior-posterior, lateral oblique and lateral are negative for acute fracture, or dislocation. An increase in soft tissue density is noted over the dorsal lateral left foot.

CURRENT SCOPE:

A letter is written by the podiatrist/chiropractor to the patient's primary care physician recommending biopsy and/or referral to a dermatologist. The patient returns to the primary physician who recently informed her "don't worry about it". A delay in diagnosis of amelanotic malignant melanoma (Amelanotic melanomas are more typically mis-diagnosed or overlooked and just as lethal) occurs and the lesion progresses to a depth where limb amputation is required and mortality risks are increased.

PROPOSED/EXPANDED SCOPE:

An incisional biopsy is performed at the margins of the lesion by the podiatrist on the same day examination occurred. The biopsy specimen is sent to the local pathologist and a diagnosis of amelanotic melanoma is confirmed. A recommendation by the pathologist is given for excision of the lesion with wide margins. The podiatrist performs the procedure in an outpatient clinic setting utilizing local anesthetic. The wide margin excision is confirmed by the pathologist and the patient is cured.

Case Study 7. Clinical Scenario for a Cancer Patient.

To summarize, the major patient benefits will be:

- Expanding "one stop " diagnosis and treatment of foot and ankle conditions through the provision of a more extensive continuum of care within the competencies of individual practitioners;
- Reducing the requirement for circular referrals and thereby enhancing patient convenience and the timeliness of patient diagnosis and treatment;

- Reducing or addressing the incidence of chronicity in foot and ankle ailments;
- Reducing the incidence and the morbidity of foot and ankle-related diseases, disorders and dysfunctions;
- Returning patients to the maximum pre-injury or pre-disease status possible;
- Enhancing patient access to quality foot and ankle care, particularly in areas of the Province that are currently underserved;
- Reducing wait times for elective and non-elective foot and ankle care; and
- The provision of clinically-proven safe, effective and innovative care in patient-convenient ambulatory, community-based clinics.

The services rendered by members of the podiatrist class are currently partially covered by OHIP. Chiropodists' services and the non-OHIP portion of podiatrists' services are covered by most extended health benefits insurers. The WSIB pays for chiropodists' and podiatrists' services pursuant to a fee-for-service schedule and under the WSIB's lower extremities Program of Care.

Preliminary discussions with the Ministry indicate no inclination to reduce or withdraw public funding for those podiatrists currently registered under OHIP. The College has had discussions with the Canadian Life and Health Insurance Association and kept it fully informed of the College's proposals with respect to scope of practice changes. CLHIA has expressed no concerns about what is being proposed and has given no indication that its members would reduce or withdraw coverage as a consequence. The WSIB has indicated that the reimbursement status quo would continue under an expanded scope of practice.

The Applicant believes, accordingly, there is no reasonable basis to project that patients' costs would be increased as a consequence of the proposed changes.

2. Benefits and costs to the broader healthcare service delivery system.

Ontario's Action Plan for Health Care acknowledges the need to make trade-offs and shift spending patterns to generate the best value for money. The Commission on the Reform of Ontario's Public Services' report (the Drummond Report) also called on the Ontario government to devise policies that shift people away from in-patient, acute care settings to community care, where appropriate; and to use competition to fund procedures based on price and quality. Both the Action Plan and the Drummond Report acknowledge that procedures performed in specialty clinics in community settings can be provided at a lower cost than in hospital acute care settings. Ontario's Action Plan for Health Care and

the Drummond Report aim to moderate the increase in healthcare expenditures while maintaining or enhancing quality care by:

- Reforming the manner in which procedures are delivered;
- Maintaining hospital capacity to provide inpatient and higher acuity procedures while allowing community-based healthcare providers to perform procedures currently provided in hospitals when appropriate to reduce the number of patients admitted to hospital when they may not need that level of care;
- Shifting procedures to more efficient healthcare providers while maintaining quality ; and
- Encouraging hospitals to specialize in some procedures to avoid duplication in the system and create efficiencies.

"Performing a high proportion of less complex foot and ankle surgeries is not an efficient use of highly-specialized foot and ankle (orthopedic) surgeons"

- Daniels et al, 2009. 20.

The podiatry model being proposed by the College in this Application is entirely consistent with the Action Plan and with the recommendations of the Drummond Report and will help the Ontario government achieve the objectives set by both. Implementation of the podiatry model proposed in this Application will increase system-wide efficiencies and will apply healthcare dollars for foot and ankle care more efficiently and effectively.

"... a strategy to achieve early detection and treatment of the foot and ankle conditions for patients within Ontario is required"

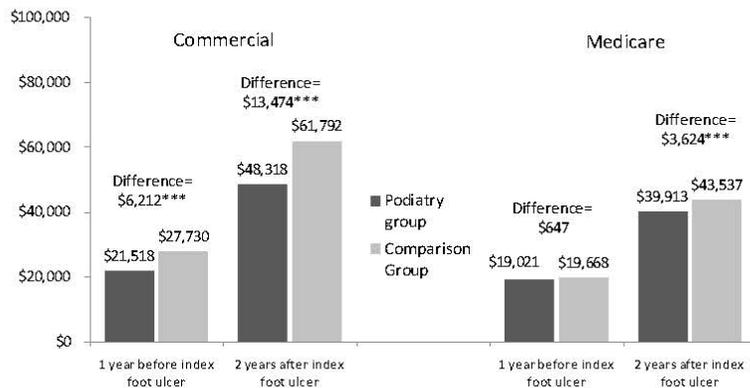
- Daniels et al, 2009.10.

“The Economic Value of Specialized Lower-Extremity Medical Care by Podiatric Physicians in the Treatment of Diabetic Foot Ulcers,” Journal of the American Podiatric Medical Association, Vol. 101, No 2, March/April 2011.

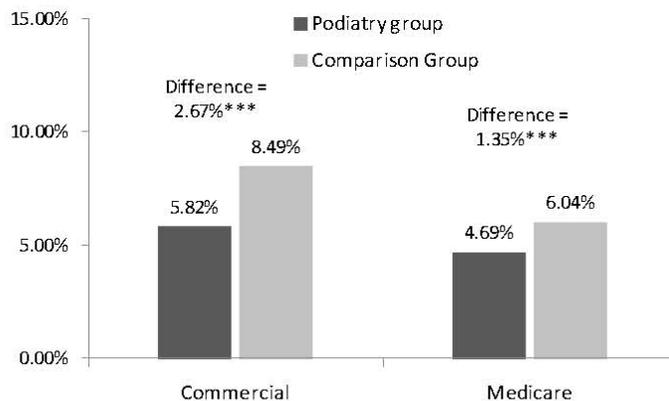
- Thomson Reuters Healthcare carried out the study utilizing its MarketScan Data Base examining claims from 316,527 patients with commercial insurance (64 year of age and younger) and 157,529 patients with Medicare and an employer sponsored secondary insurance.
- The study focused on one specific aspect of diabetic foot care: those patients who developed a foot ulcer. For those who developed a foot ulcer, the year preceding their development of a foot ulcer was examined to see if they had seen a podiatrist. Those who saw a podiatrist were compared to those who did not over a three year time period.
- A comparison was then made between those who had at least one visit to a podiatrist prior to developing the foot ulcer to those who had no podiatry care in the year prior to developing the foot ulceration.

The results were significant:

- Average savings over a three-year time period (year before ulceration and two years after ulceration occurred):
 - Commercial Insurance: Savings of **\$19,686** per patient if they had at least one visit to a podiatrist in the year preceding their ulceration
 - Medicare Insured: Savings of **\$4,271** per patient



- Decrease in amputations: Limbs saved.



- If we extrapolate these results so that all insured in the commercial and Medicare populations with diabetes and at risk for a foot ulceration had a visit to a podiatrist:
 - **\$1.97 billion** could be saved in the commercial insurance group in one year
 - **\$1.53 billion** could be saved in the Medicare insurance group in one year

The new model is projected to apply healthcare expenditures for foot and ankle care more efficiently and effectively in the following ways:

- By reducing the number of circular referrals and referrals to other healthcare practitioners and healthcare delivery venues for care that is within the podiatric scope of practice;
- According to the Ministry of Health and Long-Term Care, in 2010/11 there were 27,000 ER visits that could have been treated in alternate primary care settings. A substantial portion of the ER visits relating to diseases, disorders or dysfunctions of the foot and ankle could be drained off to podiatrists practising to their full competencies in the proposed scope of practice.
- The podiatry model revolves around the provision of care in ambulatory, community-based clinics, thereby reducing pressures on hospital inpatient resources, so those resources can be more accessible to those patients who genuinely need them;
- By helping to keep seniors ambulatory and independent as long as possible, thereby reducing the demand for long-term-care and home care;
- By reducing complications and the morbidity of foot and ankle diseases through timely and effective care, particularly in the instances of the major drivers of healthcare expenditures such as diabetes and arthritis;
- By enhancing access to expert foot and ankle care in areas of the Province that are currently underserved or not serviced at all by footcare specialists;
- By helping to “de-stress” demand for orthopedic surgeons and hospital operating rooms and, thereby reduce wait-times for complex procedures; and
- By fully utilizing the investment made in the training of chiropodists and podiatrists, by allowing them to utilize fully the competencies they have acquired.

There have been several studies comparing the cost of podiatrists performing procedures and the cost of those identical procedures being performed by orthopedic surgeons and others in hospitals. The cost of podiatric procedures usually ranges from 25 to 50% less (See Appendix B). Podiatric outcomes are as good or better. Even at that, the savings are probably significantly understated due to the hidden costs of hospital care that are not included, or at least are undervalued. (Appendix C contains a comparison of podiatrist and orthopedic surgeon Medicare fees in in British Columbia and Alberta.)

The podiatry model is not projected to increase net, per capita healthcare expenditures. There may be an apprehension that providing podiatrists and chiropodists with authority to order new or additional diagnostic tests will increase the utilization of those tests and thereby add to total healthcare expenditures. In fact, GPs currently order tests requested by podiatrists---and probably more than those

requested by podiatrists. In any event, this concern is belied by experience in other jurisdictions. When the authority to order diagnostic tests has been extended to other professions in other jurisdictions, characteristically the total number of tests has actually declined. For example, allowing physiotherapists to order radiographs in Australia and in the United Kingdom led to a reduction in the number of radiographs ordered.⁹⁸

"In 2010/11, over 271,000 emergency room visits were made to Ontario hospitals that could have been treated in alternate primary care settings."

- Report on Ontario's Action Plan for Healthcare (January, 2014).

3. Benefits and costs associated with wait times:

According to a 2013 report by The Fraser Institute, Ontario (with New Brunswick and Labrador) leads Canada in reducing wait times for surgical procedures. Nevertheless, the same report found that the wait times for orthopedic procedures in Ontario still exceed clinical guidelines. The actual median wait time between the first specialist consultation and orthopedic surgery is 18.9 weeks versus the median-clinically reasonable wait of 11.2 weeks; a difference of 69%.⁹⁹ The estimated number of procedures for which patients are waiting after an appointment with a specialist is 269,617 in Ontario, of which 43,676 fall under the Orthopaedic Surgery specialty, an increase of 10% from 2012.¹⁰⁰ Of the procedures pertaining to the foot or ankle, many could be safely and effectively performed by podiatrists under the proposed scope of practice, such as 3,120 for Meniscectomy/Arthroscopy, 1,887 for Removal of Pins, 29,114 for Arthroplasty (Hip, Knee, Ankle, Shoulder), 1,004 for Arthroplasty (Interphalangeal, Metatarsophalangeal), 599 for Hallux Valgus/Hammer Toe, 2,220 for Digit Neuroma, 1,174 for Rotator Cuff Repair, 3,000 for Osteotomy (All Types), and 1,559 for Routine Spinal Instability.

4. Workload, training and development costs:

As explained elsewhere in this Application, the performance of any of the proposed new or expanded authorized acts by current College registrants who are grand-parented into the new College will not be mandatory. Those grand-parented registrants who choose to perform any or all of the new or expanded authorized acts and who require refresher or upgrading courses in order to do so, will be required to

⁹⁸ Ontario Physiotherapy Association. "Physiotherapy and Diagnostic Imaging". OPA. September 17, 2012. 1.

⁹⁹ Barua, Bacchus and Esmail, Nadeem. "Waiting your turn: Wait times for health care in Canada, 2013 Report". Fraser Institute, October 2013. Digitalized report. 62.

¹⁰⁰ "Waiting your turn: Wait times for health care in Canada, 2013 Report". October 2013. 64,71.

complete those courses at their own cost. The College has undertaken to expend best efforts to make such courses reasonably available in Ontario. At this time, however, the College cannot project what the cost of those courses might be and the cost per practitioner would vary materially on a practitioner-by-practitioner basis.

The College does not anticipate a net increase in workload for present members of the profession. At this time, most members of the profession are working at or very close to capacity. For the profession as a whole, we anticipate a progressive movement into the surgical components of the existing and proposed scope of practice and progressively less focus on the nonsurgical/public domain components. The College anticipates that increased demand for the public domain components of the scope of practice will be increasingly provided by members of other regulated and unregulated professions, either on their own or in collaboration with podiatrists.

5. Costs associated with educational and regulatory sector involvement:

The College has used two sources to endeavour to calculate the start-up and operating costs of a University-level podiatry program in Ontario: The Université de Québec that has had a four-year DPM program operational for about four years and a Business Plan prepared by the University of Alberta to set up a four-year DPM program. Both are based on an intake of 25 students per year, for a total of 100 students in-stream in full, four-year, operation. The actual total operating cost of the UQTR program is \$1.7 million annually. The projected cost of the Alberta program was \$2.5 million (which included amortized start-up costs). The extent and nature of start-up costs in Ontario would vary materially depending on the type of institution launching the program, in particular whether the program is incorporated with an existing medical school. If a podiatry program is grafted onto an existing medical school, the startup costs would be minimal and the operating costs would be calculated on a marginal cost basis. If a podiatry program is launched de novo, the startup costs (likely amortized in the annual operating costs) can be expected to be substantial.

Offset against these costs would be the current operating expenditures required to provide the three-year Advanced Diploma Program in Chiropody at the Michener Institute. The College asked The Michener Institute for revenue and expenditure data pertaining to the Institute's administration of the chiropody program. The Institute responded that the information "is not publicly available". Accordingly, it is not possible for the College to project the net costs of launching a podiatry program at an Ontario University.

There will be net additional costs for the proposed College of Podiatrists and for any interim or transitional work conducted by the College of Chiropodists to devise and implement the transitional and foundational regulations, By-Laws, standards of practice, policies, guidelines and competency evaluation for grand-parented registrants and to communicate the changes and their implications to members, the public, other professions and stakeholders. Those costs are expected to be substantial. Nonetheless, the College believes that the transitional costs can be covered by the College's existing financial reserves

and resources and thereafter by existing registration fees. Some cost pressures currently faced by the College will be reduced and regulatory efficiencies enhanced by regulating a single profession and by removal of the podiatric cap. The College also anticipates that the enhanced scope of practice proposed in this Application and removal of the podiatric cap will lead to an increase in membership that exceeds historical trends. See response to Question # 7 in the Submission in response to HPRAC's 18 Additional Questions.

Q 32: *"Is there any other relevant information that HPRAC should consider when reviewing your proposed request for a change in scope of practice?"*

Response: The College wishes to emphasize several points that are fundamental components of the rationale to convert to a podiatry scope of practice:

1. The proposal for change in scope of practice entails a change in practice model. The traditional chiropody model on which the current *Chiropody Act, 1991* is founded is based on chiropodists functioning as salaried personnel within hospitals and analogous healthcare institutions. The podiatry practice model is primarily, but not exclusively, a de-centralized non-institutional model where diagnosis and treatment are performed, including surgical procedures that can be safely and effectively conducted outside of institutions. The traditional chiropody model may well have been consistent with the healthcare delivery paradigm of the late 1970s and early 80s when the model was instituted. The proposed podiatry model of practice is clearly consistent with the healthcare delivery paradigm articulated by the current government and will lead to enhanced access to care, system-wide efficiencies, more patient convenience and more effective use of scarce healthcare resources.
2. The history of chiropody and podiatry in Ontario demonstrates that, for the better part of last 100 years, successive Ontario governments have grappled with the design of the appropriate footcare delivery model for Ontario. The current chiropody model is very much a construct of past governments' policies, rather than a response to external and internal pressures and forces that usually define the evolution of healthcare professions. One result is that Ontario has been left behind in its footcare delivery model. The College believes and the clinical evidence indicates that a North American podiatry model of care represents best practices. An objective of the proposed scope of practice change is to acknowledge and adapt the evolution of footcare delivery, regulation and practice models that has occurred in comparable jurisdictions and has generated positive outcomes for patients and for the healthcare system generally.
3. A gap in the demand for the footcare services contemplated in the proposed scope of practice and authorized acts and the supply of practitioners competent to provide those services has been documented in this Application. That gap exists today and is projected to widen as the population ages. Addressing that gap requires a number of substantive changes: a) Revocation of the podiatric cap; b) Implementing a broader scope of practice that allows existing practitioners to use their competencies to the fullest, create a more extensive, seamless continuum of care and to create an incentive for future

practitioners to enter the profession; c) Implementing a broader scope of practice that will activate a practice model that will enhance patient access to care.

4. Despite whatever else may happen as a consequence of this Review, the College urges HPRAC to correct mismatches in the current scope of practice and authorized acts of chiropractic and podiatry. It is anomalous, if not nonsensical, for chiropractors and podiatrists to be authorized to perform surgical procedures below the dermis, but not be authorized to order the laboratory tests necessary to plan, perform and follow-up on those procedures safely and effectively. It is anomalous, if not nonsensical, for podiatrists to be authorized to surgically break bones and joints, but not have the authority to set them. The same applies to the authority of chiropractors to assess, diagnose and treat diseases and dysfunctions of the foot, but not being able to order or utilize "forms of energy" such as MRIs. These "mismatches", that are arguably a result of the institution-based chiropractic practice model that was adopted in the late 1970s and early 1980s, have become evident as chiropractors abandoned that practice model, are particularly anomalous for members of the podiatrist class and would be even more anomalous under the proposed podiatry delivery model.

Ontario's Action Plan for Healthcare aims to achieve "*Access to the right care at the right time in the right place.*"

The Minister has articulated two subsidiary components to judge proposed changes or innovations in healthcare delivery:

"Is it better for patients?"

"Is it a more cost-effective use of healthcare dollars?"

The College is absolutely convinced that the proposals set out in this Application satisfy or exceed these criteria and are therefore entirely consistent with and supportive of the government's policy objectives for healthcare in Ontario.

REVIEW

of the Chiropody and Podiatry Professions

Application to the
Health Professions Regulatory Advisory Council

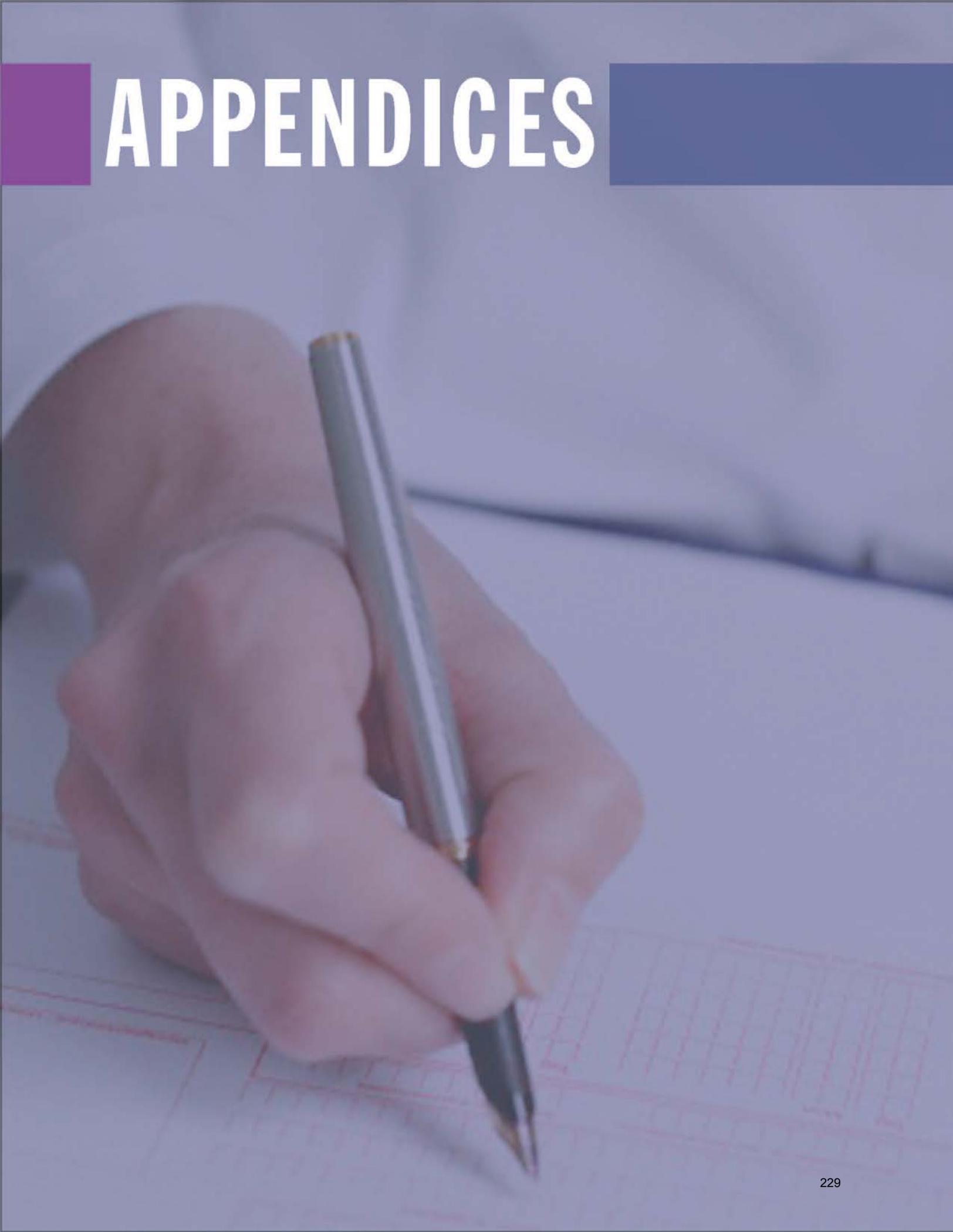
*" Better Patient Care and Better Value for Healthcare Dollars by Adopting
a Podiatry Model of Foot and Ankle Care"*

PART 2 - APPENDICES

Submitted by
The College of Chiropodists of Ontario

November 28, 2014

APPENDICES



APPENDIX A



**Professional
Examination Service**
Credentialing Insight

FINAL REPORT OF THE COMPETENCY ASSESSMENT PROJECT

THE COLLEGE OF CHIROPODISTS OF ONTARIO

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February 19, 2013

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Background

This is the final report of the competency assessment project that Professional Examination Service (ProExam) conducted on behalf of the College of Chiropodists of Ontario (College). The College's registration processes are designed to ensure that practitioners entering practice in Ontario are prepared to perform the core competencies of the profession safely and effectively.

The competency assessment project involves evaluating the College registrants' current educational and practical preparation to what is necessary to practise within a proposed expanded scope of practice. The findings from the project will be used by the College in developing their submission to Health Professions Regulatory Advisory Council (HPRAC) in support of the scope expansion.

In considering the feasibility of adopting the proposed scope expansion in Ontario, it is expected that HPRAC will need to know how many current College registrants would be able to function safely and effectively within the expanded scope of practice, and how many current registrants would require some form of bridging program(s) in order to acquire additional competencies necessary to practise safely and effectively.

With the assistance of the Competency Review Steering Committee (Steering Committee), ProExam is engaged in characterizing the competencies of different cohorts of current College registrants in relation to the competencies required to practise in the expanded scope of foot care that the College is recommending. The broad questions posed are: Are registrants prepared to perform the range of professional activities within the expanded scope? Are there gaps in registrants' education and training that would hinder their ability to perform the scope of practice and controlled acts entailed in the proposed Podiatry model safely and effectively?

Current and Expanded Scope of Practice in Ontario

Current competency expectations for College members are defined in *the Profile of Competencies (Profile)* required of members of the College¹. The *Profile* outlines the competencies that may be performed by members. Competencies restricted to the Podiatrist class of registrants are noted as such in the document.

The expanded scope of practice that the College will be recommending to HPRAC appears in Appendix A.

¹ <http://www.cocoo.on.ca/pdfs/competencies-doc.pdf>.

Study Cohorts

At present there are 603 members of the College. Of these, 70 are in the Podiatrist class. Appendix B summarizes the number of members per county, academic institution, and year of degree or diploma. Of the 533 members not in the Podiatrist class, 475 trained in Canada (CA), 39 trained in the United Kingdom (UK), 15 trained in the US, 3 trained in South Africa (SA), and 1 trained in Australia (AU). All 70 College members in the Podiatrist class trained in the United States (US) at accredited programs and hold DPM degrees awarded prior to 1994.

For comparative purposes, the members of the College have been grouped into cohorts. These cohorts are illustrated in Table 1. The members of the Podiatry class form a unified cohort that is clearly distinct (cohort B). Performance of acts within the expanded scope is already permitted for this class of registrants, although bone surgery in the current scope is restricted to the forefoot only. Cohorts within the larger, non-Podiatrist membership have been established on the basis of country of training and program within country (Cohorts A and C – F).

Table 1
Study Cohorts

Cohort	Number of registrants
A. Graduates of and students currently enrolled in the Chiropody Program at the Michener Institute for Applied Health Sciences in Toronto (hereinafter "the Michener")	323
B. Graduates of United States (US) Podiatry colleges in the Podiatrist class of registrants	70
C. Graduates of the Chiropody program offered by George Brown College in Toronto between approximately 1982 and 1993	151
D. Graduates of training programs outside of Canada or the US	
1. UK	39
2. Australia	1
3. South Africa	3
E. Graduates of United States (US) Podiatry colleges <i>not</i> in the Podiatrist class of registrants	15
F. Graduates of l'Université du Québec a Trois-Rivières (UQTR)	1
TOTAL NUMBER OF COLLEGE MEMBERS	603

The letters associated with each cohort were established during earlier stages of this project, and do not correspond to the order in which findings are presented in this report. The cohorts and their training and preparation to practise within the expanded scope will be discussed in the following order.

A. Cohorts B and E: Graduates of US Podiatry colleges

The 70 are members of the Podiatrist class of registrants are the members of study cohort B. The other 15 are members of study cohort E. All 85 registrants hold a DPM degree from an accredited school of podiatric medicine. Depending on their dates of training, they may have undertaken a 1-year or a 2-year residency.

B. Cohorts A and C: Graduates of Ontario training programs

A total of 323 registered chiropodists were trained in Ontario through the Michener Institute – 270 of these registrants hold a Diploma in Chiropody and 53 hold a Diploma in Podiatric Medicine. The Michener graduates are in study cohort A. Another 139 registered chiropodists graduated with a diploma from the George Brown College of Applied Arts. Finally, 12 registered chiropodists graduated with a diploma listing both George Brown and the Michener Institute as the awarding institutions. These diplomas were awarded during the transition period between the two programs (i.e., 1991 through 1994). The latter two groups make up study cohort C.

C. Cohort F: Graduates of Quebec's training program

Currently, there is one College member who was trained in Quebec. This individual is the sole member of study cohort F. This individual attended l' Université du Québec à Trois-Rivières (UQTR) and graduated with a DPM degree.

D. Cohort D: Graduates of training programs outside of Canada or the US**1. UK**

There are 39 Ontario registrants in the Chiropodist class who received their training in the UK. These individuals make up study cohort D1. A total of 21 different schools are represented by this cohort. Of the 39 registrants, 7 can be verified as having attended universities accredited by the Health Care and Professions Council (HCPC), which is the health care providers governing body in the UK.

2. Australia

There is currently one registered chiropodist practicing in Ontario who was trained in Australia, making up study cohort D2. This individual graduated from the Queensland University of Technology in 2006.

3. South Africa

There are currently three registered chiropodists practicing in Ontario who were trained in South Africa, making up study cohort D(3). All three chiropodists attended the now defunct Technikon Witwatersrand. The school became what is now the University of Johannesburg.

The Canadian Context

Podiatrists in Alberta and British Columbia currently perform the full range of activities that are included in the proposed expanded scope of practice. As described in the Government of Alberta's filing of a legitimate objective under the Agreement on Internal Trade (AIT):

Podiatrists in Alberta diagnose, order and interpret diagnostic tests such as blood tests, culture and sensitivity of infections, diagnostic radiology (Xrays, CT and MRI scans, bone scans, ultrasound), prescribe any medications relevant to the treatment of the foot, and a full range of other treatment modalities including surgery on the foot and osseous structures. Podiatrists in Alberta are independent medical practitioners.

Applicants to the Alberta College of Podiatric Physicians must have graduated from a college of podiatric medicine in Canada or the United States approved by the Council on Podiatric Medical Education (CPME) and received the Doctor of Podiatric Medicine (DPM) degree. They must also have successfully completed all three levels of the American Podiatric Medicine Licensing Examination (AMPLE) sponsored by the National Board of Podiatric Medical Examination (NBPME), as well as a 2-year residency accredited by the CPME.

In British Columbia, the College of Podiatric Surgeons of BC is the licensing body and the registration requirements are similar to those described above for Alberta, however, the scope of practice in British Columbia appears somewhat broader than that in Alberta. The Alberta regulations reference the "foot and ankle," while the British Columbia regulations refer to the "foot and lower leg".

Currently, only US-trained DPMs who have completed the required residency are registered to practise podiatry in Alberta and British Columbia. Therefore, neither provincial authority has needed to perform a gap analysis or create a bridging program for graduates from other programs.

Adoption of Alberta and British Columbia Registration Requirements as Benchmark

The provincial authorities in Alberta and British Columbia require members to have education and training equivalent to that provided in US DPM and approved residency training. This education and training has been deemed by these provincial authorities as sufficient preparation to practise the full range of activities in the expanded scope of practice. Because of this, the project Steering Committee has recommended that these requirements serve as a benchmark against which all other education programs be evaluated.

Gap Identification – Current versus Expanded Scope

ProExam and the project Steering Committee undertook an exercise to compare the current competencies of Ontario practitioners, as outlined in the *Profile* and in legislation, with the competencies reflected in the US residency standards (which themselves support practise within expanded scope and are sufficient as preparation to practise in Alberta and British Columbia). The exercise makes explicit any gaps between the current and proposed expanded scope of practice. The results of this exercise are found in Appendix C.

The gaps are extensive, particularly for registrants who are not in the Podiatrist class. Gaps can be found with respect to diagnostic testing, forefoot osseous surgical management (except for the Podiatrist class of registrants), rearfoot osseous surgical management, and competencies related to a patient's general medical and surgical status. It is important to note that, while the Podiatrist class of registrants is restricted by legislation from performing a number of competencies, members of this class of registrants may have received *training* relevant to these competencies.

Education and Preparation to Practise

The extent of education and training that each cohort of registrants received that might support performance of the "gap" competencies identified above is described in this section. To the extent that education has been provided, this may mitigate the need for extensive bridging processes.

United States (Cohorts B and E)

According to the American Association of Colleges of Podiatric Medicine (AACPM), training in a DPM program prepares the podiatrist to act as a specialist in the prevention, diagnosis, and treatment of lower extremity disorders, diseases, and injuries. This individual works independently, utilizes x-rays and laboratory tests for diagnostic purposes, prescribes medications, orders physical therapy, sets fractures, and performs surgery. The scope of practice of podiatrists in the United States is defined by state law and varies from state to state. While scopes differ across jurisdictions, the majority permit the range of activities envisioned in the expanded scope proposed by the College.

There are nine accredited podiatric medical schools in the US. Specific educational competencies that the schools must build into their curricula in order to be accredited appear in Appendix D. These competencies were developed by the Council of Deans of the American Association of Colleges of Podiatric Medicine and approved by both the Council of Deans and the Council on Podiatric Medical Education

While a minimum of three years or 90 semester hours of undergraduate college credit at an accredited institution is required for admission, over 97% of the students who enter a school of podiatric medicine have a bachelor's degree. All of the schools of podiatric medicine

require undergraduate courses in biology, inorganic chemistry, organic chemistry, and physics.

The course of instruction leading to the DPM degree is four years in length. The first two years are devoted to classroom instruction and laboratory work in the basic medical sciences, such as anatomy, physiology, microbiology, biochemistry, pharmacology, and pathology. During the third and fourth years, students concentrate on courses in the clinical sciences, gaining experience in clinics and accredited hospitals. Clinical courses include general diagnosis (history taking, physical examination, clinical laboratory procedures, and diagnostic radiology), therapeutics (pharmacology, physical medicine, orthotics, and prosthetics), anesthesia and surgery.

Exhibit 1 shows a general four-year curriculum; all of the podiatric colleges vary in the course names, durations and in what year the courses are offered.

Exhibit 1
Sample US Podiatric College Course Sequence

Year 1*	Year 2	Year 3	Year 4
Anatomy Lower Extremity Anatomy Biochemistry Neurosciences Physical Diagnosis Physiology Introduction to Podiatric Medicine Microbiology** Immunology** Genetics** Biomechanics** Research**	Pathology Pharmacology Physical Diagnosis Microbiology** Immunology** Genetics** Biomechanics** Research** Medicine*** Orthopedics*** Podiatric Surgery*** Radiology***	Microbiology Immunology Genetics Biomechanics Research Medicine*** Orthopedics*** Podiatric Surgery*** Radiology***	Clinical All colleges offer clinical rotations in Emergency Medicine, Internal Medicine, General Surgery, & Radiology Clerkships
<p>* Note: Some colleges offer a separate course in a subject (such as Embryology), whereas others offer it as part of another course. ** courses that may be offered in year 1 or year 2 *** Didactic courses that may be offered in year 2 or year 3</p>		<p>Other Pediatrics Public Health Practice Management Sports Medicine</p>	

From <http://www.aacpm.org/html/careerzone/pdfs/AACPM%20CIB-2013%20Entering%20Class.pdf>

The three-part American Podiatric Medical Licensing Examination (APMLE) is offered by the National Board of Podiatric Medical Examiners (NBPME). The content of the AMPLE reflects the knowledge base required of DPM program graduates. Part I, usually taken after the completion of the second year of podiatric medical school, covers General Anatomy; Lower Extremity Anatomy; Biochemistry; Physiology; Medical Microbiology and Immunology; Pathology; and Pharmacology. Part II, taken shortly after completion of or during the fourth year in school, covers General Medicine; Dermatology; Radiology; Orthopaedics/ Biomechanics; Surgery/Anaesthesia/Hospital Protocol; and Community Health/ Jurisprudence. Part III covers both Part I and Part 2 content and is required for state licensure to practise.

After completing the four-year curriculum required by podiatric medical schools, a new podiatric physician is required to participate in residency training. Currently, most states require a minimum of two years of postgraduate residency training in an approved healthcare institution for licensure purposes. However, by 2015, all accredited residencies will be three years in duration, and the states are expected over time to adopt this as a requirement for practice over time. Residency programs are accredited by the CPME. The standards for accreditation incorporate a set of competencies expected to be successfully acquired during the residency process.

Post-licensure certification in podiatric surgery is offered by the American Board of Podiatric Surgeons (ABPS). Currently, candidates must complete a minimum of two years of residency training in a program approved by the Council on Podiatric Medical Education (CPME). One of the two years of training must be in a CPME-approved podiatric surgical residency. Candidates who attend a 24-month podiatric medicine and surgery (PM&S) program are eligible only for Certification in Foot Surgery. Candidates who attend a 36-month PM&S program are eligible for both Certification in Foot Surgery and Certification in Reconstructive Rearfoot/Ankle Surgery. Presumably the residency training requirement will expand to 36 months for all candidates, in keeping with recent changes in residency training accreditation requirements.

Ontario (Cohorts A and C)

George Brown College – Cohort A

The program at George Brown, at its inception in 1981, consisted of 88 weeks of training, with 3 terms per year across a two year span. The clinical component of training was provided at the Chiropody clinic at Toronto General Hospital. Graduates of the George Brown program were awarded a Diploma in Chiropody. Early revisions to the program, through approximately 1983, included increases in the number of clinical hours, and additional courses in introductory psychology, biomechanics, healthcare systems, and jurisprudence. The 1983 course list for the program appears in Exhibit 2.

**Exhibit 2
George Brown Course List 1983**

<p>First Semester</p> <ul style="list-style-type: none"> • Introduction to Chiropody • Human Anatomy and Physiology • Histology • Anatomy & Physiology of the Lower Extremities • Introductory Psychology • Language & Communications I • Podology I • Fundamental Principles • Pre-Clinical Skills <p>Second Semester</p> <ul style="list-style-type: none"> • Biology • Anatomy & Physiology of the Lower Extremities • Microbiology • Language and Communications II • Ethics for Health Sciences • Podology II • Orthotics • Clinical Skills (In-Clinical Practice) <p>Third Semester</p> <ul style="list-style-type: none"> • Pathology I • Pharmacology • Emergency Care • Biomechanics I • Podology III • Clinical Skills 	<p>Fourth Semester</p> <ul style="list-style-type: none"> • Pathology II • Society & Health Care • Communications & Health Care • Biomechanics II • Podology IV • Clinical Skills <p>Fifth Semester</p> <ul style="list-style-type: none"> • Applied Orthopaedics & Vascular Surgery • Dermatology • Pediatric Podology • Gerontology • Public Health & Jurisprudence • Biomechanics III • Clinical Skills <p>Sixth Semester</p> <ul style="list-style-type: none"> • Clinical Skills
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Beginning with the cohort that entered in 1986, the program was delivered in 2 terms per year across a three year span with a total of 108 weeks of training. At that time, a number of new courses were added, including Elementary Medical Science, Chiropodial Therapeutics and Physical Therapy, and Case Presentations; and the number of hours of pharmacology instruction and clinical training were increased. The 1986 course list appears in Exhibit 3.

Exhibit 3
George Brown Course List 1986

<p>First Semester</p> <ul style="list-style-type: none"> • Introduction to Chiropody • Pre-Clinical Skills • Podology and Orthotics • Chiropodial Therapeutics • General Elementary Medical Science (Medical Terminology, Anatomy and Physiology, and Microbiology) • Histology • Language & Communications I • Introductory Psychology <p>Second Semester</p> <ul style="list-style-type: none"> • Podology I • Chiropodial Therapeutics and Physical Therapy • Emergency Care (including CPR) • Field Trips • Case Presentations 1 • Clinical Skills I • Anatomy & Physiology of the Lower Extremities • Language and Communications II • Ethics for Health Sciences <p>Third Semester</p> <ul style="list-style-type: none"> • Podology I • Pharmacology • General Pathology • Biomechanics I • Case Presentations II • Society & Health Care • Communications & Health Care • Clinical Skills II 	<p>Fourth Semester</p> <ul style="list-style-type: none"> • Podology III • Surgery • Biomechanics II • Pathology • Gerontology • Public Health & Jurisprudence • Clinical Skills III • Seminar in Solving Problems in Professional Relationships <p>Fifth Semester</p> <ul style="list-style-type: none"> • Administration • Pediatric Podology • Dermatology • Clinical Skills IV (including Orthotics and Operating Room rotations) • <p>Sixth Semester</p> <ul style="list-style-type: none"> • Pre Graduate experience (including Field Clinical Placements, High Risk Clinics, Orthotics)
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The Michener Institute of Applied Health Sciences – Cohort A

The George Brown program was taken over by the Michener Institute around 1990. The Michener program includes seven semesters of study over a 3-year span. It was originally a post-secondary program, and students were awarded a Diploma in Chiropody (or Podiatric Medicine, depending on the year of graduation). Beginning with 2007 admissions, it became a post-bachelor's program and the diploma awarded is a Graduate Advanced Diploma of Health Sciences (Chiropody).

The Michener Institute's current course list can be found in Exhibit 4. In addition to the course topics covered in the George Brown program, the Michener Institute's curriculum includes courses specific to soft tissue surgery, “high risk” foot care, legislation and management, inter-professional collaboration, and research methodology.

Exhibit 4
Michener Institute Course List

<p>First Semester</p> <ul style="list-style-type: none"> • Foundations of Interprofessional Collaboration I • Structure and Function of the Lower Limb • Lower Extremity Anatomy Dissection • Pathophysiology • Podiatric Medicine I • Dermatology <p>Second Semester</p> <ul style="list-style-type: none"> • Foundations of Interprofessional Collaboration II • Podiatric Biomechanics I • Pathophysiology II • Clinical Pharmacology • Podiatric Medicine II • Podiatric Practice I <p>Third Semester</p> <ul style="list-style-type: none"> • Research • Laboratory Diagnosis and Imaging • Podiatric Biomechanics II • Podiatric Anesthesia and Injections • Podiatric Medicine III • Podiatric Clinical Practice II 	<p>Fourth Semester</p> <ul style="list-style-type: none"> • Interprofessional Collaborative Clinical Simulation • Management of the High Risk Foot • Podopediatrics • Podiatric Sports Medicine • Podiatric Soft Tissue Surgery • Podiatric Clinical Practice III <p>Fifth Semester</p> <ul style="list-style-type: none"> • Leadership in Health Care • Evidence Based Medicine Care • Podiatric Clinical Practice IV • Legislation & Practice Management <p>Sixth Semester</p> <ul style="list-style-type: none"> • Podiatric Clinical Placements (Clinical Practice V) <p>Seventh Semester</p> <ul style="list-style-type: none"> • Podiatric Clinical Externships • Research Project
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Quebec (Cohort F)

In Quebec, podiatrists are primary care practitioners who diagnose diseases, deformities, and injuries of the human foot and communicate diagnoses to patients. They treat patients using braces, casts, shields, orthotic devices, physical therapy, or prescribed medications. Podiatrists may also perform surgery on the bones of the forefoot and the subcutaneous soft tissues of the foot. Quebec podiatrists are permitted to perform radiography provided they have received the appropriate training and endorsement to do so.

The UQTR is the only university in Quebec offering a degree in podiatry. The program was established in 2004 and based largely on the United States podiatry programs. A Diploma of Collegial Studies (DCS) or the equivalent is required for admission, along with basic science prerequisite courses. These are the same prerequisites that are required for admission to medicine and dentistry programs in Quebec. The UQTR program was designed to meet the standards of accreditation of the CPME. This is a doctorate program culminating in the DPM degree. The program incorporates clinical practice in a variety of settings including hospitals affiliated with the New York College of Podiatric Medicine. The UQTR current course list can be found in Exhibit 5.

Exhibit 5
University of Quebec at Three Rivers Course List

<p>Autumn Semester, First Year</p> <ul style="list-style-type: none"> • Human Anatomy* • Clinical Biochemistry 1 • Histology: General Morphology • Podiatry I • Introduction to Orthopedics • Podiatric Clinical Observation Rotation • Human Physiology I <p>Winter Semester, First Year</p> <ul style="list-style-type: none"> • Anatomy of the Central Nervous System • Clinical Biochemistry II • Kinesiology in physical education and health • Histology: Systems Morphology • Podiatry II ▲ • Human Physiology II <p>Autumn Semester, Second Year</p> <ul style="list-style-type: none"> • Podiatric Anatomy • Microbiology and Infectious Diseases* • General Podiatric Clinical Surgery • Biomechanics and Podiatry • Podiatric Surgery I • Pathology* • Biophysics and Radiation Protection • Podiatric Radiology ▲ <p>Winter Semester, Second Year</p> <ul style="list-style-type: none"> • Pharmacology • Pathomechanics • Podiatry III • Orthotics and Prosthetics • Podiatric Surgery II ▲ • Introduction to Psychopathology <p>Summer Semester, Third Year</p> <ul style="list-style-type: none"> • Podiatric Clinic I • Scientific Documentation in the Clinical Sciences <p>Autumn Semester, Third Year</p> <ul style="list-style-type: none"> • Dermatology ▲ • Emergency Care • Internal Medicine • Clinical Neurology • Pharmacology and Podiatry • Podiatry IV • Podiatric Orthopedics I ▲ • Podiatric Clinic II • Radiology Clinic I • Pediatric Clinic I • Orthopedic Clinic I • Podiatric Surgery Clinic I • Laboratory Analyses 	<p>Winter Semester, Third Year</p> <ul style="list-style-type: none"> • Traumatology • Podiatric Orthopedics II ▲ • General Orthopedics • Podogeriatrics • Peripheral Vascular Diseases (PVD) • Podopediatrics • Podiatric Pathology ▲ • Forefoot Surgery ▲ • Podiatric Clinic III • Radiology Clinic II • Pediatric Clinic II • Orthopedic Clinic II • Podiatric Surgery Clinic II • Epidemiology and Community Health <p>Summer Semester, Fourth Year</p> <ul style="list-style-type: none"> • Reconstructive Surgery ▲ • Sports Podiatry • Podiatric Clinic IV • Radiology Clinic III • Pediatric Clinic III • Orthopedic Clinic III • Podiatric Surgery Clinic III • Rotation in Internal Medicine ♦ • Externship in Podiatric Medicine I ♦ <p>Autumn Semester, Fourth Year</p> <ul style="list-style-type: none"> • Clinic Management • Physical Medicine • Medical Ethics and Legal Issues • Podiatric Surgery III ▲ • Podiatric Clinic V • Radiology Clinic IV • Pediatric Clinic IV • Orthopedic Clinic IV • Podiatric Surgery Clinic IV • Externship in Podiatry II ♦ • Elective Externship ♦ <p>Winter Semester, Fourth Year</p> <ul style="list-style-type: none"> • Radiology Clinic V • Pediatric Clinic V • Orthopedic Clinic V • Podiatric Surgery Clinic V • Clinical Practicum in Private Clinic <p><u>Total Credits: 195</u></p> <p>* 2 semester course ♦ Practicum carried out at NYCPM ▲ Theoretical course offered by NYCPM</p>
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Programs outside Canada and the United States (Cohort D)

Save for some differences in terminology, there is a strong similarity in the scopes of work and the educational preparation pathways in the UK (cohort D1), AU (cohort D2), and SA (cohort D3). In the UK, the title Podiatrist is used to describe a practice that closely mirrors the current practice scope for chiropodists in Ontario.² In SA and AU, the scope of practice (the terms podiatry and chiropody are used interchangeably in these countries) is closely aligned with the UK scope. The academic preparation programs in the UK, SA, and AU are generally 3-year post-secondary programs.

United Kingdom – Cohort D1

The HCPC accredits 13 programs of podiatry/chiropody. The term "podiatry" in the UK describes a professional practice that is quite similar to that of a chiropodist in Ontario.

Of these 13, 3 schools are represented in the registrant pool (University of Salford, University of Brighton, and Queen Margaret University). All programs are 3-year post-secondary programs resulting in the award of a bachelor's degree. Seven of the 39 members of cohort D1 have attended schools that are among those currently accredited.

A summary of UK training across all of the programs from which registrants graduated is beyond the scope of this study. Samples are provided from current programs for illustration purposes. The program outline for one accredited school, the University of Salford, which is represented by five registrants, is shown in Exhibit 6.

Exhibit 6
University of Salford Program Outline

<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>
Concepts in Health Care Integrated Life Science Introduction to Professional Practice Professional Studies and Practice	Professional Studies Practice (2 classes) Human Gait Studies Foundation Medicine Gait and Locomotion Therapies (2 classes) Prescription only Medicine Local Analgesia	Diagnosis and Management (2 classes) Management and Leadership in Clinical Practice (2 classes) Clinical Practice Methods of Enquiry

A brief description of each class can be found on the University of Salford website. A second institution, the University of Wales - Cardiff provided their course sequence, which is displayed in Exhibit 7.

² As noted previously, members of the Podiatrist class of registrants perform within a broader scope than this.

Exhibit 7
University of Wales-Cardiff Program Outline

<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>
Podiatric Medicine 1	Podiatric Surgery 1	Project
Preclinical Studies	Placement Practice 1	Pharmacology
Professional Development 1	Clinical Practice 2	Podiatric Surgery 2
Medical Sciences 1	Professional Development 2	Placement Practice 2
Musculoskeletal Studies 1	(including Behavioural Studies)	Clinical Practice 3
Podiatric Medicine 1	Medical Sciences 2	Professional Development 3
	Musculoskeletal Studies 2	Podiatric Medicine 2
	Podiatric Medicine 2	

A benchmark statement issued by the Quality Assurance Agency for Higher Education in 2001 summarizes the competencies currently taught in the UK programs. The competencies listed in the benchmark document appear in Appendix E. They generally align with the competencies of the College members as defined in legislation and the Profile.

Australia – Cohort D2

Podiatry in Australia was originally closely modeled on its British counterpart, and the introduction of a uniform three year training program in the late 1960s established an educational equivalence that remains broadly extant. A description of the practice of Podiatry in Australia can be found in Appendix F. This practitioner is the general equivalent of the Chiropodist practicing within the current scope.

Podiatrists in Australia are primary health care professionals responsible for the care and treatment of the foot. They diagnose foot abnormalities and institute appropriate treatment, which may include the use of diagnostic radiography, podiatric instruments, clinical dressings, topical and oral drugs, local anaesthesia, minor surgical procedures, electrical treatment, and the prescription of orthoses. Most podiatrists in Australia work in private practice. Others work in hospitals, local government clinics, community health centres, and aged care facilities. (*Recognition of Podiatry Qualifications in Australia*, Australasian Podiatry Council, May 2006).

The Queensland University of Technology (QUT) program, from which the single member of cohort D2 graduated, is a 4-year bachelor's degree program preparing individuals to practise within the podiatry scope described above. The QUT website offers a very detailed program outline with specific course objectives and topics covered. A typical course sequence in podiatry is shown in Exhibit 8. The Ontario chiropodist who studied at QUT is a recent graduate of the program.

Exhibit 8
QUT Course of Study (Sample)

<p>Year 1, Semester 1</p> <ul style="list-style-type: none"> • Anatomy • Chemistry for Health and Medical Science • Contemporary Public Health • Interpersonal Processes and Skills <p>Year 1, Semester 2</p> <ul style="list-style-type: none"> • Biomechanics • Advanced Anatomy • Biomolecular Science • Human Physiology <p>Year 2, Semester 1</p> <ul style="list-style-type: none"> • Podiatric Clinical Gait Analysis • Disease Processes • Epidemiology • Podiatric Medicine 1 <p>Year 2, Semester 2</p> <ul style="list-style-type: none"> • Pharmacology For Health Professionals • Microbiology • Rehabilitation Medicine and Physical Therapies • Podiatric Medicine 2 	<p>Year 3, Semester 1</p> <ul style="list-style-type: none"> • Pharmacotherapeutics for Podiatrists • Radiographic Image Interpretation • Medicine • Podiatric Medicine 3 <p>Year 3, Semester 2</p> <ul style="list-style-type: none"> • Podiatric Anesthesiology • Clinical Therapeutics for Podiatrists • Orthopaedics and Sports Medicine • Podiatric Medicine 4 <p>Year 4, Semester 1</p> <ul style="list-style-type: none"> • Professional Placement 1 • Podiatric Medicine 5 • Podiatric Surgery <p>Year 4, Semester 2</p> <ul style="list-style-type: none"> • Transition to the Clinical Profession • Professional Placement 2 • Podiatric Medicine 6
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To practise as a podiatric surgeon in Australia, a podiatrist must have completed extensive, post-graduate medical and surgical training, which enables them to perform reconstructive surgery of the foot and ankle. Podiatric surgeons principally operate in private hospitals within a surgical team, which includes anaesthetists, medical practitioners, surgical assistants and nursing and hospital staff.

Candidates must complete a fellowship training program with the Australian College of Podiatric Surgeons. Requirements for admission to this program include completion of an accredited undergraduate degree in podiatry, a minimum of two years postgraduate podiatric clinical practice, and completion of an accredited master's degree program in podiatric surgery, podiatric medicine, medical science, or public health.

The fellowship program consists of lectures, case studies; a skills development course; clinical rotation; peer review activities; progressive development of preoperative, perioperative, and postoperative skills; mentoring; and research and preparation of publications. The first phase of training focuses on knowledge base development and is followed by a general surgical sciences exam. The second phase focuses on the acquisition and application of perioperative management skills and is followed by a Foot and Ankle Surgical Theory Exam. The third phase focuses on attaining competence in all aspects of surgery. This phase includes rearfoot and ankle surgery workshops and international preceptorship in the US. Each phase is roughly 1 year in duration.

South Africa- Cohort D3

Detailed information for the podiatry program at the Technikon Witwatersrand, the program at which the three South African registrants graduated was not available. However, a basic outline of the program and a comprehensive list of courses offered for the Baccalaureus Technologiae degree were provided in a dissertation written by Richard Matsoetsa, a former student of the Technikon Witwatersrand.

The program was a three-year, post-secondary degree program. The course sequence is shown in Exhibit 9.

Exhibit 9 Technikon Witwatersrand Course Sequence

<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>
<ul style="list-style-type: none"> • Podiatric Medicine 1 (podiatry and microbiology) • Social Studies (psychology, sociology, and communication) • Anatomy and Physiology • Chemistry 	<ul style="list-style-type: none"> • Podiatric Medicine 2 (pathology and medicine, and podiatry) • Podiatric Anatomy II • Physiology II • Clinical Studies II 	<ul style="list-style-type: none"> • Podiatric Medicine III (podopaediatrics, podogeriatrics, and sports medicine) • Clinical Studies III (theory and practical) • Research Project • Health Management Systems

Graduates of the program are eligible to practise with in the South African podiatry scope. Although the South Africa regulations describe the profession as podiatry, the scope is similar to the Chiropractic scope as practised in Ontario. Government regulations (Medical, Dental and Supplementary Health Service Professions Act, 1974) specify the scope of practice of the profession of podiatry as:

- The diagnosis of foot disorders and foot disabilities.
- The treatment of foot disorders and foot disabilities by means of:
 - the removal of corns, callosities, plantar warts and similar keratinous lesions;
 - the correction of nail abnormalities; and
 - appliances.
- The use and prescription of treatment, medicines, and corrective footwear to effect the aforesaid treatments.

Curriculum Comparison across Cohorts

ProExam, assisted by members of the Steering Committee and external subject-matter experts, undertook comparisons between available curriculum documentation from Ontario,

Quebec and Australian training programs³ and the knowledge deemed acceptable by Alberta and British Columbia (operationalized in this study as the knowledge competencies assessed in the AMPLE). It was assumed that graduates of US DPM programs already possessed these knowledge bases, as they had previously passed the AMPLE.

The results of these comparisons are shown in Appendix G. General anatomy is not well covered in the Ontario programs, but is covered in Quebec and Australia. Lower extremity anatomy is addressed across all four programs, as is biochemistry and physiology. Microbiology appears to be a gap for Ontario graduates. Radiology is covered for all but graduates of the George Brown program. Orthopedics, Biomechanics and Sports Medicine knowledge is addressed across the four programs. A significant gap exists for osseous surgery for all but the UQTR graduate.

One issue that is not revealed by this comparison is the depth of coverage of any given content area. It might be assumed that programs of two or three years' duration might not be able to impart the same depth and breadth in knowledge as those of four years duration.

Draft Temple University Bridging Program for Ontario and British Trained Chiropodists

Temple University designed a "Flexible DPM" program in the early 2000s for Ontario and British trained chiropodists to be awarded the DPM degree. The course was designed to accommodate chiropodists who were working full time, and could be completed in 3 to 5 years. While the program was never put into place, its design documents gaps identified at that time that required bridging. In addition, and more importantly, the format of the course (weekend courses in Canada plus clinical training and placements in the U.S., each of 2 and 4 weeks duration) offer a potential model for a bridging process.

The program design was coordinated by Sheree Aston, PhD, Associate Dean of Medical Education, with input from Temple University faculty. Review of the Michener program and several of the UK programs was undertaken to identify the necessary components of training.

Prior to admission to the program, students were to undergo a 3 day assessment process addressing 14 course areas. A prepared syllabus, learning objectives, and a suggested reading list were provided for each course. Based on their performance on the examination, students could earn credit for up to seven courses:

- Histology
- General anatomy

³ South Africa was excluded from the comparison because detailed curriculum materials were unavailable, despite numerous attempts to contact the educational institution and the professional association. The UK was excluded because there was no way to identify a core curriculum across the multiple training programs.

- Lower extremity anatomy
- Neuroscience
- Biochemistry
- Physiology
- Medical microbiology and immunology

The other seven courses, for which students could not be awarded transfer credit, were:

- Pharmacology
- Pathology
- Foot and ankle radiology
- Pathomechanics
- Physical medicine and rehabilitation
- Podiatric surgical principles
- Operating room principles

The draft curriculum consisted of:

- Advanced lower extremity anatomy – 40 hours – and practical
- Research design – 6 hours
- Pathology I and II – 40 hours
- Clinical pharmacology I and II – 40 hours
- Radiology sessions (in clinic)
- Podiatric skills assessment
- Dermatology – 20 hours
- Cadaver surgery course and lab – 33 hours
- Physical diagnosis workshops (full body history and physical) – 36 hours
- Vascular medicine – 22 hours
- Digital metatarsal surgery I and II – 40 hours
- Internal medicine I and II – 40 hours
- Clinical rotations: anesthesia & vascular, diabetes/wound care/diagnosis/PMI, and surgery I and surgery II – 2 weeks each
- Traumatology – online
- First ray surgery – 20 hours
- General orthopedics – 20 hours
- Reconstructive surgery I and II – 40 hours
- Clinical neurology – 20 hours
- Geriatrics – online
- Community health – online
- Internal medicine rotation – 4 weeks

- Surgery externship – 4 weeks
- Core externship – 4 weeks

Two factors may have led to the decision not to launch the program. First, the Michener Institute's program changed soon after the Flexible DPM program was to be launched. Second, when the assessment and placement test was first offered, nobody signed up.

Temple University Advanced Standing Program

In the mid- to late 2000s, Temple University accepted a number of Michener graduates into its DPM program through an advanced standing process. Temple is no longer accepting students through this route.

Michener graduates were awarded transfer credit for courses that were determined to be equivalent to Temple courses. An applicant in 2008 reported receiving transfer credit for Michener courses in general anatomy, neuroscience, podiatric practice 1, biomechanics, and research. The candidate was required to complete online course in six areas prior to admission: pharmacology, biochemistry, histology, immunology, pathology, and radiology. The candidate had taken some of these courses at Michener, but was not awarded transfer credit for them.

Michener graduates were admitted to year 3 of the 4 year Temple program. The 2008 applicant interviewed for this report had to take two of Temple's year 2 courses (gerontology and principles of digital and metatarsal surgery) in addition to the standard year 3 courses during her first year at Temple.

Once admitted, courses taken at Temple to "bridge" to the DPM were:

Year 3

- Principles of first ray surgery
- Fundamentals of dermatology
- Introduction to internal medicine
- Traumatology
- Reconstructive surgery of the foot and leg
- Professional administration and development
- Community health
- The law and podiatric medicine
- Cadaver surgery
- Rotations in peripheral vascular disease, neurology, infectious disease, and general orthopedics

Year 4

- Clerkships and externships

Gap Identification – Education and Training

United States (Cohorts B and E)

In general, the 85 college members who graduated from US DPM programs can be assumed to have received training to perform activities in the expanded scope of Ontario practice.

The 70 members of Cohort B, who received their degrees prior to 1995, are currently *permitted* to perform most of the activities within the expanded scope (excluding rearfoot surgery). However, it is not known whether all of the members of this cohort have *actually* been performing these activities. Some sort of bridging may be required for members of Cohort B whose practice activities in recent years do not reflect the full range permitted by legislation.

The 15 members of Cohort E, who received their degrees more recently than Cohort B (i.e., after 1994), have *not* been permitted to perform the activities in the expanded scope. However, members of this cohort, who completed their degrees and residencies most recently, may be well qualified to perform the activities.

For the members of Cohorts B and E, recency of degree as well as recency of on-the-job (or residency) performance should be considered when determining specific competency gaps.

If Ontario podiatrists will be administering general anaesthesia as part of the expanded scope, a potential gap in training exists related to administration of general anaesthesia. Podiatrists in the United States are not trained to administer general anaesthesia. US podiatrists may perform surgeries that require the use of general anaesthesia or monitored anaesthesia care; however, it must be administered by an anaesthesiologist.

Ontario (Cohorts A and C)

Both the George Brown program and the Michener Institute program were designed to prepare graduates to practise within the current scope of chiropody practice. Neither program prepared graduates to perform activities in the expanded scope.

It appears that neither the George Brown nor the Michener curriculum provided comprehensive coverage of biochemistry, physiology, microbiology, and immunology. There may be less obvious gaps related to a more limited time in which to cover material relative to a DPM program. In addition, neither program prepared graduates to perform osseous surgery, to manage such surgical cases, or to administer general anesthesia. Finally, the programs did not provide the training required to assess and manage a patient's general medical or surgical status. Bridging will be required for Cohorts A and C.

Quebec (Cohort F)

Minimal, if any, gaps appear exist for graduates of the UQTR, although post-degree surgical residency would likely be necessary.

UK (Cohort D1)

Education varies across UK programs, and the paucity of available documentation makes it challenging to summarize coverage and gaps. In general, it appears that anatomy, physiology, biochemistry, microbiology and pathology may be addressed at a more superficial level than would be desirable in the expanded scope. Anatomy and physiology education appears to focus exclusively on the lower limb. General medicine, osseous surgery, and diagnostic imaging are not covered. Research methodology does not appear to be addressed. There may be more significant gaps in education for the non-accredited schools.

A recent development in the UK is training and HPCP endorsement in Podiatric Surgery. Training in surgery involves acquisition of a master's degree and undergoing three years of supervised training followed by an examination. Aspects of this program may be informative during the development of surgical bridging programs for College members.

Australia (Cohort D2)

Australia's QUT program prepares individuals to practise within a scope that is akin to the chiropody scope in Ontario. Foundational sciences in anatomy, physiology, biochemistry, immunology, pharmacy, and medicine appear to be fairly well covered. These appear to be gaps related to laboratory testing, emergency medicine, special imaging modalities, and virology and immunology. General anesthesia also does not appear to be addressed in the curriculum. Surgical training focused on soft-tissue procedures only.

South Africa (Cohort D3)

From the minimal information available, it is difficult to draw conclusions regarding potential gaps. However, as noted previously, the scope of practice of South African podiatrists is similar to that of Ontario chiropodists. Similarities in training exist as well – the duration and scope of training appears somewhat similar to that provided by the Michener Institute, although without more detailed documentation, such comparisons are difficult to draw with any certainty. In the absence of additional information, gaps may be assumed similar to those identified for cohorts A and C.

Recommendations

Bridging will be required for Cohorts A, C, and D. The extent and nature of the bridging program(s) is yet to be determined. The draft Temple University upgrade program for Ontario and UK graduates may provide direction in this regard. However, it should be noted that the Michener Institute's curriculum has changed since that program was developed, so the actual coursework proposed in the model would need to be re-evaluated. Additional guidance in bridging program development may also be found in the UK and AU post-graduate training programs in podiatric surgery.

More limited refresher training may be required within Cohorts B and E, depending on individual circumstances. If the registrant received training related to the expanded scope more than 5 or 10 years ago, is this recent enough to ensure safe and effective practice? Has technology changed significantly? Another consideration is recency of actual performance of activities within the expanded scope. If the registrant has not performed surgical procedures recently (either in residency or in actual practice), might this indicate the need for additional training?

Bridging program content for a given cohort can be established based on the results of this competency assessment. At the same time, it may be helpful to consider individual differences within a cohort. A registrant may have undertaken post-diploma or post-degree training related to aspects of the expanded scope as part of their continuing education activities. The use of a placement test might be helpful to determine what bridging requirements should be met on an individual basis.

The College will need to investigate potential university, clinic, and hospital partners in Ontario, Quebec, and/or the US to develop the didactic and clinical components of the training. The College may wish to consider partnering with a DPM program in the US to deliver some or all of the clinical aspects of training. The UQTR's partnership with the New York College of Podiatric Medicine in delivering their DPM program content is an example of the utility of such a model.

In designing a bridging program, it may be helpful to look to the US and AU residency competencies for guidance. The CPME accreditation requirements for US podiatric residency training programs outline the specific competencies expected to be acquired during residency. The recently issued podiatric surgery accreditation requirements of the Australian and New Zealand Podiatry Accreditation Council (ANZPAC) also outline specific competencies to be acquired during post-degree training. In addition, the UK master's degree programs in the theory of podiatric surgery describe education content relevant to podiatric surgery. All are potential information resources for bridging program design, particularly around training in osseous surgical techniques.

Whatever its eventual content, the bridging program must fit the needs of the already registered members of the College. It may be best to include webinars, podcasts, and

flexible scheduling within the bridging programs design such that members will be able to pursue furthering their practice while maintaining their work and personal schedules. The use of distance learning, weekend courses, and brief clinical experiences will facilitate access to and participation in the bridging process.

Appendix A
Proposed Authorized Acts and Scope of Practice

**Proposed Authorized Acts & Scope of Practice
For
HPRAC Review
Approved by Council - June 8, 2012**

In the course of engaging in the practice of podiatry, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to perform the following:

1. Communicating a diagnosis identifying a disease or disorder of the foot or ankle as the cause of a person's symptoms.
2. Performing a procedure on tissues below the dermis to treat condition of the ankle or foot.
3. Setting or casting a fracture of a bone or dislocation of a joint, in the foot or ankle.
4. Administering, by inhalation, a substance designated in the Regulations.
5. Administering, by injection, a substance designation in the Regulations.
6. Applying or ordering the application of a prescribed form of energy.
7. Prescribing, dispensing and selling a drug designated in the Regulations.

Scope of Practice

The scope of practice statement would be expanded as follows:

“The practice of podiatry is the assessment or diagnosis of the foot and ankle and the treatment and prevention of diseases, disorders or dysfunctions of the foot, ankle and structures affecting the foot or ankle by therapeutic, orthotic or palliative means.”

Appendix B
Summary of Registrants in Podiatrist and Chiropodist Class

Podiatrist Class of Registrant

Country, Institution, Year of Degree	Count
USA	70
Dr. Wm M Scholl Col of Podiatric Medicine (former IL College of Podiatric Medicine)	18
1964	1
1975	1
1976	1
1980	1
1982	3
1983	2
1986	1
1987	1
1989	1
1991	4
1993	2
California College of Podiatric Medicine	4
1975	1
1981	2
1991	1
New York College of Podiatric Medicine	7
1953	1
1970	1
1973	2
1986	1
1992	2
Ohio College of Podiatric Medicine	37
1961	1
1964	2
1971	2
1972	3
1973	1
1974	3
1975	1
1976	1
1977	2
1978	4
1979	2
1980	5
1981	1
1982	3
1984	2

Podiatrist Class of Registrant

Country, Institution, Year of Degree	Count
USA	70
1987	2
1992	1
1993	1
Pennsylvania College of Podiatric Med.	4
1975	1
1981	2
1993	1
Grand Total	70

Classification: Regular Member

Country, Institution, Year of Degree or Diploma	Count
Australia	1
Queensland University of Technology 2006	1 1
Canada	475
George Brown College	112
1983	13
1984	11
1985	11
1986	15
1987	18
1989	13
1990	17
1991	9
1994	5
George Brown College/Michener Institute (Both on Diploma)	39
1991	9
1992	15
1993	8
1994	7
Michener Institute	323
1995	17
1996	23
1997	16
1998	14
1999	23
2000	17
2001	12
2003	19
2004	20
2005	16
2006	15
2007	27
2008	3
2009	24
2010	29
2011	26
2012	22
University of Quebec at Trois Rivières	1
2010	1

Classification: Regular Member

Country, Institution, Year of Degree or Diploma	Count
United Kingdom	39
Birmingham School of Podiatry, Matthew Boulton College	1
2003	1
Brighton Polytechnic	1
1988	1
Chelsea School of Chiropody	4
1976	1
1986	1
1987	1
1989	1
Coll. of Further Ed., School of Chiropody	1
1984	1
Edinburgh School of Chiropody	4
1975	1
1980	2
1983	1
Glasgow School of Chiropody	3
1980	1
1981	1
1985	1
Huddersfield Polytechnic	1
1982	1
London Foot Hospital	2
1976	1
1988	1
Manchester Foot Hospital & School of Chiropody	2
1965	1
1969	1
Northern College of Chiropody	1
1985	1
Northern Ireland School of Chiropody	1
1987	1
Plymouth School of Podiatry	1
2000	1
Queen Margaret College	1
1993	1
Queen`s University of Belfast	1
1997	1
Salford/Manchester Foot Hospital	1
2010	1

Classification: Regular Member

Country, Institution, Year of Degree or Diploma	Count
Great Britain (cont.)	
Sussex School of Chiropody	2
1987	2
The SMAE Institute	1
2002	1
University of Brighton	2
1993	1
2009	1
University of Huddersfield	2
2009	1
2011	1
University of Salford (formerly Salford Col of Tech)	5
1984	1
1997	1
2000	1
2007	1
2008	1
University of Wales - Podiatric Studies	2
2006	1
2011	1
South Africa	3
Technikon Witwatersrand, South Africa	3
1993	1
1994	1
2001	1
USA	15
Dr. Wm M Scholl Col of Pod Med	2
1996	1
2002	1
Barry University School of Podiatric Medicine	1
1993	1
California College of Podiatric Medicine	1
1999	1
New York College of Podiatric Medicine	3
1985	1
1993	1
1997	1
Ohio College of Podiatric Medicine	6
1968	1
1993	1
2002	1

Classification: Regular Member

Country, Institution, Year of Degree or Diploma	Count
USA	
Ohio College of Podiatric Medicine (cont.)	
2004	1
2005	1
2008	1
Temple University School of Podiatric Medicine	2
2001	1
2006	1
Grand Total	533

Appendix C
Mapping of Ontario Core Competencies against Residency Competencies

Mapping of the College of Chiropodists of Ontario Core Competencies and Legislation against Competencies Acquired During Residency Training⁴

Competencies Acquired during Residency Training	All Registrants	Podiatry Class of Registrant
A. Prevent, diagnose, and medically and surgically manage diseases, disorders, and injuries of the pediatric and adult lower extremity.		
1. Perform and interpret the findings of a thorough problem-focused history and physical exam, including:		
problem-focused history	✓	✓
neurologic examination	✓	✓
vascular examination	✓	✓
dermatologic examination	✓	✓
musculoskeletal examination	✓	✓
biomechanical examination	✓	✓
gait analysis	✓	✓
2. Formulate an appropriate diagnosis and/or differential diagnosis	✓	✓
3. Perform (and/or order) and interpret appropriate diagnostic studies, including:		
<input type="checkbox"/> Medical imaging, including		
plain radiography	Can interpret only	Can order and & interpret
stress radiography	Can interpret only	Can order and & interpret
fluoroscopy	GAP	✓
nuclear medicine imaging	GAP	GAP
MRI	GAP	GAP
CT	GAP	GAP
diagnostic ultrasound	✓	✓
vascular imaging	GAP	GAP
<input type="checkbox"/> Laboratory tests in hematology, serology/ immunology, toxicology, and microbiology, to include blood chemistries, drug screens, coagulation studies, blood gases, synovial fluid analysis, urinalysis	GAP	Can order as non-billable service & interpret
<input type="checkbox"/> Pathology, including anatomic and cellular pathology	GAP	GAP
<input type="checkbox"/> Other diagnostic studies, including electrodiagnostic studies, non- invasive vascular studies, bone mineral densitometry studies, compartment pressure studies	GAP	GAP

⁴ ✓ indicates competency is mapped and no gap exists

Competencies Acquired during Residency Training	All Registrants	Podiatry Class of Registrant
4. Formulate and implement an appropriate plan of management, including:	✓	✓
<input type="checkbox"/> Direct participation of the resident in the evaluation and management of patients in a clinic/office setting		
- perform biomechanical cases and manage patients with lower extremity disorders utilizing a variety of prosthetics, orthotics, and footwear	✓	✓
<input type="checkbox"/> Management when indicated, including		
- dermatologic conditions	✓	✓
- manipulation/mobilization of foot/ankle joint to increase range of motion/reduce associated pain and of congenital foot deformity	✓	✓
- closed fractures and dislocations including pedal fractures and dislocations and ankle fracture/dislocation	GAP	GAP
- cast management	✓	✓
- tape immobilization	✓	✓
- orthotic, brace, prosthetic, and custom shoe management	✓	✓
- footwear and padding	✓	✓
- injections and aspirations	Some permitted according to regulation; GAP ankle	✓
- physical therapy	✓	✓
- pharmacologic management, including the use of NSAIDs, antibiotics, antifungals, narcotic analgesics, muscle relaxants, medications for neuropathy, sedative/ hypnotics, peripheral vascular agents (topical only podiatrist only), anticoagulants, antihyperuricemic/ uricosuric agents, tetanus toxoid/immune globulin, laxatives/cathartics, fluid and electrolyte management, corticosteroids, anti-rheumatic medications	More limited prescriptive authority	More limited prescriptive authority
<input type="checkbox"/> Surgical management when indicated, including		
- evaluating, diagnosing, selecting appropriate treatment and avoiding complications		
- preoperative, intraoperative, and postoperative assessment and management in surgical areas including		
1 Digital Surgery (lesser toe or hallux)		
1.1 partial ostectomy/exostectomy	GAP	✓
1.2 phalangectomy	GAP	✓
1.3 arthroplasty (interphalangeal joint [IPJ])	GAP	✓
1.4 implant (IPJ)	GAP	✓
1.5 diaphysectomy	GAP	✓
1.6 phalangeal osteotomy	GAP	✓
1.7 fusion (IPJ)	GAP	✓
1.8 amputation	GAP	✓

Competencies Acquired during Residency Training	All Registrants	Podiatry Class of Registrant
1.9 management of osseous tumor/neoplasm	GAP	✓
1.10 management of bone/joint infection	GAP	✓
1.11 open management of digital fracture/dislocation	GAP	Dislocation only
1.12 revision/repair of surgical outcome	GAP	✓
1.13 other osseous digital procedure not listed above	GAP	✓
2 First Ray Surgery		
<u>Hallux Valgus Surgery</u>		
2.1.1 bunionectomy (partial ostectomy/Silver procedure)	GAP	✓
2.1.2 bunionectomy with capsulotendon balancing procedure	GAP	✓
2.1.3 bunionectomy with phalangeal osteotomy	GAP	✓
2.1.4 bunionectomy with distal first metatarsal osteotomy	GAP	✓
2.1.5 bunionectomy with first metatarsal base or shaft osteotomy	GAP	✓
2.1.6 bunionectomy with first metatarsocuneiform fusion	GAP	GAP
2.1.7 metatarsophalangeal joint (MPJ) fusion	GAP	✓
2.1.8 MPJ implant	GAP	✓
2.1.9 MPJ arthroplasty	GAP	✓
<u>Hallux Limitus Surgery</u>		
2.2.1 cheilectomy	GAP	✓
2.2.2 joint salvage with phalangeal osteotomy (Kessel-Bonney, enclavement)	GAP	✓
2.2.3 joint salvage with distal metatarsal osteotomy	GAP	✓
2.2.4 joint salvage with first metatarsal shaft or base osteotomy	GAP	✓
2.2.5 joint salvage with first metatarsocuneiform fusion	GAP	GAP
2.2.6 MPJ fusion	GAP	✓
2.2.7 MPJ implant	GAP	✓
2.2.8 MPJ arthroplasty	GAP	✓
<u>Other First Ray Surgery</u>		
2.3.1 tendon transfer/lengthening/capsulotendon balancing procedure	GAP	✓
2.3.2 osteotomy (e.g., dorsiflexory)	GAP	✓
2.3.3 metatarsocuneiform fusion (other than for hallux valgus or hallux limitus)	GAP	GAP
2.3.4 amputation	GAP	✓
2.3.5 management of osseous tumor/neoplasm (with or without bone graft)	GAP	✓
2.3.6 management of bone/joint infection (with or without bone graft)	GAP	✓
2.3.7 open management of fracture or MPJ dislocation	GAP	GAP
2.3.8 corticotomy/callus distraction	GAP	✓
2.3.9 revision/repair of surgical outcome (e.g., non-union, hallux varus)	GAP	✓
2.3.10 other first ray procedure not listed above	GAP	✓

Competencies Acquired during Residency Training	All Registrants	Podiatry Class of Registrant
3 Other Soft Tissue Foot Surgery		
3.1 excision of ossicle/sesamoid	GAP	✓
3.2 excision of neuroma	GAP	✓
3.3 removal of deep foreign body (excluding hardware removal)	GAP	✓
3.4 plantar fasciotomy	GAP	✓
3.5 lesser MPJ capsulotendon balancing	GAP	✓
3.6 tendon repair, lengthening, or transfer involving the forefoot (including digital flexor digitorum longus transfer)	GAP	✓
3.7 open management of dislocation (MPJ/tarsometatarsal)	GAP	✓
3.8 incision and drainage/wide debridement of soft tissue infection (including plantar space)	GAP	✓
3.9 plantar fasciectomy	GAP	✓
3.10 excision of soft tissue tumor/mass of the foot (without reconstructive surgery)	GAP	✓
3.11 (procedure code number no longer used)		✓
3.12 plastic surgery techniques (including skin graft, skin plasty, flaps, syndactylization, desyndactylization, and debulking procedures limited to the forefoot)	GAP	✓
3.13 microscopic nerve/vascular repair (forefoot only)	GAP	✓
3.14 other soft tissue procedures not listed above (limited to the foot)	GAP	✓
3.15 excision of soft-tissue tumor/mass of the ankle (without reconstructive surgery)	GAP	GAP
3.16 external neurolysis/decompression (including tarsal tunnel)	GAP	✓
4 Other Osseous Foot Surgery		
4.1 partial ostectomy (including the talus and calcaneus)	GAP	GAP beyond forefoot
4.2 lesser MPJ arthroplasty	GAP	✓
4.3 bunionectomy of the fifth metatarsal without osteotomy	GAP	✓
4.4 metatarsal head resection (single or multiple)	GAP	✓
4.5 lesser MPJ implant	GAP	✓
4.6 central metatarsal osteotomy	GAP	✓
4.7 bunionectomy of the fifth metatarsal with osteotomy	GAP	✓
4.8 open management of lesser metatarsal fracture(s)	GAP	✓
4.9 harvesting of bone graft distal to the ankle	GAP	✓
4.10 amputation (lesser ray, transmetatarsal amputation)	GAP	✓
4.11 management of bone/joint infection distal to the tarsometatarsal joints (with or without bone graft)	GAP	✓
4.12 management of bone tumor/neoplasm distal to the tarsometatarsal joints (with or without bone graft)	GAP	GAP
4.13 open management of tarsometatarsal fracture/dislocation	GAP	GAP
4.14 multiple osteotomy management of metatarsus adductus	GAP	✓
4.15 tarsometatarsal fusion	GAP	GAP
4.16 corticotomy/callus distraction of lesser metatarsal	GAP	✓

Competencies Acquired during Residency Training	All Registrants	Podiatry Class of Registrant
4.17 revision/repair of surgical outcome in the forefoot	GAP	✓
4.18 other osseous procedures not listed (distal to the tarsometatarsal joint)	GAP	✓
4.19 detachment/reattachment of Achilles tendon with partial ostectomy	GAP	GAP partial ostectomy
5 Reconstructive Rearfoot/Ankle Surgery		
<u>Elective - Soft Tissue</u>		
5.1.1 plastic surgery techniques involving the midfoot, rearfoot, or ankle	GAP	GAP ankle
5.1.2 tendon transfer involving the midfoot, rearfoot, ankle, or leg	GAP	GAP
5.1.3 tendon lengthening involving the midfoot, rearfoot, ankle, or leg	GAP	GAP
5.1.4 soft tissue repair of complex congenital foot/ankle deformity (clubfoot, vertical talus)	GAP	GAP
5.1.5 delayed repair of ligamentous structures	GAP	✓
5.1.6 ligament or tendon augmentation/ supplementation/restoration	GAP	✓
5.1.7 open synovectomy of the rearfoot/ankle	GAP	GAP
5.1.8 (procedure code number no longer used)		
5.1.9 other elective rearfoot reconstructive/ ankle soft-tissue surgery not listed above	GAP	GAP ankle
<u>Elective - Osseous</u>		
5.2.1 operative arthroscopy	GAP	GAP
5.2.2 (procedure code number no longer used)		
5.2.3 subtalar arthroeresis	GAP	✓
5.2.4 midfoot, rearfoot, or ankle fusion	GAP	GAP
5.2.5 midfoot, rearfoot, or tibial osteotomy	GAP	GAP
5.2.6 coalition resection	GAP	GAP
5.2.7 open management of talar dome lesion (with or without osteotomy)	GAP	GAP
5.2.8 ankle arthrotomy with removal of loose body or other osteochondral debridement	GAP	GAP
5.2.9 ankle implant	GAP	GAP
5.2.10 corticotomy or osteotomy with callus distraction/correction of complex deformity of the midfoot, rearfoot, ankle, or tibia	GAP	GAP
5.2.11 other elective rearfoot reconstructive/ ankle osseous surgery not listed above	GAP	GAP
<u>Non-Elective - Soft Tissue</u>		
5.3.1 repair of acute tendon injury	GAP	✓
5.3.2 repair of acute ligament injury	GAP	✓
5.3.3 microscopic nerve/vascular repair of the midfoot, rearfoot, or ankle	GAP	✓
5.3.4 excision of soft tissue tumor/mass of the foot (with reconstructive surgery)	GAP	✓
5.3.5 (procedure code number no longer used)		
5.3.6 open repair of dislocation (proximal to tarsometatarsal joints)	GAP	GAP

Competencies Acquired during Residency Training	All Registrants	Podiatry Class of Registrant
5.3.7 other non-elective rearfoot reconstructive/ankle soft tissue surgery not listed above	GAP	✓
5.3.8 excision of soft tissue tumor/mass of the ankle (with reconstructive surgery)	GAP	GAP
<u>Non-Elective - Osseous</u>		
5.4.1 open repair of adult midfoot fracture	GAP	GAP
5.4.2 open repair of adult rearfoot fracture	GAP	GAP
5.4.3 open repair of adult ankle fracture	GAP	GAP
5.4.4 open repair of pediatric rearfoot/ankle fractures or dislocations	GAP	GAP
5.4.5 management of bone tumor/neoplasm (with or without bone graft)	GAP	GAP
5.4.6 management of bone/joint infection (with or without bone graft)	GAP	GAP
5.4.7 amputation proximal to the tarsometatarsal joints	GAP	GAP
5.4.8 other non-elective rearfoot reconstructive/ankle osseous surgery not listed above	GAP	GAP
6 Other Podiatric Procedures		
6.1 debridement of superficial ulcer or wound	✓	✓
6.2 excision or destruction of skin lesion (including skin biopsy and laser procedures)	✓	✓
6.3 nail avulsion (partial or complete)	✓	✓
6.4 matrixectomy (partial or complete, by any means)	✓	✓
6.5 removal of hardware	GAP	✓
6.6 repair of simple laceration (no neurovascular, tendon, or bone/joint involvement)	✓	✓
6.7 biological dressings	✓	✓
6.8 extracorporeal shock wave therapy	✓	✓
6.9 taping/padding (limited to the foot, and ankle)	✓	✓
6.10 orthotics (limited to the foot, and ankle casting for foot orthosis and ankle orthosis)	✓	✓
6.11 prosthetics (including prescribing and/or dispensing toe filler and prosthetic feet)	✓	✓
6.12 other biomechanical experiences not listed above (may include, but is not limited to, physical therapy, shoe prescription shoe modification)	✓	✓
6.13 other clinical experiences	✓	✓
6.14 percutaneous procedures, i.e., coblation, cryosurgery, radiofrequency ablation, platelet-rich plasma.	3.8.9, 3.8.10 platelet-rich plasma only	3.8.9, 3.8.10 platelet-rich plasma only
<input type="checkbox"/> Anesthesia management when indicated, including		
Local	✓	✓
General	GAP	GAP
Spinal	GAP	GAP
Epidural	GAP	GAP
Regional	✓	✓

Competencies Acquired during Residency Training	All Registrants	Podiatry Class of Registrant
Conscious sedation	GAP	GAP
<input type="checkbox"/> Consultation and/or referrals	✓	✓
<input type="checkbox"/> Lower extremity health promotion and education	✓	✓
5. Assess the treatment plan and revise it as necessary	✓	✓
<input type="checkbox"/> Direct participation of the resident in urgent and emergent evaluation and management of podiatric and non-podiatric patients	GAP	GAP
B. Assess and manage the patient's general medical and surgical status.		
1. Perform and interpret the findings of comprehensive medical history and physical examinations (including pre-operative history and physical examination), including (see Appendix A):		
<input type="checkbox"/> Comprehensive medical history	GAP	GAP
<input type="checkbox"/> Comprehensive physical examination		
- vital signs	✓	✓
- physical examination including head, eyes, ears, nose, and throat, neck, chest/breast, heart, lungs, abdomen, genitourinary, rectal, upper extremities, neurologic examination	GAP	GAP
2. Formulate an appropriate differential diagnosis of the patient's general medical problem(s)	GAP	GAP
3. Recognize the need for (and/or order) additional diagnostic studies, when indicated, including (see also section A.3 for diagnostic studies not repeated in this section)		
<input type="checkbox"/> EKG	GAP	GAP
<input type="checkbox"/> Medical imaging including plain radiography, nuclear medicine imaging, MRI, CT, diagnostic ultrasound	GAP	GAP
<input type="checkbox"/> Laboratory studies including hematology, serology/immunology, blood chemistries, toxicology/drug screens, coagulation studies, blood gases, microbiology, synovial fluid analysis, urinalysis	GAP	GAP
<input type="checkbox"/> Other diagnostic studies	GAP	GAP
4. Formulate and implement an appropriate plan of management, when indicated, including appropriate therapeutic intervention, appropriate consultations and/or referrals, and appropriate general medical health promotion and education	GAP	GAP
5. Participate actively in medicine and medical subspecialties rotations that include medical evaluation and management of patients from diverse populations, including variations in age, sex, psychosocial status, and socioeconomic status	GAP	GAP

Competencies Acquired during Residency Training	All Registrants	Podiatry Class of Registrant
6. Participate actively in general surgery and surgical subspecialties rotations that include surgical evaluation and management of non-podiatric patients including, but not limited, to: <ul style="list-style-type: none"> <input type="checkbox"/> Understanding management of preoperative and postoperative surgical patients with emphasis on complications <input type="checkbox"/> Enhancing surgical skills, such as suturing, retracting, and performing surgical procedures under appropriate supervision <input type="checkbox"/> Understanding surgical procedures and principles applicable to non-podiatric surgical specialties 	GAP	GAP
7. Participate actively in an anesthesiology rotation that includes pre-anesthetic and post-anesthetic evaluation and care, as well as the opportunity to observe and/or assist in the administration of anesthetics. Training experiences must include, but not be limited to: <ul style="list-style-type: none"> <input type="checkbox"/> Local anesthesia <input type="checkbox"/> General, spinal, epidural, regional, and conscious sedation anesthesia 	GAP	GAP
8. Participate actively in an emergency medicine rotation that includes emergent evaluation and management of podiatric and non-podiatric patients	GAP	GAP
9. Participate actively in an infectious disease rotation that includes, but is not limited to, the following training experiences: <ul style="list-style-type: none"> <input type="checkbox"/> Recognizing and diagnosing common infective organisms <input type="checkbox"/> Using appropriate antimicrobial therapy <input type="checkbox"/> Interpreting laboratory data including blood cultures, gram stains, microbiological studies, and antibiotics monitoring <input type="checkbox"/> Exposure to local and systemic infected wound care. 	GAP	GAP
10. Participate actively in a behavioral science rotation that includes, but is not limited to: <ul style="list-style-type: none"> <input type="checkbox"/> Understanding of psychosocial aspects of health care delivery <input type="checkbox"/> Knowledge of and experience in effective patient-physician communication skills <input type="checkbox"/> Understanding cultural, ethnic and socioeconomic diversity of patients <input type="checkbox"/> Knowledge of the implications of prevention and wellness 	GAP	GAP
C. Practice with professionalism, compassion, and concern in a legal, ethical, and moral fashion.		
1. Abide by state and federal laws, including the Health Insurance Portability and Accountability Act (HIPAA), governing the practice of podiatric medicine and surgery	✓	✓
2. Practice and abide by the principles of informed consent	✓	✓
3. Understand and respect the ethical boundaries of interactions with patients, colleagues, and employees	✓	✓
4. Demonstrate professional humanistic qualities	✓	✓
5. Demonstrate ability to formulate a methodical and comprehensive treatment plan with appreciation of healthcare costs	✓	✓

Competencies Acquired during Residency Training	All Registrants	Podiatry Class of Registrant
D. Communicate effectively and function in a multi-disciplinary setting.		
1. Communicate in oral and written form with patients, colleagues, payors, and the public	✓	✓
2. Maintain appropriate medical records	✓	✓
E. Manage individuals and populations in a variety of socioeconomic and healthcare settings.		
1. Demonstrate an understanding of the psychosocial and healthcare needs for patients in all life stages: pediatric through geriatric	✓	✓
2. Demonstrate sensitivity and responsiveness to cultural values, behaviors, and preferences of one's patients when providing care to persons whose race, ethnicity, nation of origin, religion, gender, and/or sexual orientation is/are different from one's own	✓	✓
3. Demonstrate an understanding of public health concepts, health promotion, and disease prevention	✓	✓
F. Understand podiatric practice management in a multitude of healthcare delivery settings.		
1. Demonstrate familiarity with utilization management and quality improvement	✓	✓
2. Understand healthcare reimbursement	✓	✓
3. Understand insurance issues including professional and general liability, disability, and Workers' Compensation	✓	✓
4. Understand medical-legal considerations involving healthcare delivery	✓	✓
5. Demonstrate understanding of common business practices	✓	✓
G. Be professionally inquisitive, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice.		
1. Read, interpret, and critically examine and present medical and scientific literature	✓	✓
2. Collect and interpret data and present the findings in a formal study related to podiatric medicine and surgery	N/A	N/A
3. Demonstrate information technology skills in learning, teaching, and clinical practice	N/A	N/A
4. Participate in continuing education activities	✓	✓

Appendix D
US Educational Competencies

Appendix to the CPME Accreditation Standards

The following expanded list of required competencies were developed by the Council of Deans of the American Association of Colleges of Podiatric Medicine and approved by both the Council of Deans and the Council on Podiatric Medical Education. The competencies reflect and are guided by the recommendations of the Educational Enhancement Project of the American Podiatric Medical Association.

- 1. Demonstrate knowledge of the pre-clinical sciences which provide the foundations of podiatric clinical training, residency training, and practice.**
 - a. Demonstrate knowledge of normal human anatomy, physiology, molecular biology, and the biochemical structure and function of the human body and its organ systems.
 - b. Demonstrate knowledge of the causes of disease and of altered structure and function of the human body and its organ systems.
 - c. Demonstrate knowledge of pharmacological principles and pharmacological interventions.
 - d. Demonstrate knowledge of microbes (bacteria, fungi, viruses, and parasites) and the diseases that they cause.
 - e. Demonstrate knowledge of the structure and function of the immune system.

- 2. Prevent, diagnose, and manage diseases and disorders of the lower extremity in a cost effective manner.**
 - a. Perform and interpret a history and physical examination as related to pathology of the systems of the lower extremity, with specific consideration given to gender, racial and ethnic background, social, and cultural differences.
 - b. Perform and/or interpret the most frequent clinical, laboratory, imaging, gait and biomechanical analyses, and other diagnostic studies used to detect and diagnose pathologies of the lower extremity.
 - c. Demonstrate knowledge of the pathologic manifestations of common conditions of the lower extremity.
 - d. Formulate an appropriate differential diagnosis and management plan, which may include patient education, prevention programs, and treatment strategies.
 - e. Actively participate in the performance of treatment techniques using medical and surgical means, recognizing the need to refer to other healthcare providers when necessary.
 - f. Perform specific technical procedures:
 - Demonstrate the application of universal precautions
 - Demonstrate the principles of sterile or aseptic technique
 - Apply simple splints and casts
 - Biomechanical examination
 - Perform basic primary podiatric skills
 - g. Assess treatment plans and revise as necessary.

- 3. Assess medical conditions that affect the lower extremity and refer, as appropriate, those patients with conditions identified during the evaluation.**
 - a. Perform a complete medical history and physical.
 - b. Recognize abnormal medical history and physical findings and formulate a differential diagnosis.
 - c. Demonstrate knowledge of the most frequent clinical, laboratory, imaging, and pathological manifestation of common illness.
 - d. Develop management plans incorporating health promotion and education, diagnostic modalities, and appropriate referrals.
 - e. Recognize patients with life threatening emergencies and institute initial therapy.

- 4. Practice with professionalism, compassion, and concern and in an ethical fashion regardless of the patient's social class, gender, or racial, or ethnic background.**
 - a. Demonstrate knowledge of the ethical and legal boundaries of the doctor-patient relationship.
 - b. Demonstrate knowledge of state laws governing the practice of the profession.
 - c. Demonstrate knowledge of the principles of bioethics including customary and accepted standards of professional practice.
 - d. Demonstrate knowledge of the principles of self-regulation of the profession. e. Practice with honesty and integrity avoiding conflicts of interest.
 - f. Recognize the need to deliver care in a caring, compassionate, and humane way to meet the needs of patients regardless of their individual circumstances.

- 5. Demonstrate the ability to communicate and work collaboratively with others and to function in a professional manner in an interprofessional setting.**
 - a. Demonstrate proficient listening and interviewing skills.
 - b. Communicate orally and in writing with patients, peers, other professionals, and the public.
 - c. Demonstrate knowledge of other healthcare providers and determine under what circumstances to refer to these providers.
 - d. Demonstrate appropriate choice and method of referral to other healthcare providers and agencies.

- 6. Practice and manage patient care in a variety of communities, healthcare settings, and living arrangements.**
 - a. Demonstrate interpersonal skills and an understanding of patient needs related to age, gender, racial and ethnic background, cultural, and economic differences.
 - b. Demonstrate knowledge of public-health, health promotion, disease prevention, and clinical epidemiology.

7. Demonstrate an understanding of podiatric practice in a multitude of health-delivery settings.

- a. Demonstrate familiarity with the principles of practice management and quality assurance.
- b. Demonstrate knowledge of health-care insurance products, including fee for service, independent practice associations (IPA), preferred provider organizations (PPO), health maintenance organizations (HMO), capitation, etc.
- c. Demonstrate knowledge of insurance issues, including professional and general liability, disability, and worker's compensation.
- d. Possess a basic understanding of third party reimbursement
- e. Demonstrate knowledge of other systems and resources to properly manage a practice, including federal and state regulations, STARK, DEA license requirements, and scope of duties for podiatric assistants.
- f. Demonstrate knowledge of medical/legal considerations.

8. Demonstrate the ability to understand research methodology and other scholarly activities.

- a. Be professionally inquisitive, lifelong learners.
- b. Retrieve and interpret medical and scientific literature.
- c. Demonstrate knowledge of the principles of research methodology.
- d. Demonstrate knowledge of the principles of evidence based medicine.
- e. Perform ongoing self assessment to optimize patient outcomes.

Appendix E
UK Benchmarking Competencies

UK Benchmarking Competencies

Nature and extent of programmes in podiatry

Podiatry is practised by specialist practitioners who are capable of both independent and interdisciplinary clinical practice. They are skilled in assessing the needs of their patients and of managing both chronic and acute conditions affecting foot and lower limb function. These skills are often practised independently of medical referral and medical supervision. The key role of the podiatrist is to maintain and enhance locomotion function and tissue viability, to alleviate pain and reduce the impact of disability thereby maintaining/improving the quality of life for patients. Podiatric practitioners can provide care to the whole population and so provide clinical services for a diverse range of patients. These particularly include children, the elderly, athletes, people with a learning disability, people with a physical impairment and patients whose health status place the viability of their lower limb at high risk.

Podiatric management is predicated on accurate assessment and diagnosis that leads to the implementation of an appropriate management plan. This recognises the inter-relationship of systemic and extrinsic factors with the function of the lower limb. Effective management is achieved by the implementation of a range of approaches including health promotion, surgical, mechanical, and pharmacological therapies.

Podiatrists work predominately in primary care in single-handed community practice and also as members of specialist multi-disciplinary teams in both the primary and acute sectors within the NHS. In addition, many podiatrists work in private or commercial environments.

As competent professionals, podiatrists subscribe to the maintenance and development of their skills and knowledge to maintain their clinical currency within the expanding evidence base available to the profession. They are responsible for the quality of care they provide for their patients by employment of the principles and practice of clinical governance.

Podiatrists work within the context of a sound knowledge and understanding of health policy, business principles, and health economics, treating their patients with an ethical and caring approach. Effective practice requires the recognition and understanding of the social and economic context of their patients in assessing, planning, delivering, and evaluating care. This can only be achieved through the effective application of interpersonal and personal transferable skills.

A The podiatrist working as a professional**A1 Professional autonomy and accountability**

The award-holder should be able to:

- maintain the standards and requirements for state registration in podiatry;
- appreciate the role of professional and statutory bodies in podiatry;
- understand the legal responsibilities and ethical considerations of professional podiatric practice;
- have a detailed knowledge and understanding of the legal implications of the supply and administration of prescription only medicines available to chiropodists/podiatrists in accordance with the relevant exemption order of the 1968 Medicine Act and subsequent orders;
- comply with the requirements of the Statement of Conduct of the Chiropodists Board in accordance with the 1960 Professions Supplementary to Medicine Act and any subsequent statutory regulation;
- comply with statutory obligations in respect of the limitations placed on the podiatrist, eg in the use of local anaesthetic drugs;
- demonstrate an awareness of aspects of employment law and health and safety regulations in relation to the self employed podiatric practitioner;
- understand the particular considerations relating to podiatric private practice, eg business planning, confidentiality, informed consent, appropriate fee structures, taxation, local licensing, planning, and marketing;
- demonstrate an understanding of the 'professional self' including aspects of professionalism in manner, dress, speech, integrity and confidentiality consistent with contemporary standards and values and which recognise cultural differences;
- recognise the need for lifelong learning and continuing professional development in order to maintain fitness for practice;
- demonstrate time management skills including the ability to prioritise competing demands.

A2 Professional relationships

The award-holder should be able to:

- participate effectively in multi-professional approaches to health care appropriate to the practice of podiatry;
- recognise the unique contribution that podiatric practice can make to multi-professional care;
- recognise the value of the podiatrist as a health educator;

- demonstrate the ability to recognise the limits of one's own practice, referring or discharging the patient as necessary;
- understand the principles involved in working with foot care assistants, technical, support, and administrative staff, delegating tasks and responsibilities where appropriate and in accordance with accepted practice;
- understand that patients' rights override personal/commercial considerations in the practice of podiatry.

A3 Personal and professional skills

The award-holder should be able to:

- exercise a professional duty of care to patients/clients/carers in the context of independent single-handed practice within the NHS, private practice and the industrial setting;
- practise in an anti-discriminatory/anti-oppressive manner;
- understand the responsibilities associated with independent podiatric diagnosis and the use of all of those podiatric techniques and treatments that fall within the podiatrist's scope of practice;
- administer or supply pharmacological agents relevant to podiatric practice (to include local analgesia, anaesthetics, topical pharmacology and prescription only medicines schedules with reference to podiatrists' access to drugs);
- conduct surgical interventions for foot pathologies (ie procedures performed under local anaesthesia, skin and nail surgery);
- perform operative and psychomotor skills using a high degree of manual dexterity (eg scalpel reduction of skin and nail lesions);
- conduct non-surgical interventions for foot pathologies in the administration of:
 - appropriate mechanical therapies (eg taping, padding and strapping, footwear modifications, casted and non-casted orthoses, chair-side orthoses);
 - appropriate physical therapies (eg exercise, manipulation, rehabilitation, principles of physio-therapeutic modalities - ie ultrasound, electrosurgery, laser therapy, infra-red, heat & cold, cryo-surgery and chemical cautery).
- understand the principles of orthopaedic foot surgery;
- recognise the need to develop and maintain current psychomotor skills necessary for effective patient assessment and management. In doing so ensure that skills development satisfies medico-legal requirements of podiatric practice and meets the needs of the work place setting obligation to maintain fitness for practice;
- practise with an appropriate degree of self-protection and contribute to the well-being and safety of people in the work place;
- demonstrate an understanding of the need to manage and respond effectively to the rapidly changing nature of the profession of podiatry and the context in which it is practised;

- evaluate podiatric and related research and other evidence to inform and develop practice with regard to the function and disorders of the lower limb and foot;
- continue to develop specific podiatric treatment strategies for the treatment of locomotor and foot disorders;
- demonstrate a basic level of understanding of the evolving policy agenda that impacts on the delivery of health care and the practice of podiatry;
- uphold the principles and practice of clinical governance.

A4 Profession and employer context

The award-holder should be able to:

- contribute to and maintain a safe health care environment within a range of working environments e.g. private practice, the National Health Service, patients' own homes, care homes;
- demonstrate an understanding of the role of the podiatrist within public and private health care sectors;
- know about current developments in health care policy and how these impact on podiatry;
- recognise the value of research and other scholarly activity in relation to the development of the podiatry profession and for the benefit of patient care;
- practise podiatry independently, particularly in the context of both the public and private sectors, recognising the particular demands of the commercial sector in relation to self-employment;
- recognise the value of professional, organisational, business and financial skills needed for self-employed single-handed podiatric practitioners.

B The application of practice in podiatry

This section describes the principles and concepts held by the profession of podiatry that are applied to maintain or improve lower limb and foot health.

B1 Identification and assessment of health and social care needs

The award holder should be able to:

- communicate effectively with the patient, or the patient's relative/guardian/carer or other health care practitioner, to obtain a general physical, medical, social, and behavioural history together with a detailed history of the presenting complaint;
- conduct appropriate and valid neurological, vascular, biomechanical, dermatological and podiatric examinations of the patient's lower limb and associated structures, modifying practice according to patient need;
- conduct or requisition, where appropriate, specialist clinical or laboratory tests (eg X-ray, blood test, microscopy and culture) in order to reach accurate conclusions relating to lower limb health status;

- utilise contemporary technologies that aid in patient assessment, eg computerised gait analysis equipment;
- recognise situations where the best interests of the patient can be more appropriately served by a different health professional or a multi-disciplinary approach to care.

B2 Formulation of plans and strategies for meeting health and social needs

The award holder should be able to:

- use a problem-solving approach to identify and integrate the findings gathered from patient history taking and physical examination, to formulate and test a diagnosis and arrive at and implement a negotiated podiatric treatment plan;
- understand the need to seek a second opinion and/or consult with colleagues and/or other members of the health care team to inform the treatment plan;
- in negotiation with the patient/patient guardian/carer, select appropriate podiatric techniques in accordance with current best practice/research. These can be selected from mechanical debridement of skin and nails, prescription and manufacture of orthoses, administration of prescription only and non-prescription medicines, local analgesia techniques, surgical procedures for skin and nail conditions, physical therapeutic modalities, and use of chair-side devices;
- demonstrate the ability to record and communicate accurately the outcomes of patient assessment, diagnosis and management plans.

B3 Practice

The award holder should be able to:

- demonstrate the ability to utilise safely the full scope of treatment regimes available to the podiatrist in the successful management of a patient presenting with a lower limb problem;
- effectively use appropriate clinical techniques in accordance with the best accepted practice;
- demonstrate competency in:
 - mechanical debridement of skin and nails;
 - prescription and manufacture of orthoses;
 - administration of prescription only and non-prescription medicines,
 - local anaesthesia techniques;
 - surgical procedures for skin and nail conditions;
 - physical therapeutic modalities;
 - use of chair-side orthoses.
- demonstrate competency in the use of appropriate therapeutic technologies that aid patient treatment, eg ultrasound, electrosurgery, laser therapy, infra-red, heat & cold, cryosurgery and chemical cautery;

- demonstrate a competence in the recognition and adaptation of approaches to practice to meet the needs of modifying circumstances to include specific client groups eg children and the older person, and taking into consideration physical, psychological, social, environmental, cultural, occupational activity and economic factors;
- demonstrate the ability to identify and respond to a range of clinical incidents, threats and psycho-social crises, eg violent patients, alcohol, substance and drug abuse;
- demonstrate the ability to act swiftly and appropriately in the best interest of the patient and in accordance with contemporary practice for the maintenance of life in a clinical emergency, such as anaphylaxis, toxic reaction, epileptic attack, faint, hypo/hyperglycaemic attack, heart attack;
- provide written instructions to a patient concerning details of a podiatric treatment regime requiring patient self-treatment/advice;
- obtain and record informed consent for the treatment plan;
- conform to current data protection legislation;
- the podiatric management plan and its evaluation in order to convey precise meaning to the podiatrist and/or others who may be required to follow-up the treatment and to satisfy medico-legal requirements.

B4 Evaluation

The award holder should be able to:

- in the context of evidence based practice, demonstrate the ability to conduct an ongoing evaluation of the podiatric management plan against treatment milestones using recognised health outcome measures;
- use information gathered in evaluating the podiatric management plan to judge its effectiveness, reviewing and revising the plan as necessary in negotiation with the patient;
- demonstrate effective listening and re-assessing skills to ensure that podiatric treatment is appropriate;
- recognise that clinical problem solving can be an inexact art, and in solving one problem another may arise for which further action may need to be taken;
- demonstrate an ability to undertake clinical audit in a podiatric context;
- use the knowledge and critical appraisal of relevant podiatric and related research and evaluation methodologies to enable and facilitate an evidence based approach;
- demonstrate the ability to recognise the limits of one's own practice, referring or discharging the patient as necessary.

C Subject knowledge, understanding and associated skills that underpin the education and training of a podiatrist

This section describes the subject knowledge, understanding and associated skills that are essential to underpin informed, safe and effective podiatric practice. In order to be able to carry an appropriate podiatric assessment, diagnosis and treatment plan, the award holder should be able to demonstrate:

C1 Systematic knowledge and understanding of the key concepts that underpin podiatry

Anatomy and human locomotion studies

Human anatomy with particular reference to the foot and lower limb, that includes an overview of the gross anatomy of organ systems underpinning the later study of podiatry, podiatric biomechanics, surgery, pharmacology and medicine. He/she will have an understanding of the development of normal human bipedal stance and locomotion across the life cycle in order to develop competence in analysing gait.

Histology

Detailed knowledge of the cell and its intra-cellular components, the structure and function of tissues with special reference to skin that underpins understanding of general and podiatric tissue pathology.

Physiology/immunology

Homeostatic mechanisms, cell physiology and biochemistry; cardiovascular, respiratory, neurological and endocrine systems plus an overview of hepatic, renal and digestive systems that provides knowledge of normal human functioning and underpinning for the study of pathology and medicine. Understanding of aspects of microbiology and immunology to underpin understanding of pathological processes as applied to the lower limb and foot.

Podiatric orthopaedics and biomechanics

General knowledge and understanding of the basic principles of biomechanics; causes and mechanisms of dysfunction with a specific focus on effects on the lower limb and foot; detailed study of congenital and acquired changes to normal structure and function; the effects of abnormal structure and function on stance and locomotion and the tissues of the lower limb.

Systemic and podiatric pathology

Systemic disease and the local manifestations that occur in the lower limb and foot, eg diabetes melitus, the arthropathies, neurological disorders, peripheral vascular disease, dermatology, oncology, blood dyscrasias; the sources and effects of acute and chronic trauma to the foot and lower limb; effects of systemic and local infections on the foot.

Podiatric therapeutic sciences

The underpinning theory that relates to the management of podiatric pathologies. This includes therapeutic indications, contraindications and complications that may arise from podiatric intervention using:

- pharmacology (to include local analgesia, anaesthetics, topical pharmacology and prescription only medicines schedules with reference to podiatrists' access to drugs);

- surgical interventions (this includes procedures performed under local analgesia, skin and nail surgery, principles of orthopaedic foot surgery);
- operative and psychomotor skills (including scalpel reduction of skin and nail lesions and foot ulcer debridement);
- mechanical therapies (to include the therapies underpinned by biomechanical principles such as the prescription of casted and non-casted orthoses, chair-side devices and footwear modifications);
- physical therapies (to include exercise, manipulation, rehabilitation, principles of physio-therapeutic modalities, eg ultrasound, electrosurgery, laser therapy, infra-red, heat & cold, cryosurgery and chemical cauterly).

Behavioural sciences

- Social and psychological factors that have an impact on patients' health and their implications for, and contribution to, patient care, recognising the psychosocial effects of loss of mobility and pain and the role of the podiatrist in their amelioration. This is in the context of improving the patient's quality of life, mobility and independence;
- The significance of non-compliance/concordance in relation to foot health and its effect on the patient/practitioner relationship;
- The human factors that impact on the patient/practitioner relationship, eg in special populations;
- The principles of non-discriminatory practice.

Foot health promotion/education

- The principles and challenges of behaviours and extrinsic factors that impinge on foot health. The principles underlying strategies employed by patients' in self-care of the feet.

Professional studies

The nature and scope of the podiatry profession to include:

- concepts of the 'professional self' including aspects of professionalism in manner, dress, speech, integrity and confidentiality consistent with contemporary standards and which recognise cultural differences;
- health service policies, the organisation and delivery of health care;
- multi-disciplinary working;
- codes of conduct, regulatory and legislative frameworks that apply to podiatry.

C2 Skills

Information gathering

The award holder should be able to demonstrate:

- the ability to gather, evaluate and synthesise evidence and information from a wide range of sources in order to derive a credible podiatric diagnosis;

- the ability to use validated methods of enquiry to collect and interpret data in order to provide information that informs the podiatric evidence base.

Problem solving

The award holder should be able to demonstrate:

- logical and systematic thinking in the management of their individual patient and also in their management of podiatric practice;
- the ability to draw reasoned conclusions and sustainable judgements in the context of podiatric practice;
- the ability to undertake a research project that includes some original thinking utilising established methods of enquiry.

Communication

The award holder should be able to demonstrate:

- effective skills in communicating information, advice, instruction and professional opinion to colleagues, patients, clients, their relatives and carers; and, when necessary, to groups of colleagues or clients;
- the ability to provide information to the patient in the context of obtaining informed consent;
- competence in the maintenance of patient records in order to meet their medico-legal responsibilities.

Numeracy

The award holder should be able to demonstrate:

- the ability in understanding, manipulating, interpreting and presenting data;
- the ability to use number skills to enable good practice in respect of calculation of dose, interpretation of physiological, biomechanical and research data.

Information technology

The award holder should be able to demonstrate:

- the ability to engage with technology, particularly the effective and efficient use of information and communication technology;
- a working knowledge of the specialist equipment used in analysing gait, assessing vascular and neurological status;
- the ability to safely use a range of therapeutic equipment in podiatric management;
- the ability to operate technological systems that facilitate the management of podiatric practice;
- Information technology skills that include a knowledge of the use of statistical packages and the ability to make use of word processing packages for report writing.**

Appendix F
Scope of Practice Description by Australasian Podiatry Council

Scope of Practice Description by Australasian Podiatry Council

<http://www.apodc.com.au/scope-of-practice/> (Retrieved September 26, 2012)

Podiatry deals with the prevention, diagnosis, treatment and rehabilitation of medical and surgical conditions of the feet and lower limbs. The conditions podiatrists treat include those resulting from bone and joint disorders such as arthritis and soft-tissue and muscular pathologies, as well as neurological and circulatory disease. Podiatrists are also able to diagnose and treat any complications of the above which affect the lower limb, including skin and nail disorders, corns, calluses and ingrown toenails. Foot injuries and infections gained through sport or other activities are also diagnosed and treated by podiatrists.

A range of skills are employed by podiatrists. Direct consultations include a clinical history composition, physical examination, diagnosis, preparation of a treatment plan and provision of a range of therapies. Clinical assessment techniques aim to secure a diagnosis and prognosis and take into account clinical, medical and surgical history, footwear, occupational and lifestyle factors, and may incorporate the use of diagnostic equipment such as vasculoscopes or radiology. Gait analysis will often be undertaken through visual or computerised means and might include range of motion studies, postural alignment evaluation or dynamic force and pressure studies.

Clinical services require skilled use of sterilised instruments and appropriate infection control procedures, along with appropriate application of pharmacological agents, specialist wound dressings and a variety of physical therapies. Prescription foot orthoses (in-shoe devices) offer permanent solutions in the treatment and prevention of corns, callous and necrotic ulceration in their capacity to provide pressure redistribution. As a technique for providing consistent weightbearing realignment they are utilised in the treatment of acute and chronic foot conditions such as tendonitis, recurrent ankle sprain, chronic knee pain and stress fractures, to supplement and enhance clinical care.

Foot health education regarding self care techniques and prevention of foot pathology is an important component of individual care but is also frequently implemented on a greater scale, either to specific target groups or as community projects.

In order to facilitate enhanced clinical care, podiatrists establish and maintain collaborative relationships with other health care providers, often working within a site-based, multi-disciplinary team.

Appendix G
Knowledge Mapping and Gap Analysis

Curriculum Mapping and Gap Analysis

Topic	Ontario (Michener)	Ontario (George Brown 1983)	Quebec (UQTR)	Australia (Queensland UIT)
General Anatomy				
A. Major peripheral vascular and neurologic structures of the head and neck			Anatomy of the CNS	Anatomy
B. Torso (including upper extremities)			Human Anatomy I	Anatomy
C. Histology	Pathophysiology** Pathophysiology II*	Histology* Human Anatomy & Physiology*	Histology: General Morphology Histology: Systems Morphology Internal Medicine Human Anatomy I	Anatomy
D. Neuroanatomy		Human Anatomy & Physiology (CNS only)*	Anatomy of the CNS Clinical Neurology	Anatomy Human Physiology
Lower Extremity Anatomy				
A. Osteology	Structure & Function of the Lower Limb Lower Extremity Anatomy Dissection	Anatomy & Physiology of the Lower Extremity	Podiatric Anatomy	Advanced Anatomy
B. Arthrology	Structure & Function of the Lower Limb Lower Extremity Anatomy Dissection	Anatomy & Physiology of the Lower Extremity	Podiatric Anatomy	Anatomy Advanced Anatomy
C. Myology	Structure & Function of the Lower Limb Lower Extremity Anatomy Dissection	Anatomy & Physiology of the Lower Extremity	Podiatric Anatomy	Anatomy Advanced Anatomy
D. Angiology	Structure & Function of the Lower Limb Lower Extremity Anatomy Dissection	Anatomy & Physiology of the Lower Extremity	Podiatric Anatomy	Advanced Anatomy
E. Peripheral nervous system	Structure & Function of the Lower Limb Lower Extremity Anatomy Dissection	Human Anatomy & Physiology	Podiatric Anatomy	Advanced Anatomy
F. Integument	Dermatology	Dermatology	Dermatology Podiatric Anatomy	Advanced Anatomy
G. Limb development	Structure & Function of the Lower Limb Lower Extremity Anatomy Dissection	Pediatric Podology	Biomechanics Pathomechanics Pediatrics	?
Biochemistry				
A. Biophysical principles	Clinical Pharmacology*	Human Anatomy & Physiology* Pathophysiology*	Clinical Biochemistry I?	Chemistry for Health & Medical Science
B. Carbohydrates: function and metabolism	Pathophysiology* Pathophysiology II* Clinical Pharmacology*	Human Anatomy & Physiology*	Clinical Biochemistry I	Chemistry for Health & Medical Science Biomolecular Science
C. Krebs cycle and oxidative phosphorylation	Pathophysiology* Pathophysiology II* Clinical Pharmacology*	Human Anatomy & Physiology*	Clinical Biochemistry II	Biomolecular Science

* Briefly reviewed; not comprehensive

Topic	Ontario (Michener)	Ontario (George Brown 1983)	Quebec (UQTR)	Australia (Queensland UIT)
D. Proteins: structure, function, and metabolism	Pathophysiology* Pathophysiology II* Clinical Pharmacology*	Human Anatomy & Physiology*	Clinical Biochemistry II	Chemistry for Health & Medical Science Biomolecular Science
E. Lipids: structure, function, and metabolism of triglycerides, steroids, cholesterol, and lipoproteins	Clinical Pharmacology	Human Anatomy & Physiology*	Clinical Biochemistry II	Chemistry for Health & Medical Science Biomolecular Science
F. Purine and pyrimidine metabolism			Clinical Biochemistry II	?
G. Molecular biology			Clinical Biochemistry I	Biomolecular Science
H. Molecular properties of hormones, growth factors, and receptors	Pathophysiology* Pathophysiology II* Clinical Pharmacology*	Human Anatomy & Physiology*	Clinical Biochemistry II	Biomolecular Science (partial coverage)
I. Blood chemistry and other tissues	Pathophysiology II Clinical Pharmacology	Human Anatomy & Physiology*	Clinical Biochemistry I Internal Medicine	?
J. Amino acid synthesis			Clinical Biochemistry II	Biomolecular Science
K. Bone chemistry	Pathophysiology II; Clinical Pharmacology	Human Anatomy & Physiology*	?	?
Physiology				
A. Neurophysiology	Pathophysiology*; Pathophysiology II* Clinical Pharmacology*	Human Anatomy & Physiology*	Human Physiology I Human Physiology II	Human Physiology
B. Physiology of skeletal muscle	Not covered	Human Anatomy & Physiology*	?	Human Physiology
C. Physiology of smooth muscle	Not covered	Human Anatomy & Physiology*	?	Human Physiology
D. Cardiovascular physiology	Not covered	Human Anatomy & Physiology*	Human Physiology I	Human Physiology
E. Respiratory function and regulation	Pathophysiology II* Clinical Pharmacology* Podiatric Anesthesia & Injections*	Human Anatomy & Physiology	Human Physiology I	Human Physiology
F. Renal physiology	Pathophysiology II Clinical Pharmacology	Human Anatomy & Physiology	Human Physiology I	Human Physiology
G. Endocrine physiology	Pathophysiology II Clinical Pharmacology Podiatric Anesthesia & Injections	Human Anatomy & Physiology	Human Physiology II	Human Physiology
H. Gastrointestinal and hepatic function	Not covered	Human Anatomy & Physiology	Human Physiology II	Human Physiology
Microbiology and Immunology				
A. Bacteriology		Microbiology*	Microbiology and Infectious Diseases	Microbiology
B. Mycology		Microbiology*	Microbiology and Infectious Diseases	Microbiology
C. Virology		Microbiology*	Microbiology & Infectious Diseases	Microbiology
D. Parasitology			Microbiology & Infectious Diseases	Microbiology
E. Infection control	Podiatric Medicine I Podiatric Practice I	Microbiology*	Microbiology & Infectious Diseases	Microbiology
F. Emerging drug resistance			?	?
G. Immunology	Pathophysiology II*	Pathology I*	Microbiology & Infectious Diseases	Microbiology*
Pathology				
A. General principles	Pathophysiology	Pathology I	Pathology Podiatric Pathology	Disease Processes
B. Laboratory testing	Laboratory Diagnosis & Imaging		Pathology Laboratory Analyses	

Topic	Ontario (Michener)	Ontario (George Brown 1983)	Quebec (UQTR)	Australia (Queensland UIT)
C. Metabolic and endocrine disorders, immune diseases, and genetic disorders	Pathophysiology	Pathology II**	Pathology	Disease Processes
D. Diseases of the musculoskeletal and nervous systems and skin	Pathophysiology II	Pathology II**	Pathology Clinical Neurology Dermatology Pathomechanics	Disease Processes
E. Diseases of the cardiovascular, hematopoietic, reticuloendothelial, and respiratory systems	Pathophysiology Pathophysiology II	Pathology I & II**	Pathology Peripheral Vascular Disease	Disease Processes
F. Diseases of the urinary, gastrointestinal, and reproductive systems	Pathophysiology II	Pathology II**	Pathology	Disease Processes
Pharmacology				
A. General principles	Clinical Pharmacology	Therapeutics	Pharmacology	Pharmacology for Health Professionals
B. Mechanisms of drug action	Clinical Pharmacology	Therapeutics	Pharmacology Pharmacology & Podiatry	Pharmacology for Health Professionals
C. Drug interactions	Clinical Pharmacology	Therapeutics	Pharmacology	Pharmacology for Health Professionals
D. Anesthetics	Clinical Pharmacology	Therapeutics	Pharmacology & Podiatry	Pharmacology for Health Professionals Pharmacotherapeutics for Podiatrists
E. Anticonvulsants	Clinical Pharmacology	Therapeutics	Pharmacology	Pharmacology for Health Professionals
F. Antidepressants, anxiolytics, and stimulants	Clinical Pharmacology	Therapeutics	Pharmacology Pharmacology & Podiatry	Pharmacology for Health Professionals
G. Antidiabetic agents	Clinical Pharmacology	Therapeutics	Pharmacology	Pharmacology for Health Professionals
H. Anti-infectives	Clinical Pharmacology	Therapeutics	Pharmacology Pharmacology & Podiatry	Pharmacology for Health Professionals Pharmacotherapeutics for Podiatrists
I. Anti-inflammatories and analgesics	Clinical Pharmacology	Therapeutics	Pharmacology Pharmacology & Podiatry	Pharmacotherapeutics for Podiatrists
J. Antineoplastics		Therapeutics	Pharmacology	Pharmacology for Health Professionals
K. Cardiovascular agents	Clinical Pharmacology	Therapeutics	Pharmacology	Pharmacology for Health Professionals
L. Gastrointestinal agents	Clinical Pharmacology	Therapeutics	Pharmacology	Pharmacology for Health Professionals
M. Sedative-hypnotics	Clinical Pharmacology	Therapeutics	Pharmacology	Pharmacology for Health Professionals
N. Skeletal muscle relaxants	Clinical Pharmacology	Therapeutics	Pharmacology	Pharmacology for Health Professionals
Medicine				
A. Infectious diseases	Pathophysiology	Microbiology	Microbiology & Infectious Diseases	Microbiology
B. Neurologic disorders	Pathophysiology II Management of the High Risk Foot	Pathology II & Podology III**	Clinical Neurology	Disease Processes Medicine
C. Cardiovascular disorders	Pathophysiology Management of the High Risk Foot	Pathology II & Podology III**	Internal Medicine	Disease Processes Medicine

** *Emphasis on conditions frequently encountered in Chiropractic*

Topic	Ontario (Michener)	Ontario (George Brown 1983)	Quebec (UQTR)	Australia (Queensland UIT)
D. Rheumatologic disorders	Pathophysiology & Pathophysiology II Podiatric Medicine III	Pathology II & Podology III**	Internal Medicine	Disease Processes Medicine
E. Metabolic and endocrine disorders	Pathophysiology Management of the High Risk Foot	Pathology II & Podology III **	Internal Medicine	Disease Processes Medicine
F. Hematologic disorders	Pathophysiology	Pathology II**	Internal Medicine	Disease Processes Medicine
G. Immunologic disorders	Pathophysiology	Pathology II**	Internal Medicine	Disease Processes Medicine
H. Respiratory disorders	Pathophysiology II	Pathology II**	Internal Medicine	Disease Processes Medicine
I. Behavioral medicine			Introduction to Psychopathology	
J. Emergency medicine (medical/surgical)	Medical emergencies covered in Podiatric Anesthesia & Injections as of 2009; surgical emergencies not covered	Medical emergencies covered in Emergency Care; surgical emergencies not covered	Emergency Care	
K. Dermatology	Dermatology	Dermatology	Dermatology	Podiatric Medicine 1 Medicine
Radiology				
A. Radiation protection and safety			Biophysics & Radiation Protection Radiology Clinic	Radiographic Image Interpretation
B. Positioning	Laboratory Diagnosis & Imaging		Podiatric Radiology Radiology Clinic	Radiographic Image Interpretation
C. Radiographic pathology	Laboratory Diagnosis & Imaging	Addressed in clinical training	Podiatric Radiology Radiology Clinic	Radiographic Image Interpretation
D. Normal radiographic anatomy, normal anatomical variations, developmental landmarks, and biomechanical interpretation	Laboratory Diagnosis & Imaging	Addressed in clinical training	Podiatric Radiology Radiology Clinic	Radiographic Image Interpretation
E. Special imaging modalities, including CT scan, MRI, and contrast studies	Laboratory Diagnosis & Imaging		?	Ultrasound only
Orthopedics, Biomechanics, and Sports Medicine				
A. Function and structure (normal and abnormal) 1. Osseous system 2. Muscular system 3. Neurologic system 4. Kinesiology and gait analysis	Podiatric Biomechanics I	Biomechanics I, II & III	Biomechanics & Podiatry General Orthopedics Kinesiology in Physical Education & Health Pathomechanics	Biomechanics Podiatric Clinical Gait Analysis Podiatric Medicine 2
B. Trauma 1. Sprains, strains, and soft tissue injuries 2. Fractures and dislocations	Podiatric Biomechanics II Podiatric Medicine II Podiatric Sports Medicine	Podology III	General Orthopedics Sports Podiatry Traumatology Orthopedic Clinic I - V	Podiatric Medicine 3 Orthopedics and Sports Medicine
C. Physical medicine and rehabilitation 1. Evaluation and assessment 2. Diagnosis 3. Treatment (physical medicine modalities, footgear, orthoses, bracing, and biomaterials)	Podiatric Biomechanics II Podiatric Medicine II Podiatric Clinical Practice I – IV & VI	Biomechanics III Orthotics I & II Podology I - III	Orthotics & Pathomechanics Prosthetics Physical Medicine Orthopedic Clinic I - V	Rehabilitation Medicine & Physical Therapy Orthopedics & Sports Medicine Podiatric Medicine 3
D. Pediatric orthopedics	Podopediatrics	Pediatric Podology	Pediatric Clinic I - V	Integrated into Podiatric Medicine 2 and 3

Topic	Ontario (Michener)	Ontario (George Brown 1983)	Quebec (UQTR)	Australia (Queensland UIT)
Anesthesia and Surgery				
A. General anesthesia 1. Types of anesthetics (including pharmacological and clinical properties – indications, contraindications, and complications) 2. Perioperative considerations	Podiatric Anesthesia & Injections*		Podiatric Surgery I	Podiatric Anesthesiology
B. Regional anesthesia 1. Spinal anesthesia (including pharmacological and clinical properties – indications, contraindications, and complications) 2. Local anesthesia (including pharmacological and clinical properties – indications, contraindications, and complications) 3. Techniques of local anesthesia	Podiatric Anesthesia & Injections (local anesthesia only)	Addressed in clinical training	Podiatric Surgery I	Podiatric Anesthesiology (local anesthesia only)
C. Intravenous sedation			Podiatric Surgery I	
D. Surgical principles 1. Wound healing 2. Wound management 3. Perioperative emergencies 4. Surgical hemostasis 5. Surgical anatomy 6. Biomaterials and fixation techniques	Podiatric Soft Tissue Surgery	Wound healing addressed in clinical training	General Podiatric Clinical Surgery Podiatric Surgery I – V Surgery Clinic I - V	Podiatric Surgery
E. Podiatric surgery 1. Foot procedures 2. Ankle procedures 3. Lower leg procedures 4. Surgical complications 5. Trauma 6. Infection	Podiatric Soft Tissue Surgery Podiatric Clinical Practice IV (soft tissue forefoot only)	Soft tissue addressed in clinical training	General Podiatric Clinical Surgery Reconstructive Surgery Forefoot Surgery Podiatric Surgery I – V Surgery Clinic I - V	Podiatric Surgery Clinical Placement (soft tissue surgery only)
F. Hospital and operating room protocol 1. Wound dressing, bandaging, and casting 2. Preparations of OR personnel for surgery 3. Preparation of the patient 4. Surgical instruments and materials	Podiatric Soft Tissue Surgery (soft tissue forefoot only)	Addressed in clinical training in relation to soft tissue surgery	Podiatric Surgery I Surgery Clinic I - V	Podiatric Surgery Clinical Placement
G. Integrated pain management			?	
Community Health, Jurisprudence, and Research				
A. Critical skills necessary for the analysis of medical literature (including basic biostatistics, epidemiology, and research design)	Evidence Based Practice		Scientific Documentation in the Clinical Sciences	Epidemiology
B. Disease prevention and control 1. Acute and chronic diseases (metabolic, degenerative, and nutritional disorders) 2. Substance abuse 3. Standard (universal) precautions 4. OSHA regulations	Podiatric Medicine II	Safety covered in clinical training	Epidemiology & Community Health	Assume integrated into clinical training/practical experience component

Topic	Ontario (Michener)	Ontario (George Brown 1983)	Quebec (UQTR)	Australia (Queensland UIT)
C. Health care management 1. Health care delivery systems 2. Standards and quality assurance 3. HIPAA	Canadian versions of these topics are covered throughout the various Michener "Interprofessional Courses"	Healthcare delivery systems covered in Public Health & Jurisprudence	Transition to the Clinical Profession	Assume Australian equivalents covered
D. Jurisprudence	Legislation & Practice Management	Public Health & Jurisprudence	Medical Ethics & Legal Issues	
History and Physical				
Comprehensive medical history and physical	Podiatric Clinical Practice I – IV & VI (limited to lower extremity issues)		Podiatric Medicine I – V Podiatric Clinic I	?
Problem focused medical history and physical	Podiatric Clinical Practice I – IV & VI	Podology I, II	Podiatric Clinic II Podiatric Medicine I – V Clinical Placement	Assume integrated into clinical training/practical experience component

APPENDIX B



Costs/Benefits of Podiatric Services

Appendix B: Articles on the Costs/Benefits of Podiatry

2011 Diabetes in Canada Facts and figures from a public health perspective

According to this publication by the Public Health Agency of Canada, 2011, nearly 2.4 million Canadians in 2008/09 (6.8%) were living with diabetes with up to 20% of cases going undiagnosed. Adults aged 20 to 49 with diabetes see a family physician twice as often as those without, resulting in per capita health care costs 3 or 4 times greater than the costs of populations without the disease. A major issue surrounding the disease and in particular lower extremity complications/amputations, is that in 2007 only 51% of individuals with diabetes met the clinical practice guidelines for physician foot examinations.

A cost analysis of diabetic lower-extremity ulcers

According to this article, published in 2000, Medicare expenditures for lower-extremity ulcer patients were on average 3 times higher than those for Medicare patients in general (\$15,309 vs. \$5,226). Most of the ulcer related costs were on the inpatient side (73.7%) with proportionally smaller amounts going to physicians and nursing home facilities. As a result, any wound care intervention that could prevent even a small percentage of wounds from progressing to the stage at which inpatient care is required may have a favourable cost effect.

An economic evaluation of toenail surgery performed by podiatrists and surgeons

According to this article, published in 2005, substituting podiatric care for care by other practitioners for 528 patients with ingrown toenails would have saved £250,000.

Cost-Effectiveness of Prevention and treatment of the Diabetic Foot-A Markov analysis

According to this article, published in 2004, following guideline-based care of the diabetic foot resulted in improved life expectancy, a gain of quality-adjusted life-years (QALYs) and reduced incidences of foot complications. The lifetime management cost, following guideline-based care, resulted in a cost per QALY gained of just under \$25,000.

Disease management for the diabetic foot: Effectiveness of a diabetic foot prevention program to reduce amputations and hospitalizations

According to this article, published in 2005, the implementation of a disease management program including screening and treatment by podiatrists resulted in the incidence of amputations

decreasing by 47% from 12.89 per 1,000 diabetics per year to 6.18. The number of foot-related hospital admissions also declined by 37.8% from 22.86 per 1,000 members per year to 14.23

Elective Foot Surgery: Relative Roles of Doctors of Podiatric Medicine and Orthopedic Surgeons

According to this article, published in 1987, DPMs provided over 60% of all elective insured foot surgery. The average per procedure charge submitted by an orthopedist was 17% higher than that of a DPM; orthopedists were five times more likely to perform procedures on an inpatient basis with longer hospital stays; DPMs performed a greater number of procedures per episode but overall charges per average surgical foot episode were 30% lower.

Expert recommendations for Optimizing Outcomes Utilizing Apligraf for Diabetic Foot Ulcers: Evaluating Response to Conventional Therapy

According to this document, a study comparing 206 patients with Wagner grade 1 or 2 Diabetic Foot Ulcers who had weekly vs every-other-week visits found that weekly follow-up reduced the median time to wound closure by more than 50% (28 days vs 66 days). The result of increased rates of wound closure is fewer trips to the hospital for treatment.

Foot and Ankle Surgery Project Literature Review

According to this publication, published in 2008, roughly ten thousand foot and ankle procedures are performed each year by podiatric surgeons at a cost to Medicare of over \$14 million dollars (AUD) to the Australian Government. The utilization of podiatric surgeons in service provision has been identified as a potential solution to the high demand for foot and ankle surgery. They also note that a recent publication by Deloitte Access Economics states that podiatric surgery is less costly than orthopedic surgery in all categories of procedure on average by \$3,635 per procedure and a relative gain in well-being worth \$5,016 per procedure relative to orthopedic surgery.

Foot-In-Wallet Disease: Tripped Up By “Cost Saving” Reductions

According to this study, carried out in 2013, inpatient-related outcomes associated with diabetic foot infection among adult beneficiaries of Arizona Medicaid worsened significantly following the implementation of a 2009 announcement to eliminate podiatric care reimbursement. Prior to the change the mean length of stay per case was 7.1 ± 6.4 days, mean charges were $\$50,096 \pm \$56,888$ or \$234 million (USD 2012) and severe aggregate outcomes (SAO) (i.e. death, amputation, sepsis or surgical complications) occurred 30.4% of the time. Following the funding changes to podiatric coverage 37.5% more inpatient DFI admissions occurred, stays were 28.9%

longer, charges were 45.2% higher and there were 49.7% more SAOs. Additionally for every \$1 removed from the Arizona Medicaid budget by eliminating podiatry coverage, a \$44 increase in costs of care resulted.

Podiatrist Care and Outcomes for Patients with Diabetes and Foot Ulcer

According to this study non-Medicare patients with foot ulcer who were previously seen by a podiatrist had a 15% lower risk of amputation and a 17% lower risk of hospitalization compared with patients not seen previously by a podiatrist. Medicare-eligible patients with foot ulcer who were previously seen by a podiatrist had an 18% lower risk of amputation, a 23% lower risk of major amputation and a 9% lower risk of hospitalization compared to those who had not previously seen a podiatrist.

Understanding the Cost Benefit of the Equity and Access for Podiatric Physicians Under Medicaid Act (H.R. 3364/S. 1309)

According to this briefing by the APMA published in 2011, a budgetary impact analysis conducted by the Congressional Budget Office (CBO) on defining podiatrists as physicians under Medicaid estimated that enacting such legislation would increase federal spending by \$200 million over 10 years. Their analysis did not take into account that care by a podiatrist prevents complications and thus saves future expenditures. Among patients with commercial insurance, each \$1 invested in care by a podiatrist results in \$27 to \$51 of savings for the health-care delivery system. For Medicare eligible patients, each \$1 invested in care by a podiatrist results in \$9 to \$13 of savings. Combined there pre-patient numbers support and estimated \$10.5 billion in savings over three years.

Prevalence, Total and Excess Costs of Diabetes and Related Complications in Ontario, Canada

According to this article, published in 2009, excess healthcare costs for patients with diabetes compared to non-diabetes controls are \$2,930 for the year of diabetes diagnosis and \$1,240 in subsequent years. If complications are present, particularly in the lower extremities, these excess costs increase.

Receipt of Care and Reduction of Lower Extremity Amputations in a Nationally Representative Sample of U.S. Elderly

According to this article, published in 2010, persons with diabetes mellitus visiting a podiatrist and a lower extremity clinician in the year before lower extremity complications developed decreased

the likelihood of amputation. Persons who visited either before developing all stage complications were 69% less likely (ulceration) and 23% less likely (cellulitis and charcot foot) to undergo amputation compared with those individuals visiting other healthcare physicians. These preventative measures also reduce cost as individuals with diabetes mellitus and foot ulcers tend to incur substantially higher expenditures on personal health care services than do persons with diabetes mellitus without foot ulcers. Expenditures of up to \$46,000 (USD) per year are attributed to foot ulcers and the cost of a first lower extremity amputation is between \$30,000-\$50,000 (USD) in addition to long-term care required and lost productivity.

The costs of diabetic foot: The economic case for the limb salvage team

According to this article, published in 2010, diabetes and its complications cost the United States \$174 billion in 2007 with an average cost per lower extremity ulcer episode sitting at \$13,179. Extensive patient education, early assessment and aggressive treatment by a multidisciplinary team including a podiatrist represent the best approach to manage high-risk patients with diabetes. The resultant improvements in outcomes results in an average cost savings of \$635/year per patient with access to a foot and ankle specialist.

The Economic Value of Specialized Lower-Extremity Medical Care by Podiatric Physicians in the Treatment of Diabetic Foot Ulcers

According to this article, published in 2011, podiatric medical care can reduce the disease and economic burdens of diabetes. Patients who visited a podiatric physician before the foot ulcer diagnosis had \$13,474 lower costs in commercial plans, \$3,624 lower costs in Medicare plans during 2-year follow-up and fewer amputations.

The Right to Bear Legs-An Amendment to Healthcare: How Preventing Amputations Can Save Billions for the US Health-care System

According to this article, published in 2008, foot ulcers and infections, the most common reason for hospital admission among individuals with diabetes, cost between \$7,439 and \$20,622 per episode. The result was roughly \$18.9 billion spent on the treatment of foot ulceration and a further \$11.7 billion spent on lower-extremity amputation. In pivotal trials, foot ulcer recurrence rates were found to decrease by 48% with a multidisciplinary approach and four podiatry visits yearly, by 53% with custom offloading footwear and by 73% with the use of a dermal thermometer and education. The potential cost savings if these initiatives were implemented nationally in the US could be between \$9 billion and \$14 billion annually.

The Society of Chiropodists and Podiatrists: A guide to the benefits of podiatry to patient care

According to this article, published in 2010, the cost benefit of investing in podiatry offers a significant benefit to the National Health System in the United Kingdom. With no increase in investment in podiatric care (for diabetic patients), costs increase by £24m per year. By funding Foot Clinics and expanding by 12.5% to match demand, not only are wait times reduced but a savings of £10.63m is generated over the status quo. If both Foot Clinics and podiatrists are invested in, amputation rates decline, demand for consultation time is reduced, patient outcomes are enhanced and a cost savings of £21.69m over the status quo is generated.

APPENDIX C



REPORT OF THE JOINT DEPARTMENT OF HEALTH AND NHS CHIROPODY TASK FORCE

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REPORT OF THE JOINT DEPARTMENT OF HEALTH AND NHS CHIROPODY TASK FORCE

INTRODUCTION

In the spring of 1993, the Department of Health, with the approval of senior management in the NHS, decided that NHS chiropody services should be reviewed. This was in recognition of the key service chiropodists provide to large sections of the community, and in particular, the central role played by this small professional group in helping to keep the growing elderly population mobile, independent, and active for longer in the community, improving the quality of life of the individual. The Department wished, also, to ensure that all NHS chiropody services were in a position to respond positively to the challenges posed by the NHS Reforms and Care in the Community plans – especially in ensuring that the planning and development of NHS chiropody services are set within the context of locally assessed needs – and to its commitment to achieving the aims of the 1989 WHO St Vincent Declaration, in so far as these would entail providing better chiropody services to diabetics.

To this end, a joint Department of Health and NHS Chiropody Task Force, chaired by Dr Muir Gray, then Director of Public Health at Oxford RHA, was set up in May 1993

‘To look at ways to secure better, more cost-efficient NHS chiropody services within available resources and to produce examples of good practice in the delivery of NHS chiropody services for dissemination throughout the NHS.’

The Task Force met between May and November 1993, and was greatly helped by a considerable amount of useful information and ideas it received on current and planned developments in chiropody services from both general and professional chiropody managers throughout the NHS and from professional organisations.

The Task Force addressed its work in the following broad categories:

- purchaser issues (for DHAs, GP fundholders)
- provider issues (NHS Trusts, GP fundholders, DMUs)
- research and development issues
- professional issues.

These categories provide the broad structure of the report.

Chiropodist or podiatrist?

It is recognised that the terms 'podiatrist' and 'podiatry' are increasingly being used within the profession and parts of the NHS in preference to the older and more familiar terms of 'chiropodist' and 'chiropody'. Throughout this report – and solely in the interests of simplicity – the older and more familiar terms are generally used.

The terms 'surgical podiatrist' and 'surgical podiatry' are used to describe, respectively, those chiropodists who have undertaken post-basic training in ambulatory foot surgery, and the specialised services they provide.

Appendices A full list of members can be found at Appendix 1.

A list of those who provided information for the Task Force can be found at Appendix 2.

1. COMMISSIONING FOOT CARE

The Chiropody Task Force based its discussions on purchasing on the NHS ME publication 'Purchasing for Health – a Framework for Action'. The publication included four speeches by Dr Mawhinney, then Minister for Health, and Sir Duncan Nichol, then Chief Executive NHSME, and these were taken as a framework for discussion.

1.1 Seven general principles to commissioning foot care

One of the most relevant parts of the speeches to the task force discussions were the seven 'stepping stones' to successful purchasing.

1.1.1 *A strategic view*

DHAs need to think beyond the annual purchasing cycle and take at least a five-year forward look. It is essential for purchasers to take a strategic view of the way they purchase chiropody, as some of the steps recommended in this report – for example, the development of surgical podiatry – will not be achieved in a single year. The strategy for chiropody also needs to be related to other important policy and strategic developments, notably Care in the Community and the shift in emphasis from secondary to primary care.

1.1.2 *Robust contracts*

At present few district health authorities or GP fundholders have explicit contracts for chiropody. The next section of the report suggests ways in which the contract could specify volume, quality and price. The guidance given to GP fundholders on contracting for chiropody services, in Section 7 of the 'Yellow Book' attached to EL(92)48, issued 20 July 1992, and in paragraphs 12 and 13 and Annexe A of HSG(92)53, issued 21 December 1992, remains relevant and should be considered in tandem with the recommendations in this report. (The guidance drew on the experience of contracting for chiropody services at the pilot sites, and covers contracting issues and draft service agreements with a Community Health Service provider.)

1.1.3 *Knowledge based decisions*

Section 4 of this report deals with the need for research and development in chiropody.

1.1.4 *Responsiveness to local people*

Many surveys have found that chiropody ranks high among the range of needs perceived by old people, the public in general, and general practitioners.

1.1.5 *Mature relations with providers*

Purchasers need to understand both the range of service chiropodists provide, such as specialist services for diabetics and children, and the changes that are taking place within the chiropody profession, including the development of surgical podiatry. Purchasers should take a mature view of the benefits that chiropodists can receive from working in teams or departments (as distinct from practitioners working alone), and take these benefits, as well as costs, into account when deciding where to place their contract.

1.1.6 *Local alliances*

Purchasers have to be flexible in their approach, looking to both the NHS and private state-registered chiropodists to provide the services their patients need. Also, there is a need to work with social services and voluntary agencies so as to improve needs assessment and develop joint purchasing.

1.1.7 *Organisational fitness*

This stepping stone was directed principally at purchasers. The Task Force hopes that this report will be helpful to purchasers as they develop their purchasing skills. The recommendations in the following Section 2 are designed to be helpful to them when assessing need or placing contracts for chiropody services.

2. ASSESSING NEED AND COMMISSIONING SERVICES

The purchasing process consists of a number of distinct steps:

- the assessment of need;
- prioritisation and resource allocation;
- specification of the services required;
- contractual agreement with providers;
- monitoring and review.

2.1 Assessing need

The ageing of the population is the main factor increasing need for all health care, but this is particularly relevant for foot care services because such a high proportion of the service is provided for older people.

There is no evidence that the diseases which cause major foot problems – namely osteoarthritis, diabetes and peripheral vascular disease – will change significantly in the forthcoming decade, or that there will be any marked change in the age-specific incidence and prevalence of these conditions. However, need will increase not only because of population ageing, but also because of technological developments, that are poised to increase the range of effective interventions for people with foot problems. If need is defined as a problem for which there is an effective intervention, the need for foot care will increase to a greater degree than would be predicted by population ageing alone.

It can also be expected that alongside an increase in need, demand for foot care services will increase as expectations rise. Those who will be elderly in the future will have higher expectations than those who are elderly today.

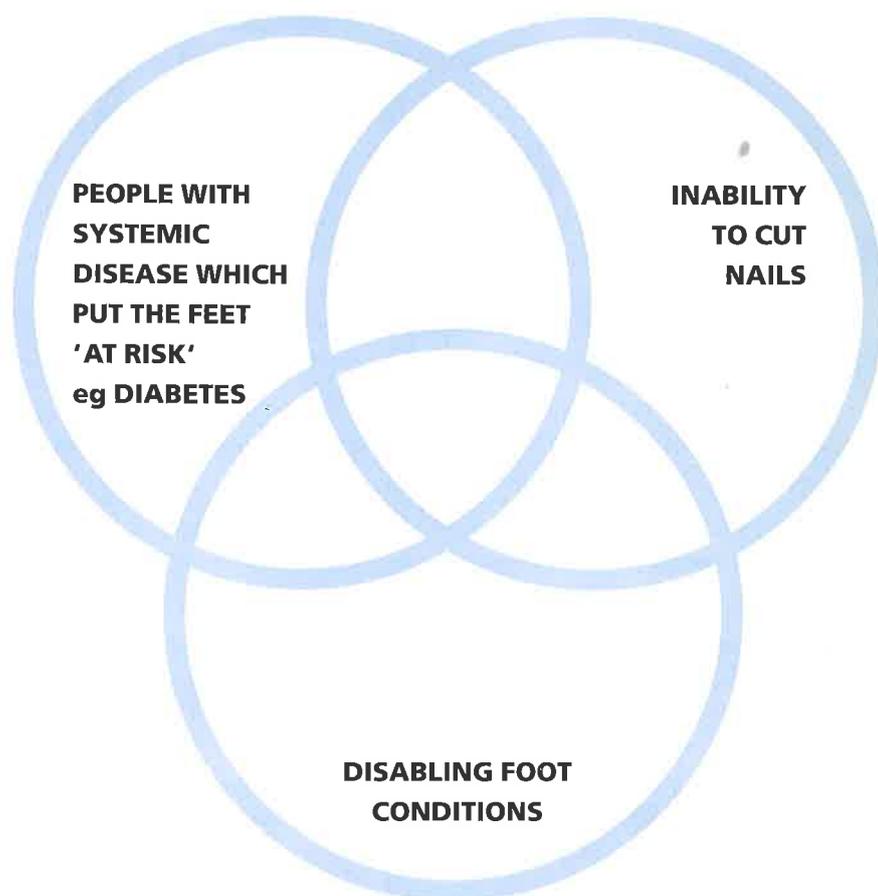
Furthermore, certain populations have a higher level of need – such as the homeless whose conditions may also be complicated by alcoholism – and the need for chiropody may be high in inner city areas.

2.2 Prioritising and resource allocation

When considering the relative priority of foot care services, it is necessary, firstly, to consider the priority of foot care as compared with other types of care and, secondly, to consider priorities within foot care.

Every survey of need in either elderly people or those who provide care most directly for them – for example, general practitioners – puts foot care high up on the list of priorities. As health services become more responsive to the needs of populations, it seems likely that the demand for additional resources to be invested in foot care will increase.

Foot problems constitute a diverse group of different needs which can be considered to be represented using a Venn diagram because more than one condition may co-exist.



2.2.1 People with 'at risk' feet

People with impaired circulation, principally because of diabetes or peripheral vascular disease, have to be considered as a separate sub-group. If nail-cutting and foot hygiene are not of high quality then infection can occur. In tissues with impaired circulation, infection is slow to heal and can affect underlying tissues which can eventually necessitate amputation.

2.2.2 Disabling foot conditions

A proportion of people with foot problems have conditions which cause severe functional incapacity with immobility and the consequences associated with it – namely, isolation and its attendant psychological effects and dependence on others. The usual cause of such problems is arthritis, (rheumatoid arthritis or osteoarthritis) and such people require more complex interventions to reduce pain and improve function.

2.2.3 Basic foot care and nail-cutting

In addition to those with 'at risk' feet or disabling foot conditions (sub-paragraphs 2.2.1 and 2.2.2 above), there are those whose requirement is simply for basic foot care and nail-cutting, but who are unable to manage this themselves because one or more of the following apply:

- they cannot reach their own feet;
- they cannot see well enough to cut their nails;
- they cannot use scissors or clippers because of a problem with their hands.

2.2.4 Choosing priorities

In the past specialist chiropody services have dealt with all these different types of foot problems. In future this may not be possible.

Although improvements in efficiency could increase the amount of foot care available, this by itself is unlikely to be sufficient to free up resources to meet the increasing need outlined in Section 2.1. At present foot care services cover a wide range of different health needs, including prevention, but in future it may be more appropriate to think of three different levels of service:

- basic foot care;
- specialist foot care;
- operative intervention.

At present chiropody services provide all three types of care with the emphasis on the first two. Orthopaedic surgery also provides the third type of care.

In future it might be more appropriate to think of chiropody services providing both specialist foot care and operative care, with the latter now being called 'surgical podiatry'. Basic foot care needs should be met by a wide variety of different helpers – for example, relatives, home carers, district nurses, and carers in residential care homes and nursing homes.

Any such changes in an existing pattern of NHS provision of basic foot care should be considered in partnership with local authority social services departments. Adequate arrangements for the initial and continuing training of carers in basic foot care provision – and such training is best undertaken by state registered chiropodists – should be in place before any change is effected.

2.3 Specifying the service required

Purchasers should be specific about the type of service they wish to purchase. They should specify which groups of patients should be given priority and indicate the volume, cost and quality of the service required.

Because of the factors influencing need, it is probable that most purchasers will wish to consider increasing the amount of resources invested in foot care.

2.3.1 Specifying volume

The volume of care to be purchased may be expressed either in terms of numbers of patients treated or number of episodes of care. In general, foot care services should seek to reduce the number of people receiving routine long-term follow-up, and should be trying to increase the proportion of patients in whom episodes of care are closed as a result of effective treatment. This will free treatment slots for patients who have not previously been assessed. Purchasers have the possibility now to specify that:

- specialised foot care is provided by state registered chiropodists who should be encouraged and facilitated to provide specialised foot care rather than basic foot care;
- state registered chiropodists are the best people to teach the skills of basic foot care to those who care for the elderly, and the service agreement should recognise this;
- operative foot care can be cost-effectively provided by chiropodists trained in surgical podiatry (who should work in close association with orthopaedic surgeons but have their own distinct professional contribution).

2.3.2 Specifying cost

As with many health services, methods of costing are in their infancy. However, it is possible to produce costs and to consider the efficiency of different types of service. That said, the ability to do this at present is limited because of the way in which overheads are handled, and cost comparisons between different services must be cautiously used until issues like these are clarified.

All services should consider employing and training foot care assistants. This will help ensure that the skills of the chiropodist are best used in tackling specialist problems, such as those posed by patients with diabetes or peripheral vascular disease. The employment of properly supervised foot care assistants, with clearly defined roles and scope of care, need not necessarily mean, however, that the service becomes fully engaged in basic foot care. Foot care assistants can increase the cost-effectiveness of the service by freeing the chiropodist to provide a special service.

2.3.3 Specifying quality

Quality measures should be kept simple and should conform to the four common categories:

- guarantees of adherence to legal requirements;
- the specification of systems to assure quality (eg chiropody audit);
- the setting of specific standards (eg waiting times);
- the setting of specific outcome requirements.

The single most important specific quality standard to be set is that chiropody should be provided by state registered chiropodists.

Present service agreements rarely include outcome requirements. However, there is a need for development of suitable measures and, possibly, for identifying outcomes that purchasers and chiropodists could use.

2.4 Contracting with providers

The main source of chiropody within the NHS is in Community Trusts, but purchasers may wish to look at other sources, providing they meet the necessary quality criteria. It is important, however, that the systems of peer review, audit, and professional development established through professional networks built up by district chiropodists over the years are maintained. It is therefore of key importance that, in reaching agreements with private practitioners, the contract must ensure that the work is subject to external audit and comparison with the work of others.

2.5 Monitoring and review

Purchasers should regularly meet with chiropodists to review the service and to improve their understanding of what a modern chiropody service has to offer.

2.6 Recommendations

2.6.1 Every Health Authority and GP fundholder should develop a foot care strategy which takes into account population ageing.

- Priority should be given to people with disabling foot disorders and people whose feet are 'at risk' as a result of impaired circulation due to diseases such as diabetes.
- Priority should be given to specialist foot care (chiropody) and to services such as diabetic foot clinics and surgical podiatry, and to the use where appropriate of foot care assistants to support the chiropodists.
- Purchasers should review their arrangements for the purchase of ambulatory foot surgery in the light of the services available from chiropodists with specialist post-basic training in surgical podiatry.

2.6.2 Quality and Value for Money (VFM) considerations

- Foot care assistants working in support of chiropodists can increase value for money by allowing the chiropodists to concentrate their time on tasks for which only they are trained.

- A basic quality standard for chiropody is that the service should be provided by state registered chiropodists, supported by appropriately trained foot care assistants.
- Basic foot care should be taught, where appropriate – and after consultation with the local authority social services departments – to those who provide care for elderly people who are unable to care for their own feet, but do not require the skilled care of a state registered chiropodist.

2.6.3 A workshop should be organised on chiropody outcomes.

3. SERVICE DELIVERY OPTIONS

3.1 General considerations

Most chiropody services are, and always should be, provided in centres with specialised equipment. Ideally, there should also be access to good orthotic services. This means that the chiropody service, like other services of this type, faces a constant battle to balance efficiency with accessibility.

One way of maximising resources and making the best use of professional time and equipment, would be for practitioners to be based at one centre, or to work a full day in a particular centre. To increase accessibility, consideration should be given to 'out of hours' clinics. This particular model of provision would, however, be likely to be more highly centralised than the present pattern, and, where only one centre is established, could carry implications for those who, by definition, have mobility problems.

The possibility of using a local authority Social Services Department day centre, or a resource centre where elderly or disabled people come for other activities or services, is worth consideration in some areas, if an appropriate clinical setting can be accommodated.

The task force considered in detail papers on the delivery of chiropody services in rural areas and, at the other extreme, in inner cities. From these, it drew observations and recommendations applicable, in many instances, to the consideration of service delivery options across the wider spectrum of geographical locations.

3.2 Rural areas – illustrative points

Accessibility is a particular issue in rural areas and the task force considered a report from one of its members on the delivery of a chiropody service in rural Wales. The paper described the problems and challenges of service provision in rural areas. In providing services to such areas managers have to balance efficiency and accessibility.

Possible service options range from those which favour accessibility (by providing, for example, mobile units) to those which favour efficiency, gained, for example, by having a centralised service; the balance to be struck according to the needs of the particular population served. The range of options is considered in the following sub-paragraphs.

Domiciliary care

Domiciliary treatment has been one of the traditional mainstays of the chiropody service. The rationale for such a service is obvious. However, domiciliary services face numerous problems. The chiropodist may call at the patient's residence and either receive no answer or be told that the patient is out. Domiciliary care also involves travelling by the chiropodist, time which

cannot be used for treatment. The cost to the NHS of domiciliary treatment works out at roughly double the cost of treatment for a patient who visits a chiropodist. The interventions that can be offered in the home are limited, and a considerable proportion of domiciliary work consists of simple foot care tasks which do not require the skill of a state registered chiropodist. Foot care is often provided by relatives and untrained carers. This needs to be recognised and appropriate help and advice given to the carers of elderly people about safe foot care and the indications for skilled intervention.

Mobile clinics

Mobile clinics have also been used to provide chiropody care in rural areas but these are expensive and are not without their problems. In many of the sites in which a mobile clinic is part, there are other chiropody facilities nearby or in the same town or village.

The general view of the task force was that investment in mobile clinics should only be undertaken where there was a very strong service and business case.

Improving transport

Accessibility is of vital importance for all health care services, particularly chiropody. In rural areas car ownership is higher than in inner city areas, but those whose need for chiropody is greatest are likely to be least able to reach a centralised service by driving a car themselves. However, in rural areas people expect to travel, for example to shop and to use services, and informal networks are often more effective than in cities. Ambulance services are expensive to use but there are examples of voluntary car schemes working well.

Integrated treatment centres

People aged over 75 are high users of health centres. Although they have difficulties in reaching the health centre, the integration of chiropody with primary care would greatly improve the access to chiropody services by disabled or elderly people. This is primarily for two reasons. Firstly, the health centre is often at the hub of a network of formal and informal transport systems. Secondly, the opportunity can sometimes be taken of a visit to the health centre on another matter to book a person in for chiropody treatment, if this is needed. The development of GP fundholding has meant that some general practitioners are already investing in chiropody facilities, sometimes by setting aside a room used only for chiropody, or by development of a multi-purpose treatment room.

This type of development will require collaboration between, on the one hand, the purchasers, (including fundholders), and, on the other hand, providers. However, it is possible, and should be considered as a model for the future.

Increasing productivity – foot care assistant

The traditional image of the foot care assistant, as someone who works alone treating individuals who do not need the full range of skills of a state registered chiropodist, is often the case in practice. Such staff may face problems of professional isolation and this should be recognised. The foot care assistant is also often tending patients who require simple foot care, providing care that could be provided by someone else (eg a carer). The more appropriate use of a foot care assistant is to provide support to the state registered chiropodist. This can be done most effectively where there are two surgeries or two chairs within the one clinic. In these circumstances, the foot care assistant can prepare patients for treatment, deal with them on the conclusion of treatment, or work under the supervision of the state-registered chiropodists.

3.3 Inner city provision – illustrative points

Issues of access are not solely confined to rural areas. In cities, car ownership may be low in certain parts and the bus service distant from the dwellings of those who are most disabled. In addition, inner-cities have many other problems. The provision of a foot care service for the inner-city was considered by the task force on the basis of a paper on inner-city issues in Inner London, prepared by a task force member.

The main points from this paper are set out below:

Homelessness

Homelessness is often associated with other health and social problems, and those who are homeless, particularly the single homeless, show a wide range of different foot problems, including, for example, chilblains, frostbite, neuropathic ulcers, and chronic nail infections. The access of such people to chiropody services reflects the problems they have in obtaining other types of health care. This again emphasises the importance of an integrated strategy for the development of foot care services.

The needs of different ethnic groups

The foot care service should be as accessible to ethnic groups as to the rest of the population, especially given the high prevalence of diabetes in some of these populations.

AIDS and HIV infection

Foot problems may occur in people with AIDS and HIV infection because of their impaired immune function. Perhaps the most important point to emphasise about this group is that they need the full range of foot care services. It has been reported that more radical forms of treatment have not been used with these groups because of the concern that these patients will have impaired healing and susceptibility to infection, but this does not appear to be a significant problem.

3.4 Implications for Health Authorities and GP Fundholders

3.4.1 A domiciliary service should be maintained. However, the focus should be on reducing the need for domiciliary skilled foot care. This could be achieved by promoting simple foot care skills in a wide range of different people and by helping people who currently receive domiciliary treatment to reach health centres and chiropody centres.

3.4.2 Purchasers should consider a bid to replace or introduce a mobile clinic very carefully, both from a point of view of the business case and the service benefits.

3.4.3 Consideration should be given as opportunities arise, to the integration of chiropody services with other primary care services. This will minimise the capital cost of service provision. The contacts made by people in need with primary care services, such as general practitioners' services, can then be used as an opportunity to provide foot care in addition to other aspects of primary care.

3.4.4 The special needs of the population of the inner-cities require more detailed attention and it is recommended that a conference be held on inner-city foot care.

4. RESEARCH AND DEVELOPMENT PRIORITIES

The task force reviewed research in foot care and chiropody and considered the implications for service development.

4.1 A review of published research

A review of published research was conducted by searching both Medline and Healthplan electronically. It is well known, however, that electronic searches reveal only a proportion of studies – no more than, say, 75% – on a particular topic; the remainder have to be found by hand searching. In the search (conducted by the librarian of Buckinghamshire Health Authority), the primary focus was on research studies examining treatment outcome and which were conducted as clinical trials.

It was also possible to review the 'Index of First and Higher Degree Research Titles in Chiropody and Podiatry' produced by the University of Brighton, Department of Podiatry, in 1991. This lists the title of the subject, together with the author and institution in which the research was based, but does not indicate whether or not the study was published. The fact that a study was not published does not necessarily reflect upon its quality. There is, for example, a well-known phenomenon called 'publication bias'; editors are much less likely to publish negative than positive findings.

4.2 Research in progress

There is no co-ordinated strategy for foot care research in the United Kingdom at present.

The Outcomes Clearing House, based at the Nuffield Institute for Health, identified six outcome projects on the outcomes project database.

4.3 Identifying research priorities

The Task Force considered research priorities and has classified its priorities into two main classes – professional intervention and health services research issues.

4.3.2 Professional interventions

The following professional interventions were identified as priority areas for research:

- prevention and foot health education;
- arthrosis;
- comparison of surgical podiatry with orthopaedic surgery;
- management of foot ulcers;
- the foot problems of diabetics;
- the orthotics/chiropody interface.

4.3.3 Health services research

Health services research assesses the cost-effectiveness of different approaches to health care delivery. Priorities within this field included:

- effective GP fundholding on chiropody;
- the use of foot care assistants to improve cost-effectiveness;
- the use of purchasing power to develop chiropody and surgical podiatry.

4.3.4 Other relevant factors

The report of the Diabetes Task Force – set up in November 1992 jointly by the Department of Health and the British Diabetic Association to advise on increased help for people with diabetes – and in particular the report of its sub-group looking at foot care services, should, when available, be considered in conjunction with the recommendations of this Chiropody Task Force report.

4.4 Recommendations

The Task Force makes the following recommendations on research aspects.

4.4.1 A meeting should be organised under the auspices of the national Research and Development programme to develop an integrated programme of foot care and chiropody research. The identification of measurable outcomes should be a priority area for research.

4.4.2 A separate report on research in chiropody and foot care should then be published drawing on the work done for the Task Force (sub-paragraph 4.1 above), and from the meeting recommended at 4.4.1 above.

4.4.3 The amount of resources put into research into specific interventions and into different patterns of care should be increased.

5. FOOT CARE PROFESSIONALS

5.1 State Registered Chiropodists

The state registered chiropodist is the bedrock of the foot care service. The remit of the task force excluded an examination of issues such as the closure of the profession. The task force had to consider the provision of services based on the present pattern of professional services.

5.1.1 Training

There are 14 Chiropody Schools in Great Britain with about 500 pupils entering training each year.

A significant proportion of those who are trained enter the private chiropody sector (making manpower planning difficult). The turnover in the NHS is not very high and the age distribution of the profession is very young. There is no clear national picture of manpower requirements.

The Department is currently considering bringing chiropodists within the scope of Working Paper 10 arrangements, and negotiations with the Department for Education have been taking place. These are temporarily suspended until the outcome of the Functions and Manpower Review of the NHS is clearer. Should this change come about, methods of predicting manpower requirements as accurately as possible, both in the NHS and private sector, will be needed.

5.1.2 Professional development

Many chiropodists work in isolation, more so in private practice than in the NHS, and, up to now, the importance of continuing professional development has been underestimated. The Society of Chiropodists and Podiatrists carried out a survey of professional development for the task force. This revealed a number of important issues with the main points being summarised below:

- Chiropodists want to develop both clinical and managerial skills, with those aged over 35 giving priority to clinical skill development; the need for management training was identified almost solely among those in the NHS.
- About three-quarters of those who responded felt the need for regular updating following basic training.
- Constraints, notably the limitation on the range of prescription-only medicines a state registered chiropodist may provide, and on direct referral, were identified as important factors in restricting the chiropodist's competence, irrespective of the level of their knowledge or skill.

- The priorities for clinical development were:

Surgical podiatry

Diabetic care

Bio-mechanical skills

Podopaediatrics

The chiropodists who responded identified the need for development of the skills of treatment planning, particularly for older patients.

The main barriers to continuing professional education were identified as lack of funding, inappropriate case loads, and the lack of commitment of managers to continuing professional development.

The development of the individual professional takes place as part of their career development. Within the NHS the careers of chiropodists are changing with the split between purchaser and provider. This split has disrupted a traditional career pattern which would allow a chiropodist to aim for the post of District Chiropodist. Chiropodists no longer work as members of one large District-wide team, even though the team involved in many Community Trusts will be significant in size.

As a substitute, individuals should be helped to identify and develop specific clinical and managerial skills throughout the course of their career. Grading could, in future, be related to the level of competence achieved rather than simply being related to years in post.

5.1.3 Surgical podiatry

Surgical podiatry has developed as a specialty within the professional practice of chiropody. This trend is to be encouraged, and the training and development of chiropodists who wish to specialise in this aspect of work needs further examination. It will be appropriate to study this topic in more detail when the report of the Working Party on Podiatry and Hospital Foot Services of the Commission on the Provision of Surgical Services of the Royal College of Surgeons (the COPSS Report) becomes available.

5.2 Foot care assistants

At present foot care assistants carry out simple foot care skills. The relationship of their training to the National Vocational Qualification (NVQ) is being considered by the Care Sector Consortium. This will allow their role to develop in line with the needs of service managers.

5.3 Recommendations

5.3.1 Continuing professional development should be encouraged and taken forward alongside the promotion of specialist skills training, especially in the areas of diabetes and surgical podiatry.

5.3.2 Steps should be taken to ensure that the NHS develops a plan for investment in chiropody training, in the light of any decision made under Working Paper 10.

5.4 Chiropodists: prescribing

The task force was aware that the profession is seeking wider powers to prescribe a limited list of drugs, including antibiotics. Subject to appropriate training, the task force would support the profession's aspirations in this area.

6. SUMMARY OF RECOMMENDATIONS

6.1 Assessing need and commissioning services (Section 2.6 of report)

a) Purchasers to develop a **foot care strategy** which takes into account population ageing.

Within the strategy, priority should be given to:

- people with disabling foot disorders and those with 'at risk' feet as a result of impaired circulation due to diseases such as diabetes;
- development of specialist foot care (chiropody) services (eg diabetic foot clinics, surgical podiatry) with the use, where appropriate, of foot care assistants in support of chiropodists;
- review, by purchasers, of arrangements for obtaining ambulatory foot surgery, in the light of the services available from chiropodists with specialist post-basic training in surgical podiatry.

b) The following **quality and value for money (VFM)** considerations should be taken account of in development of the strategy and commissioning of the service.

- Foot care assistants working in support of chiropodists can increase value for money by allowing the chiropodists to concentrate their time on tasks for which they only are trained.
- A basic quality standard for chiropody is that the service should be provided by **state registered chiropodists**, supported by **appropriately trained foot care assistants**.
- Basic foot care should be taught, where appropriate – after consultation with local authority social services departments – to those who provide care for elderly people and others who are unable to care for their own feet, but do not require the skilled care of a state registered chiropodist.

c) A **workshop** should be organised on **chiropody outcomes**.

6.2 Service delivery options (Section 3.4 of report)

a) From the consideration of service delivery options in Section 3 of the report, the following advice on implications for health authorities and general practitioners was developed.

- A domiciliary service should be maintained, but the focus should be on reducing the need for domiciliary skilled foot care. This reduction could be achieved by promoting basic foot care skills in others, and by helping people to reach the centres where chiropody is being provided.

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Mrs M Fry	Grade 6 – Department of Health, Health Aspects of the Environment & Food Admin Branch
Mr A Smith	Grade 7 – Department of Health, Health Aspects of the Environment & Food Admin Branch
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Dr A Dawson	Senior Medical Officer – Department of Health, Health Care Medical (from 1.11.93)
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Mr J Mann	Senior Executive Officer – Department of Health, NHSE, Personnel Development Division
Ms J Parker	Higher Executive Officer – Department of Health, NHSE, Personnel Development Division
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INFORMATION PROVIDED TO THE CHIROPODY TASK FORCE

1. The Department of Health and the Chairman of the Chiropractic Task Force gratefully acknowledge the very useful information provided to the Task Force by individual members of the Task Force, the Welsh Office, the Society of Chiropractors and Podiatrists, the Association of Chief Chiropractic Officers, the Podiatry Association and from a variety of sources in the NHS.

2. Among the papers received were the following:

- Guidelines on Minimum Standards of Clinical Practice (Society of Chiropractors and Podiatrists publication June 1993);
- Welsh Office, NHS Directorate: The Welsh Health Planning Forum papers – Protocol for Investment in Health Gain;
- Chiropractic Service Delivery in Rural Areas (Mr B Jones, Gwynedd Community Health Unit);
- Chiropractic in Inner Cities (Mr R Coleman, Camden and Islington Community Health Services Trust);
- Towards a Needs Based Strategy for Chiropractic Services in Nottingham (J Simpson & Dr C Williamson, Nottingham Health Authority);
- Unit Costs of Community Care (A Netten & S Smart, PSSRU, Kent University);
- Guidelines on Standards of Chiropractic/Podiatry for Barking, Havering and Dagenham (Barking, Havering and Brentwood Health Authority, and FHSA).

3. Information and papers were also received from the following sources:

The Mersey Regional Chiropractic Managers Group.

Berkshire Health Consortium.

First Community Health NHS Trust, Stafford.

Salford Health Authority.

North Mersey Community NHS Trust (Liverpool and South Sefton).

Barking and Havering FHSA.

Mr Richard Rawlings, Consultant Orthopaedic Surgeon, Bedford Hospital.

Bath West Community NHS Trust.

Dorset Healthcare NHS Trust.

Chiropractic Department, Grimsby Health.

West Berkshire Priority Care Services NHS Trust.

Merton and Sutton Community NHS Trust.

Epsom Health Care NHS Trust.

Central Manchester Healthcare Trust.

North Downs Health Authority.

The Barts NHS Trust (Smithfield, London).

South Tees Community and Mental Health NHS Trust.

Sheffield Health Authority.

North Manchester Health Authority.

Northern Health and Social Services Board (N Ireland).

Westbourne Community NHS Trust.

Blackburn, Hyndburn and Ribble Valley Health Authority.

Southend Community Care Services NHS Trust.

South Bedfordshire Community Health Care Trust (Joint Project).

REVIEW

of the Chiropody and Podiatry Professions

Application to the
Health Professions Regulatory Advisory Council

*"Better Patient Care and Better Value for Healthcare Dollars by Adopting
a Podiatry Model of Foot and Ankle Care"*

PART 3 - 18 ADDITIONAL QUESTIONS

Submitted by
The College of Chiropodists of Ontario

November 28, 2014

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Question 6: " Some stakeholders have advised of communication challenges between chiropodists/podiatrists and other healthcare providers such as family physicians. If chiropodists and podiatrists are granted the ability to order diagnostic procedures, will this potentially result in the duplication of diagnostic procedures by other healthcare professionals? Is there a need for the chiropodist/podiatrist to, for example, share these tests with the patients' family physician? What regulatory mechanisms, or other mechanisms, will the college establish in order to facilitate the sharing of information."	20
Question 7: "An expansion in scope of practice would likely require costly quality assurance and inspection programs and additional oversight obligations for the regulatory college. However, very large regulatory colleges do administer such oversight programs. Is it feasible for COCOO to establish similar programs? How much might such programs cost? How long would they take to be operational? How would COCOO fund them on a yearly basis? What would the impact be on individual members in terms of fees, staffing committees, etc.?"	22
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Question 9: "Through the initial consultation program, some stakeholders have highlighted the need for consumer protection measures related to the fitting of orthotics by many foot health care providers. If COCOO has data on related complaints and disciplinary findings, including the prescription and dispensing and fitting of orthotics, among its members, or among other foot health care providers, please share this data. How would a scope of practice change address this issue? What mitigating strategies can be implemented?"	28

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Question 17: "Do wait times differ for chiropodists and podiatrists? What are the wait times for each profession? Do wait times demonstrate that the public has problems with accessing foot care services that would be provided under an expanded scope of practice? Provide evidence." 44

Question 18: "If available, provide details on which educational institutions would develop and deliver bridging programs. How long would it take to develop these programs? What will be the cost of development and implementation?" 45

Question 1: Describe which health care practitioners, both regulated and unregulated, are providing foot care (e.g., chiropodists, podiatrists, pedorthists, orthotists, nurses, personal support workers [PSWs], nail care technicians, etc).

- What activities, procedures and controlled acts are they performing?
- How does the practice of other health care professionals overlap with the current and proposed chiropody/podiatry scope of practice?
- Where overlap occurs, which health care practitioner would be the most appropriate practitioner to deliver health care?

Response: The College refers to section 3 of the RHPA ("that individuals should have access to their healthcare practitioner of choice") and to the RHPA principal of overlapping scopes of practice. The proposed scope of practice change and removal of the podiatric cap will enhance patient choice among alternate providers and is not meant to interfere in any way with the principle of overlapping scopes. The College is not seeking a monopoly or exclusivity for any aspect of the current chiropody or the proposed podiatry scope of practice.

For some time, the College has been aware of the increasing role played by members of other professions, both regulated and unregulated, in footcare. Nevertheless, the College was surprised at the number and variety of practitioners and professions who identified themselves as being engaged in footcare through HPRAC's public consultation on Ontario's current footcare model.

This phenomenon is clearly an indication, or an illustration, of the increasing demand for footcare prompted by the unprecedented proportionate growth of the seniors demographic in Ontario and the increasing incidence of chronic diseases affecting the foot such as diabetes, arthritis, peripheral arterial disease and cancer. It is also clearly an indication, or an illustration, of the growing gap between the demand for footcare and the supply of qualified practitioners.

HPRAC has asked which health care practitioner would be the most appropriate to deliver footcare in the instance of scope overlap. The College has been unable to find any reliable research that compares interprofessional efficacy in footcare. A study published in November, 2013 by the Canadian Agency for Drugs and Technologies in Health found a number of studies indicating a positive impact of interdisciplinary diabetic footcare including podiatric care, but

"(No) evidence was identified comparing (our emphasis) the clinical evidence of podiatric care for adults with diabetes or chronic foot conditions provided by podiatrists to care led by nurses, allied health professionals or non-specialist physicians, or provided by nurses or allied health professionals compared to non-specialist physicians."¹

¹ "Delivery of Podiatry Care for Adults with Diabetes or Chronic Foot Conditions: A Review of the Clinical Effectiveness", Canadian Agency for Drugs and Technologies in Health, November 6, 2013.

The College wishes to make it crystal clear that it has no problems whatsoever with members of professions other than chiropody and podiatry providing footcare as long as they are engaged in authorized practice and are fully competent in the procedures they perform.

The College cannot claim to be definitively or fully aware of the extent and nature of footcare that members of other professions provide, or purport to provide. The College has expended best efforts to obtain that information from the professions themselves and from other sources. The results follow. The College of Chiropodists has accepted at face value the claims made by RHPA-regulated professions in terms of their roles in footcare, the procedures they perform and their competencies to do so.

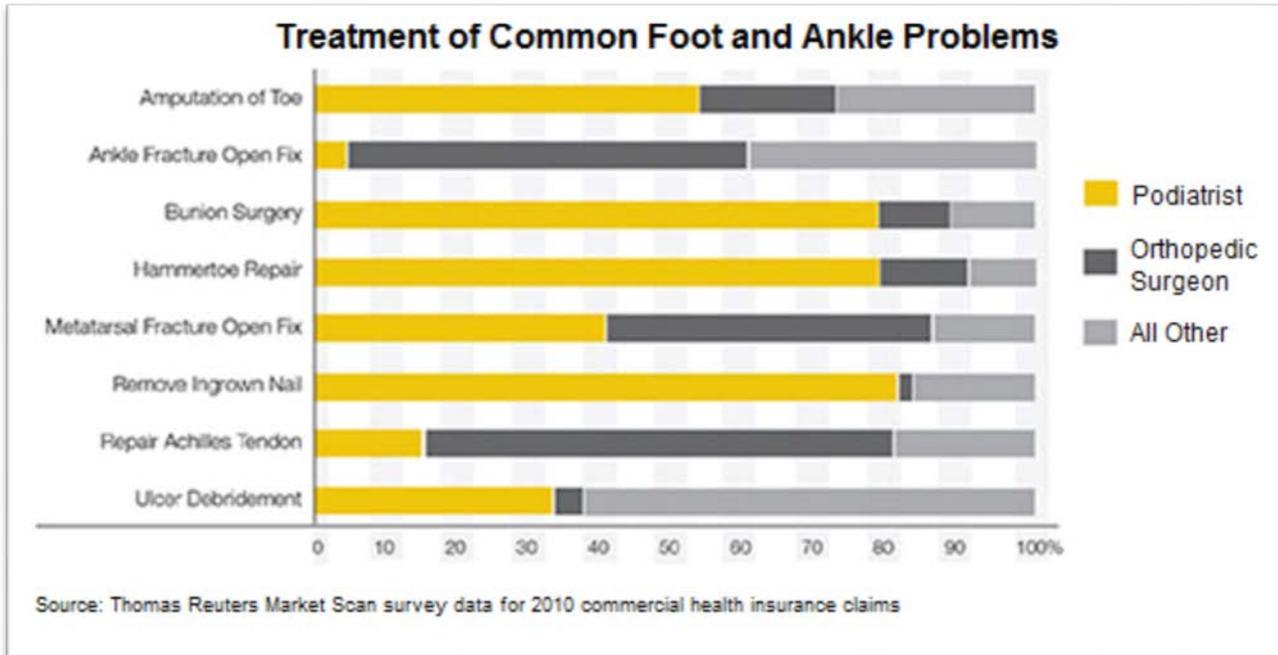
Orthopedic Surgeons: The current scope of practice of orthopedic surgeons and podiatrist Members of the College of Chiropodists overlap with respect to the podiatry authorized acts of "communicating a diagnosis identifying a disease or disorder of the foot as the cause of a person's symptoms", with respect to "cutting into subcutaneous tissues of the foot and bony tissues of the forefoot" and other podiatry authorized acts necessary or incidental thereto. According to the Canadian Orthopedic Association's submission to HPRAC², there are 24 registered orthopedic surgeons in Ontario specializing in the foot and ankle; far less than the number needed to respond to current, let alone projected demand.

The podiatry profession also asserts that, in addition to the surgical procedures authorized within its current and proposed scope, podiatrists also provide "one-stop", continuous management of patients' foot conditions, including the provision of diagnosis and/or different diagnoses, education, prevention, rehabilitation and a range of noninvasive treatment responses.

Orthopedic surgeons will continue to be the profession of choice in the diagnosis and treatment of complex conditions of the foot and ankle, involving patients who are medically compromised, or who otherwise require hospital inpatient treatment. Where competencies overlap and where procedures can be conducted safely and effectively in non-institutional settings by podiatrists, patients may choose between podiatrists and orthopedic surgeons.

The following chart illustrates the relative utilization of podiatrists, orthopedic surgeons and other surgeons in performing common foot and ankle surgical procedures in the United States.

² "Initial Consultation-Chiropody and Podiatry Review Model of Foot Care in Ontario", Ontario Orthopedic Association, June, 2014, page 3.



In Ontario, podiatrists and chiropodists frequently recommend referrals to orthopedic surgeons and in a proposed footcare model submitted to the Ministry in 2009, the orthopedic surgeons suggested that chiropodists in their current scope of practice be used to triage patients with foot ailments. Orthopedic surgeons rarely refer to a chiropodist or a podiatrist. Nonetheless, the College foresees or hopes for the development of a collaborative working relationship between podiatrists and orthopedic surgeons such as has developed in Alberta, British Columbia and in the United States. Such a relationship would utilize the competencies of both professions and the comparative advantages of both professions' practice models, in the best interests of patients. [The College has tried on numerous occasions to engage the Canadian and Ontario Orthopedic Associations in discussions around the proposed scope of practice. There has been no response.]

Personal Support Workers & Health Care Aides: Apparently there may be more than 100,000 individuals providing services as PSWs in Ontario.³ According to the Ontario PSW registry, as of November 1, 2014 there are 30,286 individuals registered with the PSW registry.⁴ The following chart indicates their distribution throughout healthcare delivery by percentage of **registered** individuals.

³ "Improving Home and Community Care for Ontario Seniors: Ontario Providing Fairness for Personal Support Workers", Ministry of Health and Long-Term Care News Release. In its consultations with organizations representing PSWs, the College sensed uncertainty as to the actual number of individuals employed in some fashion or another as PSWs.

⁴ The Registry includes healthcare aides, as well as PSWs. Health care aides completed their training before 1998 and have a more limited scope of practice than PSWs.

Sector	Percentage of Registrants (%)
Community Care	10.52
Home Care	52.54
Hospital	3.02
Long-Term Care Homes	20.79
Private Homes	0.94
Retirement Homes	4.80
Supportive Housing	7.40

From interviews with administrators of long-term care and retirement homes, the College had concluded that PSWs and to a lesser extent healthcare aides provide routine footcare to the homes' residents. The Ontario Personal Support Workers Association (OPSWA) has 23 Standards of Practice, but no Standard of Practice for footcare.⁵ Except when working under the supervision of qualified, regulated healthcare practitioners, PSWs are actively discouraged by the OPSA from treating any conditions of the foot or ankle. The prohibition is due to the risk of harm associated with treating conditions of the foot and ankle, particularly in the instance of diabetic feet; and footcare does not form a significant part of recognized PSW training. OPSWA, however, indicates that "some" PSWs have taken some training in footcare and some agencies that employ PSWs for home care may allow or require them to provide some type of footcare. [This section was prepared in consultation with the PSW Registry and with the Ontario Personal Support Workers Association.]

Nurses: Members of the nursing profession (Registered Nurses, Registered Practical Nurses and Nurse Practitioners) provide footcare to more patients and in more delivery streams than members of any other profession, including chiropody and podiatry. Because of nurses' thorough distribution throughout Ontario's health care system, they are well-placed to assess and treat foot conditions and provide preventative measures. The majority of footcare provided in long-term-care homes, home care and in wound care clinics is provided by and large by nurses.

In terms of public domain - access to controlled acts there is overlap between nurses and chiropodists and podiatrists and a particular overlap between nurses and chiropodists. However, the nursing role is quite distinct from that of chiropody and podiatry.

The scope of practice specified by Section 3 of the *Nursing Act, 1991* is sufficiently broad to include footcare. The College understands that nurses regularly assess patients' foot conditions, provide preventive care and education, promote self-care and refer to other practitioners for diagnosis and treatment when necessary. In terms of treatment, nurses are known to provide routine and noninvasive footcare services such as hygiene, clipping nails, paring corns and calluses, debriding morbid tissues, wound care and the treatment of ulcers in diabetic and other patients, applying OTC topical medicines, bandaging and wrapping, monitoring conditions of the foot and in some cases prescribing and dispensing foot orthotics. Nurses provide accessible

⁵ <http://opswa.webs.com/standards-of-practice>.

footcare as part of the delivery of comprehensive nursing care in a number of settings, including long-term care homes, hospitals, directly within the home, primary care and within the community.

There is no recognized footcare specialization within the College of Nurses of Ontario, but the Canadian Association of Footcare Nurses (CAFN) accredits footcare courses for registered nurses and is advocating for the recognition of footcare nursing as a specialization by the provincial nursing regulatory bodies. The CAFN also advocates for national guidelines for nursing footcare practices. The Association also promotes opportunities for the education of footcare nurses and at this time, the CAFN accredits 18 footcare courses for registered nurses at Ontario community colleges and elsewhere.⁶ In addition, the Registered Nurses' Association of Ontario (RNAO) provides nurses with a range of evidence-based resources to support the delivery of footcare.⁷

Nurses who fulfill the competency and other requirements specified by Part III of Ontario Regulation 275/94 ("General Regulation"), or pursuant to an order from a chiropodist or podiatrist, may perform the following controlled acts that are relevant to footcare and overlap with the scope of practice and authorized acts of chiropodists and/or podiatrists: "procedures below the dermis", "inserting an instrument, hand or finger into an artificial opening of the body" and "administer(ing) a substance by injection". Nurses are also authorized to perform acupuncture on the foot and elsewhere. [This section was prepared in consultation with the Registered Nurses Association of Ontario.]

Chiropractors: There is overlap in scope of practice between chiropractors and Members of the College of Chiropodists (particularly chiropodists), in terms of the nonsurgical treatment of foot conditions. Surgical procedures are not part of the chiropractic scope.

There is collaboration between the professions with 71% of chiropractors reporting referrals to chiropodists and podiatrists (2014 Canadian Chiropractic Association Member survey) and a number of chiropractors employ chiropodists.

According to the Ontario Chiropractic Association's submission to HPRAC, chiropractors' role in footcare includes diagnosis, treatment and education, including the recommendation of NSAIDs, the application of electrical modalities, massage, stretching, the prescription of exercises, taping, braces, exercise modalities to strengthen and improve endurance and the prescription and dispensing of foot orthotics. About 80% of chiropractors prescribe orthotics at least occasionally

⁶ Algonquin College, Anishinabek, Canador College, College of Health Studies, Conestoga College, Confederation College, Diabetic Foot Canada, Fanshawe College, Foot Care Academy, Foot Care Seminars of Eastern Ontario, Foot Care Kingston Institute, George Brown College, Length and College, Mohawk College, Northern College, Ruth Ruttan & Associates, Sault College and St Clair College.

⁷ See <http://rnao.ca/bpg/guidelines/reducing-foot-complications-people-diabetes> and <http://rnao.ca/bpg/guidelines/assessment-and-management-foot-ulcers-people-diabetes-second-edition>.

Chiropractors are also authorized to order or take radiographs of the foot and elsewhere for diagnostic purposes. Chiropractors treat both discrete foot conditions and the foot as a part of a lower kinetic chain disorder.

Under the *Chiropractic Act, 1991*, of relevance to footcare, chiropractors share with podiatrists the authorized act of "communicating a diagnosis". Chiropractors also have the authorized act of what is referred to as "spinal manipulation". That controlled act is not shared with either chiropodists or podiatrists. [The foregoing was prepared in consultation with the Ontario Chiropractic Association.]

Physiotherapists: The intersection of scopes of practice between Members of the College of Chiropodists, particularly chiropodists and physiotherapists, is similar to that of chiropractic. There is a close working relationship between physiotherapists on one hand and chiropodists and podiatrists on the other. Physiotherapists and chiropodists often work together in multidisciplinary teams and clinics and physiotherapists frequently refer to podiatrists to diagnose and treat more complex foot conditions and to perform surgical procedures on the foot.

According to the Ontario Physiotherapy Association's submission to HPRAC, in terms of footcare, physiotherapists:

Assess and diagnosis diseases, disorders and impairments that cause loss of function or pain of the foot and ankle, including the assessment and diagnosis of conditions associated with the full kinetic chain including the spine that impact on foot and ankle function.

- Assess and diagnose diseases, disorders and impairments that cause interruption of the integumentary system of the foot and ankle including pressure ulcers, ulcers as a result of circulatory issues such as diabetes and other wounds whether as a result of injury or surgical intervention.
- Conduct gait analysis and interventions to address gait issues including balance retraining, mobility aid prescription, orthotic prescription and/or dispensing, splinting, gait training, strengthening, range of motion, exercise prescription, techniques to retrain after neurological events such as stroke, proprioception exercises.
- Perform debridement and wound care, pressure redistribution and offloading (including the prescription of orthotics, corrective footwear and mobility aides), patient and caregiver education on neuropathy (a cause of injury and wounds to feet) and proprioception and balance issues. Electrotherapy modalities may also be applied to assist with healing of ulcers/wounds.
- Conduct mobilizations and other manual therapy techniques to increase the mobility of the foot and ankle complex.

- Prescribe exercises, home exercise programs and activity re-education and training to strengthen and improve function.
- Apply modalities to address pain including electrophysical, therapeutic heat/cold, acupuncture and acupressure.

In terms of controlled acts that are relevant to the foot, both physiotherapists and podiatrists are authorized to "communicate a diagnosis". Physiotherapists, together with chiropodists and podiatrists, may engage in wound care and perform acupuncture. Physiotherapists' authority to order laboratory tests and to order x-rays has not yet been proclaimed. The physiotherapy authorized act of "spinal manipulation" is not shared with chiropodists or podiatrists.

Physiotherapists are active in the prescription and to a lesser extent the dispensing of foot orthotics. Physiotherapists may also perform acupuncture on the foot and elsewhere. [The foregoing was prepared in consultation with the Ontario Physiotherapy Association.]

Orthotists and Prosthetists: Orthotists and Prosthetists are not currently regulated under the RHPA, but have approached several existing Colleges, most notably the College of Kinesiologists of Ontario, with a view to being regulated by an RHPA College. (No approach has been made to the College of Chiropodists.) The Canadian Board for Certification of Prosthetists and Orthotists (CBCPO) accredits educational programs, certifies practitioners and accredits facilities on a voluntary basis. The College understands that there are somewhat less than 200 certified Orthotists and Prosthetists currently practising in Ontario. The educational background of orthotists and prosthetists vary significantly, but in Ontario only the course at George Brown College has been certified by the CBCPO.

The Ontario Association of Prosthetists and Orthotists seeks RHPA regulation because of the significant risk of harm (physical injury, pressure points, security of function and financial risk) from prostheses and orthoses that are designed, manufactured and provided by individuals without the requisite training, competencies and enforceable regulatory oversight. The OAPO also believes that regulation will facilitate interprofessional collaboration and will enhance the visibility and credibility the profession. Nonetheless, the College understands that the OAPO is not asking for access to any RHPA controlled act. The College does understand, however, that Orthotists and Prosthetists would like to have the authority to independently order and take radiographs under the *Healing Arts Radiation Protection Act* (HARPA).

The foot prosthetics and orthotics designed and manufactured by Orthotists and Prosthetists are usually used in the instance of amputations, partial amputations or congenital and systemic chronic conditions and are thus significantly more complicated and complex than the orthotics usually prescribed and dispensed by chiropodists or podiatrists and by other professions. Orthotists and Prosthetists also do not assess or diagnose diseases, disorders or dysfunctions. Orthotists and Prosthetists are authorized under the Ministry of Health and Long-Term Care's ADP program to perform procedures to manage foot and ankle conditions under the supervision of a physician or a nurse practitioner. Neither chiropodists nor podiatrists are authorized

practitioners for the ADP program, although the College has corresponded with the Ministry about becoming part of the program.

Accordingly, there is very little in the way of scope overlap between chiropodists and podiatrists on one hand and Orthotists and Prosthetists on the other hand. There is, however, a strong case for close collaboration between chiropodists and podiatrists on one hand and Orthotists and Prosthetists on the other hand to provide a full continuum of footcare that is as seamless as possible for patients. [The foregoing was prepared in consultation with the Ontario Association of Prosthetists and Orthotists.]

Pedorthists: Canadian Certified Pedorthists claim to be orthotic and orthopaedic footwear experts trained in postural analysis, movement patterns, and musculoskeletal examination. More specifically, they claim to focus on the assessment of the lower limb and foot anatomy, muscle and joint function, as well as the interaction of the foot and lower limb with the rest of the body. They aim to help to alleviate pain, abnormalities, and debilitating conditions of the lower limb and foot.

There are four gradations of certifications as described by the College of Pedorthists:

1. C. Ped (C) - Certified Pedorthist Canada

These practitioners provide:

- Assessment through observation of surface anatomy and palpation of the limb, gait analyses, range-of-motion testing, footwear analysis and review of potentially complicated health factors;
- Casting, manufacturing, fitting and adjusting orthoses;
- Fitting and modifying standard and orthopaedic footwear;
- Accommodating/incorporating complementary assistive devices; and,
- Casting and measuring for custom footwear.

2. C. Ped MC - Certified Pedorthic Master Craftsman

The highest level of certification available. Clinical pedorthists and a custom shoemakers who provide:

- All of the skills listed for a C. Ped (C);
- Manufacturing custom orthopaedic footwear - including:
- Measuring, casting and making original shoe lasts;
- Designing and making upper patterns;
- Manufacturing fitting model of shoes; and,
- Lasting and finishing of custom shoes.

3. C. Ped Tech (C) - Certified Pedorthic Technician Canada

These practitioners provide:

- Shoe fitting;
- Shoe modification and orthotic fabrication (from laboratory prescriptions provided by footcare professionals with the scope of practice to assess);
- Orthotic fabrication;
- Shoe modifications;
- May perform duties of a clinical pedorthist under the direct supervision of a Canadian Certified Pedorthist. See the supervisory statement for further details;
- A C. Ped Tech (C) cannot independently manage patients.

4. COFS- Certified Orthopaedic Footwear Specialist

This is a closed membership category. Historically, COFS members were one of the founding groups that merged to create the Pedorthic Association of Canada.

Recognizing the contribution COFS members have made to the pedorthic profession, The CPC verified their competency and has added the COFS category.

These practitioners provide:

- Assessment for orthotics and custom footwear
- Casting and measuring for custom footwear
- manufacturing of custom orthopaedic footwear, including:
- measuring, casting and making original shoe lasts
- designing and making upper patterns
- manufacturing fitting models of shoes
- lasting and finishing of custom shoes
- Casting, manufacturing, fitting and adjusting of orthoses
- Fitting and modifying standard and orthopaedic footwear
- Accommodating/incorporating complementary assistive devices

The scope of practice overlap between pedorthists on one hand and chiropodists and podiatrists on the other hand relates to foot orthotics. Pedorthists claim to assess the anatomy of the lower limb and to cast, manufacture, adjust and dispense foot orthotics and shoes. They also claim that the skill set necessary to do so is unique to pedorthists, at least to those who have been certified by the "College of Pedorthics".⁸

The College of Chiropodists does not dispute pedorthists' training in the manufacturing, adjustment and dispensing of foot orthotics and shoes and acknowledges the important role that pedorthists play, and should continue to play, in this segment of footcare. With around 250

⁸ Pedorthic Association of Canada, Foot Care in Ontario, A Submission to the Health Professions Regulatory Advisory Council, June 25, 2014, p 2.

pedorthists currently practising in Ontario, however, they cannot--and do not-- profess to satisfy the current demand for foot orthotics, let alone the projected demand.

The College does dispute that the relevant skill set is unique to pedorthists. Chiropodists and podiatrists, as well as members of several other regulated and unregulated professions, have equivalent, comparable, or better skill sets.

The Pedorthic Association has provided insufficient evidence for the College to evaluate the claim that pedorthists have the expertise to assess lower limb anatomy and biomechanics, but notes that under the RHPA these would be public domain acts in any event.

Pedorthists and podiatrists or chiropodists rarely work together in healthcare practices and rarely refer to one another, based on the belief held by chiropodists and podiatrists that they themselves have the necessary competencies and authorities with respect to the diagnosis and treatment of diseases, disorders and dysfunctions of the foot and in the prescription, dispensing and fitting of foot orthotics. Pedorthists do work for the labs that chiropodists and podiatrists use to fabricate the foot orthotics they prescribe.

The chiropody and podiatry professions regret that pedorthists have, from time to time, advocated to insurance companies that pedorthists alone should be recognized for manufacturing, dispensing and fitting foot orthotics and orthopedic shoes and have claimed that chiropodists and podiatrists have a conflict of interest when they both prescribe and dispense foot orthotics. As explained elsewhere (see response to Question # 9), the College believes that patients are best served if chiropodists and podiatrists provide the full continuum of orthotic care. The College of Chiropodists of Ontario has also had a long-standing dispute with the "College" of Pedorthics of Canada for its use of the "College" appellation and the likely inference drawn by health care consumers that pedorthists are regulated in Ontario. [This section was prepared in consultation with the Canadian Association of Pedorthists].

Nail Care Technicians, Pedicurists, Aestheticians, Cosmetologists, Etc.: These providers' principal focus appears to be on maintaining nails (both hands and feet) in an attractive and healthy state. Some providers characterize themselves as "footcare specialists" and some purport to have the skills to identify and treat skin and nail disorders.

Their skills and training vary widely. Training programs are predominantly provided through private schools, internships in clinics, on-the-job training and there is a Certificate Program at Mohawk College. There is, however, no regulation or title protection and, therefore, virtually anyone who wishes to do so may hold themselves out as a "nail care technician", "cosmetologist", "aesthetician" and the like, even "footcare specialist".

Like a number of the groups and individuals who submitted comments to HPRAC during the footcare model consultation, the College is concerned for the public's safety when nail care technicians and the like independently perform procedures, including controlled acts, that entail a significant element of patient risk, particularly when patients are in vulnerable positions,

unable to distinguish between "regulated" and "unregulated" or "competent" and "incompetent" practitioners and unable to give informed consent to treatment. The College is also concerned when nail care technicians and the like do not follow even minimal infection control protocols and do not refer or otherwise connect with the health care practitioners involved in patients' circles of care. According to the American Podiatric Medical Association, each year about 1 million Americans contract a bacterial, viral or fungal infection due to contaminated instruments, contaminated foot baths and cuts, scrapes and scratches sustained during pedicures and unregulated toenail care.

Chiropodists and podiatrists do not provide cosmetic services to patients except as a by-product of or follow-through to therapeutic procedures. Some podiatrists and chiropodists employ aestheticians to provide noninvasive, cosmetic footcare under the podiatrists' supervision and under the same infection protocols and Standards of Practice that apply to podiatrists and chiropodists themselves. Nevertheless, there is no overlap in terms of cosmetic procedures and the College strongly holds the view that nail care technicians and the like should not be performing procedures that entail a significant risk of patient harm within the current scope of practice of chiropody and podiatry, or within the proposed scope, unless they are under the supervision of a podiatrist, chiropodist or other qualified, regulated healthcare practitioner.

Question 2: *Is there a need to develop common footcare practice standards for all footcare practitioners? If so, why? How would this improve patient care? Who would participate in developing these standards? How would, practice standards fit into an expanded scope of practice?*

Response: The College strongly agrees with the need for common footcare standards of practice that would apply to members of all professions providing footcare, particularly those who perform controlled acts. The College would enthusiastically participate in an inter-professional initiative to do so. The challenge, however, would be in their application and enforcement among unregulated practitioners.

Increasingly, unregulated care providers (UCPs) assist with, independently perform, or perform under some form of supervision aspects of care traditionally reserved for regulated practitioners. As indicated in the Application, the College has been concerned for some time about the increasing penetration of unregulated and less-than-competent practitioners, such as aestheticians, cosmetologists and unregulated "footcare specialists" into footcare, particularly when they perform controlled acts, or other procedures that constitute a material risk of harm to patients. Such procedures include but are not limited to, foot and nail hygiene, nail clipping and pairing, bunion and callous paring, application of OTC topical medicines, excision of morbid tissues, treatment of plantar warts, bandaging and removal of sutures. No matter how straightforward the procedure may be or appear to be, no matter whether the procedure is in the public domain, or the UCP is legally authorized to perform it through an order, delegation or exemption, one cannot assume that a UCP is competent to perform the procedure, or that it is appropriate for the UCP to perform it.

"We need to form a coalition of stakeholders that includes the principals on this project (University of Toronto Knowledge transfer program, Women's College Wound Healing Clinic, the Registered Nurses' Association of Ontario, the Ontario CCACs and newly formed LIHNs), the Canadian Association of Wound Care, Chiropody and Podiatry associations, the Pedorthic Association of Canada, the Canadian Association for Prosthetics and Orthotics, and other government and non-government health-care agencies to improve the approach to treating foot ulcers in the presence of neuropathy. These clients are losing their legs unnecessarily."

- Woo, Kevin, et al "An Audit of Leg and Foot Ulcer Care in an Ontario CCAC", Wound Care Canada, Vol 5, Suppl.1, Page S-26

Feet are particularly subject to infection; they are critical to mobility, balance and independence; systemic diseases often manifest themselves in the foot and too often go undiagnosed. Seniors, particularly residents of long-term care and retirement homes, are particularly vulnerable. The College has also been concerned about wide variations in, or the absence of, standards of care observed by both regulated and unregulated practitioners, such as infection control protocols. There is rarely any communication with practitioners in the circle of care when UCPs provide footcare. Outside of the chiropody and podiatry professions, the prescription, dispensing and fabrication of foot orthotics are unregulated and have become something of a "Wild West" of excessive and unnecessary utilization, usurious charges, conflicts of interest and outright fraud. The aging population and the growth of consumer interest in cosmetic procedures on the feet will exacerbate these problems.

As far as the College is concerned, the benefits of common, or *at least* consistent, standards of footcare are obvious: Reduce patient risk, which is a major preoccupation of the College; increase the effectiveness of diagnosis and treatment; reduce system-wide costs by "getting it right the first time"; reduce the incidence of complications arising from unsafe, unnecessary or less-than-competent treatment; and substantially improve interprofessional care and interprofessional collaboration.

The College has to be mindful of the self-governance framework and to the sensitivities of other Colleges. The College would propose, either directly or through the Federation of Health Regulatory Colleges of Ontario, a roundtable consisting of representatives of the College of Chiropodists, the College of Physiotherapists, the College of Physicians and Surgeons of Ontario, the College of Kinesiologists, the College of Nurses and the College of Massage Therapists and perhaps organizations such as the "College" of Pedorthics⁹ and the Canadian Association of Foot Care Nurses to develop baseline footcare practice standards that each organization could adapt as per their authorized acts and practice exigencies. There would then

⁹ The "College" of Pedorthics is based in Winnipeg, Manitoba and holds itself out as the certification and regulatory body for pedorthists nationally. It is not a "College" in the RHPA sense. The College of Chiropodists of Ontario takes the position that this usage of the terminology "College" contravenes s. 34 of the RHPA. Furthermore, because of public confusion created by the use of this terminology, the College of Chiropodists has asked the College of Pedorthics to stop referring to itself as a "College", but the College of Pedorthics has been completely unresponsive.

be the challenge of achieving reasonable observance of these standards in the unregulated sector. Reaching out to and educating patient advocacy organizations such as the Canadian Association of Retired Persons, the Diabetes Association of Canada¹⁰ and the MS Society and to health care providers and other organizations such as Cancer Care Ontario, the Ontario Association of Non-Profit Homes and Services for Seniors, the Ontario Long-Term Care Association, Community and Home Assistance to Seniors and the Ontario Community Support Association would likely prove worthwhile. A media campaign, such as the one run by the College of Dental Hygienists of Ontario pertaining to oral health care, to explain to the public how to access safe and effective oral hygiene care could also be examined as a model for public communication on accessing proper footcare.

Question 3: *Provide descriptions of the most common routes to chiropody and podiatry treatment (e.g. referrals for family doctors, hospitals, walk-ins, etc.) how will the change in scope of practice affect access to foot related health care?*

Response: As primary care practitioners, no referral is required to access podiatrists' or chiropodists' services. Neither does OHIP, the WSIB, nor extended health benefits insurers require a physician's (or other healthcare practitioner's) referral. Some extended health benefits insurers, such as Blue Cross under Veterans Affairs Canada's coverage for veterans, require a referral for coverage for chiropody and podiatry services.

According to surveys conducted by the College of Chiropodists, the most common routes to chiropody and podiatry treatment outside of hospitals are:

- Referrals from physicians: 27% of total patients.
- Referrals from non-physician healthcare practitioners (e.g. physiotherapists): 11%
- Patient Self-referral: 32%
- Referral/Recommendation from Other Patients: 28%
- Miscellaneous Other Sources: 2%

A change in scope of practice is expected to have an impact on referral volumes, but is not expected to have a direct impact on referral patterns¹¹. The footcare sector, however, is uniquely populated by myriad professional titles that are esoteric and create confusion: Not only "chiropodist" and "podiatrist", but also "pedorthist", "orthotist", "pedologist", "prosthetist", "podologist", "footcare specialist" of various types and so on. The Ontario Society of Chiropodists maintains that confusion and a lack of awareness around what the OSC characterizes as the "antiquated" "chiropodist" title discourage referrals from members of other healthcare professions, discourage interprofessional care and are major obstacles to patients self-referring to chiropodists. The College has no evidence to substantiate this claim other than

¹⁰ The College of Chiropodists has already met with representatives of the Diabetes Association of Canada and the Ontario Branch.

¹¹ There is no evidence that the College has been able to find that scope of practice expansions per se change referral patterns in Ontario. In addition, the WSIB recognized physiotherapists as direct or primary contact providers more than a decade ago, but referral patterns for worker claimants haven't changed significantly.

the College itself receiving approximately 250 inquiries per year from members of the public asking what a chiropodist is and what the differences are between chiropodists and podiatrists and other footcare practitioners. The College also has abundant anecdotal evidence that the public often confuses "chiropodists" with "chiropractors". The College often finds itself explaining what a chiropodist is and what chiropodists do even to Ministry officials, other healthcare practitioners, members of the public, insurance companies and the like. Accordingly, there is a reasonable expectation that use of the single --- and far better recognized and understood ---- title "podiatrist" will substantially reduce public and healthcare practitioner confusion and lack of knowledge around the chiropody title.

The sizes of the chiropody and podiatry professions in Ontario have been major obstacles to the visibility and marketing of the professions in the way and to anywhere near the extent that other professions, such as chiropractic, physiotherapy, dentistry, medicine and nursing market themselves. "Numbers" are also a major factor in accounting for the lack of comprehension about the chiropodist title. A scope of practice enhancement as proposed by the College, plus removal of the podiatric cap, will prompt a natural growth in the unitary profession of podiatry that will improve the visibility and marketability of the profession.

In terms of access to foot-related health care, removal of the podiatric cap will instantaneously increase the number of podiatrists (i.e. members of the podiatrist class) who are competent to perform all of the current and new authorized acts by 25-45 practitioners, namely those DPMs who are currently registered to practise as chiropodists and Ontario DPMs currently practising in United States or in other provinces who have indicated an intention to return should Ontario adopt a full-scope podiatry model. Over the medium and long-term, removal of the podiatric cap is projected to result in an annual net growth of the profession of at least 25 new registrants, being the average number of Ontario residents who graduate from out-of-province DPM programs. All of these new registrants are competent in the performance of all of the new authorized acts. In addition, as indicated in the Application, a substantial number of grand-parented chiropodists are expected to incrementally acquire the competencies they need to perform some or all of the new authorized acts.

If the podiatry cap is not removed, access issues will be exacerbated as a consequence of the entire podiatrist class cohort completely or largely disappearing over the next decade, due to attrition and retirement

Question 4: *How does confusion around the chiropody title impact patient care and outcomes?*

Response: HPRAC itself has characterized Ontario as "an anomaly re-titles-in every other province the designated term is podiatrist, but in Ontario is chiropodists;"¹² The vast number of Ontarians do not know what a chiropodist is, or what services a chiropodist provides.^{13 14} As

¹² "A Jurisdictional Review of the Professions of Chiropody & Podiatry", Health Professions Regulatory Advisory Council, November 2008, Page 2.

¹³ A survey conducted by the Ontario Society of Chiropodists apparently found that 2% of survey respondents correctly identified what a chiropodist is.

such, patients have no motivation to seek out a chiropodist to provide the specialist footcare chiropodists provide. Our stakeholder consultations also demonstrated that many healthcare practitioners do not know what a chiropodist is, or what services a chiropodist provides either. As such, many healthcare practitioners have no motivation to refer to or work with a chiropodist. Patient care and outcomes are adversely affected when patients either go without the footcare they require, or do not get the footcare they require from the right practitioner, at the right time and in the right place ---- which happens to be the third objective of the Ontario Government's Action Plan for Healthcare¹⁵ and one of the priorities specified by the Premier in her September 27, 2014 Mandate Letter to the Minister of Health and Long-Term Care.

The indisputable fact is that "podiatry" and "podiatrist" have become the internationally-recognized designations and professional descriptors and the designations "chiropody" and "chiropodist" have largely fallen into disuse, particularly in North America, Australia, New Zealand, Europe and in other comparable jurisdictions.

Question 5: *Provide details on how the proposed change in scope of practice will impact the interprofessional collaboration (IPC) of foot care providers. Will it influence the integration of chiropodists and podiatrists into interdisciplinary health care teams? How will the patient be impacted?*

Response: The American Podiatric Medical Association (APMA) advises that approximately 60% of US-licensed podiatrists practise, full or part-time, in hospitals and other multidisciplinary venues. The Canadian Podiatric Medical Association (CPMA), based on data obtained respectively from the College of Podiatric Surgeons of British Columbia and the College of Podiatrists of Alberta, reports that:

- About 85% of podiatrists in British Columbia practise full or part-time in multidisciplinary clinics, including the 10 BC podiatrists who have hospital privileges; and
- About 40% of podiatrists in Alberta practise full or part-time in multidisciplinary clinics, including the 20 Alberta podiatrists who have hospital privileges. (See following notice).

¹⁴ It is also noteworthy that the equivalent of "chiropodist" in French pursuant to Ontario's *Chiropody Act* is "podologue" (which is often also the translation for "podiatrist"). Under the *Chiropody Act* the French translation for podiatrist is "podiatre".

¹⁵ Speech by the Hon. Deb Matthews to the Toronto Board of Trade, "Making Healthy Change Happen: Ontario's Action Plan for Healthcare", January 30, 2012.

The Section of Podiatric Surgery, Department of Surgery at the University of Calgary is seeking a Board Certified/Board Qualified Podiatric Surgeon. The Section of Podiatric Surgery is comprised of 10 active surgeons involved in outpatient/in-patient reconstructive surgery of the foot and ankle, diabetic wound care and surgery as well as forefoot trauma. The position requires the individual to participate in general Podiatry call in rotation with the 5 current members of the hospital section. Participation in the outpatient Diabetic Limb Salvage Clinic is also required.

Candidates should be committed to cultivating an academic surgical practice with involvement in resident teaching and clinical and or basic science research. A strong interest in the care of persons with diabetic complications of the lower extremity is desirable. Interest in research and publication is also desired.

Qualifications include a DPM, a three-year postgraduate residency program, board qualification/certification with the American Board of Podiatric Surgery and eligibility for licensure in the Province of Alberta.

Please submit your curriculum vitae, letter of intent and three letters of reference by February 1, 2015 to:

Francois Harton, DPM, FACFAS
Chief, Division of Podiatric Surgery
Department of Surgery
University of Calgary
2675 36th St NE Suite 7
Calgary, Alberta
T1Y 5S3
francois.harton@albertahealthservices.ca

In accordance with Canadian immigration requirements, priority will be given to Canadian citizens and permanent residents of Canada. The Calgary Health Region is committed to employment equity.

It is not at all clear why podiatrists and chiropractors have not been more extensively integrated into interdisciplinary health care in Ontario. The College speculates that it could be due to factors such as the limited numbers of chiropractors and podiatrists, the lack of awareness of what chiropractors and podiatrists may contribute to healthcare, extensive overlaps in scopes of practice with other professions (particularly for chiropractors) and funding gaps in the publicly-funded system. Other professions have found that interprofessional collaboration begins with exposure to other professions and education about their role in the professional education programs. Perhaps because of the historic and current educational situation with respect to chiropractors and podiatrists in Ontario, that exposure and education hasn't happened. Nevertheless, there are encouraging signs. For the last several years, family practice residents have rotated through a podiatry clinic operated by a member of the podiatrist class practising in Windsor. A member of the podiatrist class has recently been confirmed by the University of Western Ontario as an Adjunct Assistant Professor in the Department of Family Medicine at the Schulich School of Medicine and Dentistry. Several individual hospitals have also employed podiatrists as "consultants" in the surgical treatment of foot disorders. The College hopes to establish a podiatry program in or in some affiliation with an established medical school in order to promote interprofessional understanding and collaboration between podiatrists and physicians and surgeons.

The current scope of practice and authorized acts for Ontario chiropodists was designed for hospital and similar institutional interdisciplinary practice. The proposed scope is designed to recognize current practice realities.

The proposed expanded scope of practice will create a more seamless and extensive continuum of footcare for patients, that is especially important for diabetics and others with infections, Peripheral Arterial Disease (PAD) and other comorbidities.

Implementation of the proposed scope of practice is expected to have the collateral impact (along with removal of the podiatric cap) of promoting the profession's growth making it more vibrant and responsive to health care system demands. In order to provide a full continuum of footcare, it is anticipated that podiatrists will hire, or otherwise join with, members of other professions in interprofessional practices and clinics. It is also a reasonable expectation that the ability of podiatrists to provide a full continuum of care will increase the volume of referrals from other practitioners.

As indicated elsewhere, a major barrier to IPC for chiropodists and podiatrists has been the lack of understanding of what chiropodists and podiatrists actually do, the relatively small numbers of the professions, the evident lack of a "future" for members of the podiatrist class and funding models that distort referral and usage patterns. Scope of practice changes, per se, will not address these barriers. Issues such as those relating to title, the podiatric cap and the educational program also have to be addressed.

Funding will also be a major consideration as to whether podiatrists under the proposed scope will be integrated into publicly-funded delivery venues such as Family Health Teams, Nurse Practitioner-Led Clinics and Aboriginal Family Health Teams. To date, the Ministry of Health and Long-Term Care has not funded professions whose services can otherwise be obtained in the community under OHIP.¹⁶

Question 6: *Some stakeholders have advised of communication challenges between chiropodists/podiatrists and other healthcare providers such as family physicians. If chiropodists and podiatrists are granted the ability to order diagnostic procedures, will this potentially result in the duplication of diagnostic procedures by other healthcare professionals? Is there a need for the chiropodist/podiatrist to, for example, share these tests with the patients' family physician? What regulatory mechanisms, or other mechanisms, will the college establish in order to facilitate the sharing of information.*

Response: The College has not heard this concern from stakeholders during the College's extensive stakeholder consultations. In fact, not a single stakeholder consulted by the College expressed this concern. Nor has the College heard such a complaint otherwise.

¹⁶ For example, although physiotherapists were instrumental in the original planning, physiotherapy services per se were not funded in FHTs, NPLCs and AFHTs until the funding model for community-based physiotherapy was moved out of OHIP.

The College strongly believes that it is absolutely essential to share diagnostic test results with the family physicians. The College and the professions are very much aware of the risk posed to patients, patient inconvenience and the health system costs of ordering unnecessary or duplicative diagnostic tests.

Members of the podiatrist class and some chiropractors who have DPM degrees currently order and/or take radiographs as authorized by the *Healing Arts Radiation Protection Act*.¹⁷ As a matter of practice, they will ask their patients to bring a CD of their x-rays to their consultation. If radiographs in addition to those available on the CD are required, the podiatrist will first ask the patient if he/she recalls such x-rays having been taken, when they were taken, on whose orders and so on. If the podiatrist concludes that additional radiographs are necessary, he/she will order or take them. It is important to note that rarely will radiographs of the type and nature required by a podiatrist have been ordered by another practitioner. The common experience is that the referring practitioner will leave it to the podiatrist to determine whether radiographs are required and the type needed.

Any new radiographs taken and the podiatrists' analysis thereof are shared with the family practitioner (if there is one) and the referring practitioner, if different. The results would also be shared with whomever the podiatrist may make a referral to. For the many patients who do not have a family physician, the podiatrist will do his or her best to ascertain whether relevant radiographs have recently been taken and to obtain copies if they have.

The College recommends that members of the profession who have demonstrated their competency to do so be authorized to order diagnostic tests commensurate with the current and proposed scope of practice and authorized acts. Should that authority be granted, the College undertakes to develop a Standard of Practice or Policy on the Management of Diagnostic Test Results that, inter alia, would require full consultation, the sharing of information and coordination with the family physician and referring practitioner in the ordering of and/or taking diagnostic tests. In particular, as best practices dictate, podiatrists would be required immediately to contact the family physician/referring practitioner when in receipt of clinically significant test results. In developing this Policy or Standard of Practice, the College undertakes to consult and collaborate with other Colleges, such as the College of Physicians and Surgeons of Ontario, the College of Nurses and the College of Physiotherapists, to ensure consistency and integration with their relevant policies, standards of practice and professional protocols and to address their concerns and needs. We have already met with the College of Medical Laboratory Technologists of Ontario and the Ontario Association of Medical Laboratories on this topic.

Patient consent would be obtained to share test results with other practitioners. It is not unknown for patients to consult a chiropractor or a podiatrist without the knowledge, or even against the wishes, of the family physician. In such cases, patients have been known to insist that there be no communication with the family physician.

¹⁷ The HARPA wording is “awkward” in that it refers to “graduates of a four-year course of instruction in chiropractic”.

The expansion of access to the Electronic Health Record (EHR) by chiropodists and podiatrists and their acceptance within the EHR network would obviously be exceedingly helpful in this regard. Currently, there are several EHR systems used to convey the results of laboratory tests depending on the kinds of laboratory analyzers used for testing, the hospital information system (HIS) and lab information systems (LIS) in place, what kind of test is being reported, whether the results are being sent to a hospital physician, to a primary care clinic, a medical office and so on. EHR adoption has been very limited within the chiropody and podiatry professions to date because of the relatively small sizes of the professions, the varied practice venues and other structural realities referred to in the Application. The College undertakes to work with the professions to promote and support their Members' adoption of EHR.

Question 7: *An expansion in scope of practice would likely require costly quality assurance and inspection programs and additional oversight obligations for the regulatory college. However, very large regulatory colleges do administer such oversight programs. Is it feasible for COCOO to establish similar programs? How much might such programs cost? How long would they take to be operational? How would COCOO fund them on a yearly basis? What would the impact be on individual members in terms of fees, staffing committees, etc.?*

Response: Surveys conducted by the College indicate that close to 100% of the current registrants intend to perform at least one of the proposed new or expanded authorized acts. Given the proposal for the authorization of additional surgical procedures, the College believes it to be in the public interest for the College also to have the authority to inspect clinics where podiatric surgery is performed.

It is important to emphasize that the scope of practice being proposed is a podiatric scope practised in over 80 jurisdictions. Accordingly, there are many professional regulatory and licensing bodies that are very experienced in administering quality assurance and inspection programs pertaining to that scope of practice. The College intends to learn from, employ and adapt that experience. The College has already taken advice from RHPA Colleges that have gone through a scope of practice change and will continue to do so. There are also many practitioners who are fully experienced with practice in the proposed scope, including a number currently practising in Ontario. The College intends to engage those practitioners in the development of its quality assurance and inspection programs and to employ those practitioners as inspectors.

The College currently undertakes practice assessments under the statutory QA program. Under the proposed scope of practice, the College would need to increase the frequency of its current program and to focus on those grand-parented practitioners who have been approved to practise one or more of the new or expanded authorized acts.

As indicated elsewhere in this Submission, the College has promised to expend best efforts and work with Ontario universities and colleges to make bridging or upgrading programs reasonably available to grand-parented registrants who wish to take them. The programs will have to have didactic, clinical and assessment components. The College will identify those specific programs

that grand-parented registrants will have to successfully complete in order to perform any new or expanded authorized act.

The College anticipates approximately three years between passage and promulgation of the new legislation. During that period, the expanded QA and inspection framework will be developed and readied for launch coincident with proclamation. Once the first upgrading or bridging course or courses have been completed, the College will be ready to launch its review of those Members who have chosen to practise any component of the expanded scope. The cost will be funded out of Members' fees. College staff will be responsible for the administration of the program. Year 1 and 2 reviews (post proclamation) for the enhanced scope will be carried by external experts and for the 'regular' QA reviews, by Members.

Year 1

50% of Members will upgrade (650) which is equivalent to 325 Members in total. Of those, 20% will be reviewed in the first year and 20% in the second year. Therefore approximately 165 Members will be reviewed in Year 1 and 165 Members in Year 2.

The College will hire 2-3 independent podiatrist consultants to deal with the practice reviews of those who have opted to practise in the expanded scope. These reviews will also be in place to assist Members with the actual practise of the expanded scope.

Cost will be 130 Members x \$750.00 per review = **\$123,750.000.**

Year 2

Repeat of Year 1. During both years, the consultants will be training appropriate podiatrists in the Province so that the process can repeat itself for another 2-year cycle. Cost will be 130 Members x \$750.00 per review = **\$123,750.000**

Cost: \$247,500.00

Quality Assurance

Concurrently, at the same time the remaining 325 Members who have chosen not to practise under the expanded scope will continue with the practice reviews at 100 per year x \$750.00 = \$75,000. One hundred Members will be reviewed each year on a go-forward basis in years 3+. In Year 5, the two parallel practice assessments will combine as one.

Cost: \$75,000.00 per year.

Therefore Year 1 and 2 will cost a total of \$322,500.00 or \$161,250.00 per year. Year 3+ will cost \$75,000.00 per year.

Expenditures of this quantum are within the projected financial resources of the College. The College has incurred substantial net additional costs as the Applicant in this HPRAC review. Costs of a similar magnitude will continue through the implementation phase between passage and proclamation of the legislation as the College completes the process of new By-Laws,

regulations, Standards of Practice, Policies and Guidelines. As expenditures for those activities decline, expenditures will increase to launch and administer the expanded QA and inspection programs. Accordingly, the College does not anticipate a significant fee increase to fund the expanded program.

Notwithstanding the relatively small size of College membership, the College has always populated its committees, etc. The College is absolutely confident that the scope of practice enhancements and the removal of the podiatric cap, the changes necessary or incidental thereto and the ripple affect they will create will prompt growth of the profession significantly in excess of historic trends.

Question 8: *Please characterize how foot care services are reimbursed when different health professionals such as podiatrists, chiropodists, nurses, pedorthists, PSWs and others provide care. What percentage of billings are paid by individuals, insurance companies, government? How will an expansion of practice impact the payment for foot related health care? Would members of COCOO expect to have some or all of their services reimbursed by OHIP under an expanded scope of practice?*

Response: The College has indicated privately to HPRAC its discomfort in responding to this question. Colleges do not generally get involved in reimbursement matters and the College of Chiropodists has never accumulated data on this topic, in particular data pertaining to the reimbursement of other professions involved in footcare. Nonetheless, at HPRAC's urging the College has done its best to respond to this question in consultation with the professional associations and as many as possible of reimbursement agencies involved.

Chiropodists: The chiropody model adopted by Ontario in the late 1970s was founded on a publicly-funded, institution-based delivery model, where chiropodists would work as salaried personnel as part of multidisciplinary teams. Because of the closure and downsizing of institution-based chiropody clinics, less than 20% of chiropodists work full or part-time in publicly-funded institutions today and the vast majority are now in private practice. As explained elsewhere, the private practice delivery model is incompatible with the scope of practice and controlled acts authorized for chiropodists.

Chiropodists' services are now reimbursed primarily through the private system by patients paying out-of-pocket, or by extended health benefits insurers. Chiropodists' services for foot injuries sustained in automobile accidents are reimbursable through the auto insurance system. The WSIB has a fee-for-service schedule for chiropodists and podiatrists and chiropodists were involved in the development of and may charge for services rendered to worker claimants under the MSK Program of Care (lower extremity injuries). Nonetheless, the treatment of foot injuries by WSIB claimants tend to be treated by physicians and by orthopedic and other surgeons, rather than by chiropodists¹⁸. Chiropodists who provide services in long-term-care homes may be reimbursed by the long-term-care home, by the residents themselves, or by the residents'

¹⁸ The WSIB contracts with several hospitals across Ontario (e.g. Toronto Western) to provide specialized foot and ankle clinics where orthopedic surgeons provide surgical treatments to WSIB claimants within specified wait times (usually no more than two weeks).

extended health benefits insurance. Chiropractors in publicly-funded primary care organizations such as Family Health Teams (29 chiropractic FTEs approved) or Community Health Centres are usually salaried personnel. Chiropractors' assessment and treatment of veterans on referral from a physician are reimbursable through Veterans Affairs Canada, as are the prescribed costs of foot orthotics.

Podiatrists: Podiatrists' services are partially reimbursed by OHIP. Subsection 26.1 of the General Regulation under the *Health Insurance Act* (Ontario Regulation 552) exempts any "service rendered by a podiatrist" from the prohibitions in clause 14 (1) (c) of the *Health Insurance Act* against the payment for all or any part of a service rendered to an insured person by other than OHIP. (Podiatry is the only allied health profession in Ontario that has not been delisted or partially delisted from OHIP and is the only health professional service eligible for co-billing.)

The OHIP per-visit schedule for podiatrists has not been revised since 1993. The OHIP contribution for an initial office visit is \$16.40; \$11.45 for a subsequent office visit; \$7.00 for visits in institutions such as hospitals and long-term care homes; and \$11 or \$5 for x-rays of the feet. As such, OHIP covers a small portion of the cost of diagnosis and treatment and a tiny portion of the cost of podiatric surgical procedures. Total OHIP payments for podiatry services in the Fiscal Year ending March 31, 2014 were approximately \$4.5 million. The balance of reimbursement for podiatry services is covered by most extended health benefits insurance programs, or by patients out of their own pockets. Some insurance companies refuse to provide "first dollar" coverage of podiatric treatment and insist on waiting until the patient's annual OHIP maximum (\$135) has been reached. This creates a significant barrier to access, because it discourages those who cannot pay out-of-pocket from consulting a podiatrist.

Because of OHIP's coverage for podiatrists' services, government funding is not available for podiatrists in other publicly-funded, primary care delivery venues, such as Family Health Teams.

There is a WSIB fee for service schedule for podiatry and podiatrists were involved in the development of and may charge for services rendered to worker claimants under the MSK Program of Care (lower extremity injuries). Foot injuries and diseases sustained by WSIB claimants tend, however, to be treated by physicians and, if necessary, by orthopedic and other surgeons rather than by podiatrists¹⁹. Podiatrists who provide services in long-term-care homes, retirement homes and other collective living facilities usually bill some combination or permutation of the home, the patient or the patient's extended health benefits insurer, and/or OHIP for the services rendered.

Podiatrists' assessment and treatment of veterans on referral from a physician are reimbursable through Veterans Affairs Canada as is the prescribed cost of foot orthotics.

¹⁹ The WSIB contracts with several hospitals across Ontario (e.g. Toronto Western) to provide specialized foot and ankle clinics where orthopedic surgeons provide surgical treatments to WSIB claimants within specified wait times (usually no more than two weeks).

Personal Support Workers (PSWs): Ontario's PSWs can be found throughout Ontario's publicly and privately-funded healthcare system. More than 34,000 provide care, assistance and support to seniors and others with complex care needs in their homes and in the community, including the Community Support Services, Home Care and long-term care homes sectors. They are employed on a casual or permanent basis.

Remuneration and sources of remuneration vary. The Ontario Budget for fiscal year 2014-15 included provisions ("PSW Workforce Stabilization Strategy") to increase the minimum wage for PSWs in the Community Support Services and Home Care sectors from \$12.50 to \$16.50/hour by April 1, 2016 through annual increments of \$1.50/\$1.50/\$1.00. Those increases are expected to have ripple effects in other publicly-funded sectors where PSWs are by-and-large already better paid. For example, PSWs in long-term-care homes that are municipally-owned are already paid around \$23 on average.

Outside of the publicly-funded sector, PSWs often provide their services through agencies and are paid by patients, or by patients' families. Extended health benefits may provide coverage.

Chiropractors: Chiropractic services were delisted from OHIP effective April 1, 2004. Chiropractors practise predominantly in private clinics, usually on a sole practitioner basis. About 10-15% of chiropractors' treatment is for foot injuries sustained in either a workplace accident or a motor vehicle accident. Reimbursement is through the WSIB MSK Program of Care (lower extremity injuries), through the WSIB's fee-for-service for chiropractic, or the auto insurance system for automobile accidents.

The majority of chiropractors' treatment is paid by patients out of pocket, with some covered through extended health benefits plans. About 75% of the population has such insurance coverage, but according to the Ontario Chiropractic Association, the percentage of chiropractors' patients with extended health benefits insurance is higher than the average and those without insurance coverage are less likely to consult a chiropractor.

Physiotherapists: Physiotherapists work in all sectors of the health care system both public and private.

On April 1, 2013, the Minister of Health and Long-Term Care announced a comprehensive overhaul to expand access to publicly-funded physiotherapy. That overhaul is still in the process of full implementation:

- For residents of long-term care homes (77,000), homes are allocated a budget of \$750 per bed, per annum for residents assessed as requiring one-on-one physiotherapy.
- 209 Community Physiotherapy Clinics and 33 hospitals and Community Health Centres have been designated by the Ministry to provide publicly-funded physiotherapy on an "episode of care" basis. The fee for each episode of care is \$312. Persons eligible for treatment are those 65 and older, younger than 19, persons who have been recently

discharged from a hospital and need rehabilitation services directly related to the condition for which they received hospital treatment and persons who have been referred by a physician or Nurse Practitioner as needing physiotherapy under the Ontario Disability or Ontario Works programs.

- Centralizing all publicly funded home care visits by physiotherapists under CCACs.
- Funding for physiotherapists is being allocated to primary care organizations such as FHTs, Nurse Practitioner-Led Health Teams and Community Health Centres. On November 26, the Ministry announced funding in Fiscal Year 2014-15 a total of 38.3 FTEs across different organizations in addition to those already funded in this sector.

Physiotherapists working in hospital inpatient or outpatient rehabilitation clinics and in CHCs are usually salaried employees.

Physiotherapy provided outside of the publicly-funded system is usually reimbursed through extended health benefits insurance, or by patients paying out-of-pocket.

Physiotherapists treating foot injuries sustained in a motor vehicle accident are reimbursable through the motor vehicle accident system.

Physiotherapists treating foot injuries sustained in a work-related accident are reimbursable through the MSK Program of Care (lower extremity injuries) or the WSIB's physiotherapy fee-for-service schedule.

Physiotherapists' assessment and treatment of veterans on referral from a physician are reimbursable through Veterans Affairs Canada as is the prescribed cost of foot orthotics.

It is noteworthy that registered physiotherapists are eligible to be certified by the Ministry of Health and Long-Term Care as ADP assessors.

Pedorthists: Pedorthists are free to set their own fee schedules. Typically the fees charged by pedorthists are based on a variety of factors and vary by region. Many pedorthists charge for an assessment. If a product is required to correct an abnormality the cost of the assessment is often waived. Many Pedorthists will not charge for any subsequent service for that patient related to that specific product for a period of one year. Other products and services would be billed accordingly.

The majority of pedorthists' patients have private insurance for custom made orthotics, footwear modifications and custom made orthopaedic footwear. Services (not products) provided by pedorthists are not typically covered by private insurance.

The College does not anticipate and has not recommended a change in reimbursement approaches or patterns for footcare as a consequence of implementation of the proposed scope of practice change.

The College has no view on whether OHIP should be extended to all Members of the College, or otherwise changed, and does not anticipate being involved in a discussions or negotiations on that topic.

As indicated in the response to this Question, podiatrists' services are already partially covered by OHIP. The Ontario Podiatric Medical Association has indicated to the Ministry an interest in updating the fee-for-service schedule and perhaps moving to a remuneration model similar to that implemented for physiotherapy last year. The Ministry has demurred on any discussions pending the outcome of the HPRAC review.

Question 9: *Through the initial consultation program, some stakeholders have highlighted the need for consumer protection measures related to the fitting of orthotics by many foot health care providers. If COCOO has data on related complaints and disciplinary findings, including the prescription and dispensing and fitting of orthotics, among its members, or among other foot health care providers, please share this data. How would a scope of practice change address this issue? What mitigating strategies can be implemented?*

Response: The College of Chiropodists is aware of and acknowledges that excessive prescription and dispensing of foot orthotics, including outright fraud, occurs and has been on the rise in both the regulated and unregulated sectors. With respect to Members of the College of Chiropodists:

- A total of 42 complaints relating to foot orthotics involving 35 Members of the College were received over the last five years;
- Seven complaints were received in 2010;
- Two complaints were received in 2011;
- Sixteen complaints were received in 2012;
- Eight complaints were received in 2013;
- To date, nine complaints have been received in 2014.

Of the above complaints, six were the subject of disciplinary action by the College. The Discipline Decisions can be viewed on the College website [Frizzell x 2; Tomines, Tharani, Brown-Vezeau and Quershi.]

The other complaints resulted in a range of actions, including requirements to complete ethics courses, the issuance of written cautions and practice assessments for record-keeping.

Some of the complaints made against College Members pertain to Members' insistence that the Members dispense (i.e. fit) the orthotics they prescribe in order to ensure that they fit properly. Some patients wish to obtain a prescription that they can take to another practitioner (e.g. podorthist) to manufacture and fit. Foot orthotics must be very carefully calibrated and an ill-fitting foot orthotic can, at a minimum, be ineffective and, at worst, cause serious musculoskeletal damage. When the same practitioner is both prescribing and dispensing, the patient is sure to get the recommended device and costs are contained through economies of scale when the same practitioner diagnoses, prescribes and fits the device and is involved in follow-up assessment and treatment. Accordingly, most Members of the College insist and the College agrees that to ensure foot orthotics achieve the objectives for which they were designed, the prescribing chiropodist or podiatrist may also insist on fitting the foot orthotic.

Nonetheless, unsavory practices relating to foot orthotics are of major concern. Alone amongst the Colleges whose Members prescribe and/or dispense foot orthotics, the College of Chiropodists has had a Standard of Practice for foot orthotics in place since February, 2009. A revised Standard of Practice has been prepared and is currently being circulated to College Members for comment. The comments will be considered by the full Council at its meeting in February, 2015. The College has also met with the Canadian Life and Health Insurance Association to understand insurers' experience and concerns with respect to foot orthotics.

Troubling practices of which the College is aware across the gamut of foot orthotics practices include:

- Prescribing an orthotic without a thorough biomechanical examination, including a gait analysis;
- Prescribing foot orthotics unnecessarily;
- Prescribing foot orthotics in situations where they cannot reasonably be expected to be effective in treatment;
- Dispensing off-the-shelf shoes with modified shoe inserts and calling them custom-made ("prescription") shoes at very significantly inflated costs. (The cost of bona fide Custom/Prescription/Molded footwear, such as those typically prescribed to address severe congenital or acquired deformities (e.g. post partial amputation of the foot), can often be in the \$1000-\$2000 range and are categorized separately under insurance plans NOT under the "orthotics" category);
- Significantly marking up the cost of manufacturing in the total charges to consumers;
- Ineffective gimmicks used to design or fabricate orthotics. By this, the College means any device or process other than non-weight bearing plaster or paris casting, three-dimensional non-weight bearing scanning, or non-weight bearing STS slippers or equivalents; and
- Gaming insurers and employers by prescribing the maximum number of foot orthotics allowable under each customer's policy and for each family member regardless of need.

In this regard, the College draws HPRAC's attention to a couple of relevant considerations:

- i. Among all the regulated professions, the scope of practice for chiropodists and podiatrists articulated by section 4 of the *Chiropody Act* is the only one that explicitly includes the treatment and prevention of diseases, disorders or dysfunctions of the foot by orthotic means.
- ii. Nevertheless, none of the prescription, dispensing and manufacturing of orthotics is a controlled act, unlike the situation with analogous devices such as hearing aids, eyewear and dental prostheses. As such, foot orthotics are in the public domain and are currently prescribed and dispensed by virtually anyone, including regulated and unregulated healthcare practitioners.

It is noteworthy that many extended health benefits insurers have restricted their coverage of foot orthotics to those that are prescribed by a chiropodist, podiatrist, or physician. While chiropodists and podiatrists do not appear to be the major culprits in terms of unsavory practices, the College is concerned about and is monitoring the extent to which some Members' practices rely, or are focused, on foot orthotics to the detriment of other procedures within the professions' scope of practice. This is particularly the case for the controlled acts authorized for the professions where the greatest supply/demand gaps exist.

The College agrees that additional, multi-professional, measures are required to protect the public. There are several alternatives to address abuses relating to foot orthotics:

- i. Make any one or combination of the prescription, dispensing and manufacture of foot orthotics a controlled act under the RHPA authorized for chiropodists and podiatrists and for any other profession that has the requisite competencies and scope of practice. The Colleges administering the authorized act should reach agreement on a common, or at least a baseline, Standard of Practice pertaining to the performance of the authorized act. The College understands that extended health benefits insurers and employers are opposed to this alternative because it may limit their clients' and employees' access and choice and also may inflate the cost of foot orthotics due to reduced interprofessional competition. The College also understands that at least some of the professions whose members currently prescribe and/or dispense orthotics are opposed to the creation of a new controlled act in this area.
- ii. Bring any member of an unregulated profession that engages in the act of prescribing or dispensing foot orthotics under the jurisdiction of the College of Chiropodists, or the proposed College of Podiatrists. In the College's view, however, it would be anomalous for any College to regulate the performance of these acts if they continue to be public domain acts and it would also be challenging for any college to regulate practitioners for this purpose alone.

- iii. Bring forward consumer protection legislation that applies to unregulated practitioners who prescribe, dispense or manufacture foot orthotics. The College prefers this option and would be happy to work with the Ministry of Consumer Services to develop appropriate and effective legislation.

The College also encourages the professions to work with the insurance industry to more tightly define what exactly constitutes a "prescription/custom orthotic" and the fabrication and quality control measures that must be in place to permit something to be considered a prescription/custom orthotic, a prescription/custom shoe, or an "orthopedic shoe".

The scope of practice changes proposed by the College will obviously not affect the practices of other professions, nor their Members. The expanded scope of practice proposed by the College will have an indirect impact on the prescription and dispensing of foot orthotics by podiatrists, however, by creating an expanded, seamless continuum of foot and ankle care that is focused more on surgical procedures of the foot and ankle and also expands the profession's armamentarium in the treatment and prevention of diseases, disorders and dysfunctions of the foot and ankle. An expanded scope will also allow and encourage podiatrists to focus their practices more on the controlled acts that they are authorized to perform where demand for services far exceeds supply; and focus less on public domain activities where there is a far better balance in supply and demand. The College appreciates that this evolution will not happen overnight for chiropody and podiatry, but it will not happen at all without a significant scope of practice change.

Question 10: *If HPRAC does not recommend a scope of practice change for the professions, what other changes could be made to improve the delivery of foot care in Ontario? For example how would IPC address the delivery of foot related health care?*

Response: At the very minimum, the College hopes that HPRAC would recommend:

- The addition of controlled acts that are absolutely necessary for the safe and effective performance of the CURRENT scope of practice for chiropodists and podiatrists. These controlled acts are listed in the Responses to Question 10 and elsewhere in the College's Application.
- Complete removal of the podiatric cap, in order to positively impact the current and projected HHR shortfalls in footcare.
- Adoption of a single title "podiatrist" for the profession, perhaps with rostering of registrants to reflect differences in individual competencies to perform authorized acts.

Claims that wide variations and approaches in funding and remuneration models distort referral patterns, access and patient choice among alternate practitioners and treatment streams could well be correct. Nonetheless, funding matters are not within either the mandate or the expertise of the College and, if addressed, would have to be addressed between the professions involved

on one hand and the Ministry and third-party payers on the other hand. In the current fiscal environment, it is unlikely that the Government of Ontario would significantly expand the scope of publicly-funded footcare, nor is it reasonable to expect that third-party insurers will make significant changes in their coverage or policies in the current and foreseeable economic and business environment.

Much more can be done among the colleges that have significant numbers of members involved in footcare to collaborate on the development and implementation of policies, guidelines and standards of practice to promote patient-centered, safe, effective and cost-effective care. Quite frankly, until this review was underway and, in particular, until the stakeholders responses to the consultation on Ontario's current footcare model were published, the College of Chiropodists had not grasped the full extent to which members of other professions, both regulated and unregulated, are involved in or see themselves as having a role in, footcare. Prompted by that realization, the College is motivated to do more to collaborate with those Colleges to improve the delivery, safety and effectiveness of foot-related health care. The College wishes to emphasize, however, that it believes that it has done everything that it may do within its current mandate, authorities and resources to promote safe and effective footcare by chiropodists and podiatrists and that the standard of care by chiropodists and podiatrists in Ontario compares very favourably with any other regulated profession.

Bringing currently unregulated professions into the RHPA-regulatory framework may well improve the delivery of footcare in Ontario through the application of effective and hopefully common, or at least consistent, standards, policies and guidelines, by providing access to public complaints and disciplinary processes and by facilitating interprofessional care, especially with regulated practitioners who often resist interprofessional care with unregulated providers. The College assumes that a "new professions regulation" review would be required to determine whether unregulated footcare practitioners should be brought under the ambit of an RHPA-College. It would be presumptuous of the College of Chiropodists to presuppose the outcome of such a review, or reviews.

In closing, HPRAC has included among the goals of Interprofessional Collaboration, the following:

- "(Regulating) the health professions in a manner that maximizes collective resources effectively and efficiently, while protecting the public interest,
- "(Optimizing) the skills and competencies of diverse healthcare professionals to enhance access to high-quality and safe services,
- "(Enhancing) scopes of practice to ensure that all regulated health professionals work to their maximum competence and capability".

[HPRAC, An interim Report to the Minister of Health and Long-Term Care on Mechanisms to Facilitate and Support Interprofessional Collaboration among Health Colleges and Regulated Health Professionals: Phase II, Part I (September, 2008), Page 8.]

It is difficult to perceive how any of these goals could be achieved without the scope of practice changes recommended by the College.

Question 11: *During the initial consultation session on the model of footcare in Ontario, some stakeholders reported competition between foot health care providers and other challenges in the delivery of footcare in interdisciplinary settings. Competition between healthcare providers may compromise care and negatively impact patient safety and the patient. How would an expansion of the scope of practice address these challenge (sic) and benefit the public interest?*

Response: When it comes to healthcare policy and funding, interprofessional "turf battles" are, regrettably, too common across the spectrum of healthcare delivery. Historically, the medical profession, represented by the Ontario Medical Association, has been opposed to the adoption of a podiatry model and scope of practice in Ontario. We understand this to be no longer the case from our meetings with the OMA. Historically, as well, orthopedic surgeons have opposed podiatry and have opposed expanding podiatrists' scope of practice across North America, usually without success. In British Columbia and Alberta podiatrists work very closely together. A two-year surgical residency program approved by the Council of Podiatric Medical Education (CPME) and the residency certificate is issued by a Faculty of Medicine. In United States there are many interdisciplinary clinics including podiatrists and many partnerships between orthopedic surgeons and podiatrists attending to the lower extremity needs of patients.

The College and its Members have frequently expressed concerns to patients, health delivery organizations and to other professions and practitioners about the performance of procedures on the foot and ankle in cases where the practitioner is not legally authorized, or sufficiently competent, to perform, or where reasonable standards of practice such as infection controls are not observed. The College and its Members make no apology for doing so. This is not anticompetitive; it is simply the pursuit of patient safety.

At the practice level in Ontario, there are only two regulated professions that are acknowledged, as professions, to be foot specialists: chiropody and podiatry. There are only three professions legally authorized to perform surgical/invasive procedures on the subcutaneous tissues of the foot: chiropody, podiatry and medicine (general practitioners, but primarily orthopedic surgeons and also plastic surgeons, dermatologists and general surgeons). As documented in the College's Application, it is generally recognized and accepted that there are insufficient orthopedic surgeons, chiropodists and podiatrists to meet the current, not to mention the anticipated, demand for the surgical treatment of pathologies of the foot and ankle. Accordingly, allegations or perceptions of interprofessional competition in the performance of controlled acts relating to the foot and ankle are difficult to countenance. The College has never received a complaint alleging interprofessional competition by a Member. Regardless, the College, through its Application, is recommending a more integrated and collaborative approach to the treatment

of medical problems of the lower extremity with other regulated health professionals within Ontario's healthcare delivery system.

Competition in the performance of public domain acts relating to the foot and ankle does exist, primarily in the prescription of foot orthotics. The competition is most "robust" between pedorthists on one hand (for whom the fabrication of foot orthotics is their only business) and members of other professions, primarily chiropractors, but also chiropodists and podiatrists, on the other hand. Issues relating to the prescription, dispensing and fabrication of orthotics are addressed in our response to Question #9. The College disputes that there is significant interprofessional competition in the provision of other public domain acts pertaining to the treatment of routine and low risk problems of the foot and ankle. In fact, the responses to HPRAC in the footcare model consultation clearly indicate that there is more than enough work to go around.

With respect, the College feels it necessary to take issue with the premise of this question, that "competition may compromise care and negatively impact patient safety and the patient". To the contrary, intra-and inter-professional competition should drive efficiencies, clinical best practices and should also focus practitioners on positive patient outcomes and patient satisfaction. In its submission to HPRAC as part of the Public Consultation on Inter-Professional Collaboration (June 3, 2008) the Competition Bureau of Canada stated that: "*The (Competition) Act is based on the premise that competition is the best means of ensuring that resources are allocated efficiently, that innovation is rewarded and that consumers are offered the broadest scope of services at the most competitive prices.*" The Competition Bureau has been consistently critical of policies and actions by governments, professional regulatory bodies and associations, in healthcare and elsewhere, that diminish competition.

In this regard, the College points out that patients seek out chiropodists and podiatrists even though all, or a substantial portion of, the cost of doing so must be paid out of their own pockets.

Question 12: *If possible, quantify the impact of the "podiatric cap" on access to care (e.g. wait times, etc.)*

Response: There is no evidence available to the College indicating that the podiatric cap has a significant influence on access to care within the non-surgical parts of the current scope of practice and authorized acts of the profession. As demonstrated by the submissions to HPRAC in the "current footcare model" consultation, there appear to be plenty of healthcare practitioners and workers who provide, or purport to provide, nonsurgical footcare. Whether all those practitioners and workers are providing, or are competent to provide, safe and effective care is a separate issue. The College does have its concerns in this regard, however, as indicated elsewhere.

What motivated the College's request for a referral to HPRAC is its desire to expand the scope of practice to allow Ontario to use the professional competencies and best practices available to fill the growing gap between the demand for and the supply of qualified practitioners to provide

the more (not most) complex surgical procedures of the foot and ankle where a substantial supply/demand gap has been documented and to allow the profession to provide a seamless continuum of foot and ankle care. These are procedures that can be delivered safely and effectively in non-institutional practice venues by podiatrists, but are not within the current scope of practice and authorized acts. Put more succinctly, the College wishes to expand the podiatry scope of practice into areas where supply/demand gaps exist and where wait times exceed clinical best practices. To paraphrase Wayne Gretzky, the College wants to go where the need is greatest. The podiatry profession has demonstrated its competencies elsewhere to address these gaps and wait times. Why not allow the profession to do so in Ontario through the necessary scope expansion and removal of the podiatric cap?

Wait times for podiatrists' and chiropractors' services in the current scope are distorted and are, therefore, not particularly helpful for analytical purposes because of three considerations discussed in more detail elsewhere:

- The inability of chiropractors and podiatrists to provide a full continuum of care consistent with their scope of practice and competencies because of their inability or limited ability to order diagnostic tests and to perform procedures that are necessary or incidental to their current authorized acts (e.g. setting or casting fractures). This requires circular referrals to physicians, which inflate wait times.
- The podiatric cap has caused a disproportionate proportion of podiatry class members to practise on a part-time basis, rather than retiring. Part-time practice distorts wait times data.
- Lack of public and interprofessional understanding of chiropractors and the chiropractic scope of practice that reduces the number of self-referrals and practitioner referrals to chiropractors.

Question 13: *Describe in detail how and why the "podiatric cap" has stopped the profession from evolving.*

Response: In Ontario, by the late 1970s, the clear direction of the Ontario chiropractic model was towards the US podiatry model.²⁰ Nevertheless, as explained in the College's Application, the Ontario government decided to go in a different direction and to adopt the UK chiropractic model as it then existed. The unique and unprecedented podiatric cap was both a manifestation of that decision and an integral part of that change in direction. The government obviously intended the podiatry profession to wither away, along with the authorized acts associated with it. The cap was supported by representatives of the chiropractic profession based on the belief that the chiropractic model would always be threatened as long as it had to compete with a podiatry model. The podiatry cap was a clear, unambiguous and emphatic "burn the boats" strategy to marry Ontario to the UK chiropractic model.

²⁰ O'Reilly, Patricia, L, Health Care Practitioners: An Ontario Case Study in Policy Making, University of Toronto Press, page 104.

The podiatric cap was also a manifestation of the government's decision at the time that the podiatry authorized acts and other components of podiatry practice, such as bone surgery, would be reserved for orthopedic and other surgeons within the medical profession. When seen in this light, it is obvious that the podiatric cap was not just a prohibition against the registration of new podiatrists, it was also a uniquely rigid scope of practice ceiling for the chiropody profession.

As discussed in more detail in the Application, while many countries' chiropody scopes of practice have evolved or are evolving to podiatry models and chiropodists have evolved or are evolving to podiatrists, in Ontario chiropodists cannot evolve to podiatrists or evolve to practise the authorized acts granted to podiatrists, regardless of competencies or need, because of the podiatric cap.

In 2009, the Michener Institute launched a "Graduate Advanced Diploma in Podiatric Medicine". The move was strongly supported by the professional organizations representing chiropodists. The new diploma program was supposed to be a manifestation of an expanded curriculum and the requirement of a four-year degree as a prerequisite to enter the program. The Ministry of Health and Long-Term Care required the Michener to roll back the launch on the grounds that graduates of the program, as "podiatrists", would not be eligible to practise in Ontario, except as chiropodists and would be unable to use the "podiatrist" title. The Ministry also indicated at the time that, pending the conclusion of the scope of practice review, Ontario remains committed to the chiropody scope articulated by the *Chiropody Act, 1991*. Accordingly, the Michener Diploma reverted to a "Graduate Advanced Diploma of Health Sciences (Chiropody)".

Every profession has within it an elite group of members that leads and guides the profession to best practices, greater competencies and ultimately prompts and legitimizes scope of practice enhancements. In physiotherapy it was the group practising as "extended practice physiotherapists" that led to the major scope expansion for the profession in 2010. For dental hygiene's scope of practice change in 2006, it was those dental hygienists who had acquired the competencies (and often had been authorized to perform them in other provinces) to practise independently (i.e. without an "order" from a dentist). For nursing, it was that component of the profession that came to be known and practises today as nurse practitioners. It was an elite segment of the naturopathy profession that led the charge for the scope of practice changes beyond the scope authorized under the *Drugless Practitioners Act*. For chiropody and podiatry in Ontario, the podiatric cap effectively decapitated the chiropody profession and deprived it of an elite component that would demonstrate the efficacy of and show the way to scope of practice enhancements in response to patient and health system demands.

The curricula in educational programs for regulated health professions in Ontario often teach competencies beyond what the profession is authorized to perform in terms of controlled acts. Physiotherapy education programs taught extended practice competencies long before the *Physiotherapy Act* was amended to allow physiotherapists to practise them independently.

Dental hygienists were taught how and when to perform "scaling, root planing and curettage" and the contraindications to doing so, and to prescribe and compound certain drugs long before they were authorized to perform those controlled acts independently. Today, dental hygienists are taught to order and take radiographs and to inject local anesthesia, even though these controlled acts are not authorized for the profession in Ontario. Any similar leadership by The Michener collides with the podiatry authorized acts and the explicit inability of post-1993 registrants to practise them because of the podiatric cap.

Because of the podiatric cap, since July 31, 1993 the College has been prohibited from registering anyone to perform the podiatry authorized acts, notwithstanding their competencies to do so. This has led to the completely illogical situation of the best-trained and highest qualified DPMs being limited to the chiropody scope of practice and authorized acts in Ontario, while many of them practise full-scope podiatry in other jurisdictions. It also means that proof is not available to demonstrate the practice efficacy of this elite group in Ontario, contrary to the case with other professions.

In its contacts with Ontario medical schools and university health sciences departments to promote an educational program to provide the competencies needed to practise the proposed new and expanded authorized acts, a consistent response (albeit not the only one) has been: "Get back to us when you can tell us for sure that the podiatric cap will be revoked". No University wants to train graduates who may not practise to the full extent of their competencies, or use their professional title, in Ontario. The College believes that a combination of Ontario's commitment to the former UK chiropody model and the podiatric cap has discouraged educational institutions from offering chiropody or podiatry educational programs.

It is, of course, theoretically possible to extend the scope of practice and authorized acts for chiropody, while keeping the podiatric cap intact. It would be absurd to do so, however, because it would represent a move to a podiatry scope, while retaining the chiropody title ---- and the confusion and lack of understanding associated with it. Furthermore, practitioners competent to perform additional authorized acts would, at least for a period, likely, in the main, be graduates of US and Canadian DPM programs who would be ineligible to practise in Ontario. Additionally, any amendment of the *Chiropody Act, 1991* would almost certainly bring the podiatric cap into play in light of Ontario's undertakings and requirements under the *Agreement on Internal Trade and the Fair Access to Regulated Professions Act*²¹. In short, any change to the chiropody authorized acts would require a statutory amendment because of the podiatric cap; any amendment to the *Chiropody Act* was likely to have the collateral impact of revocation of the podiatric cap; any revocation of the podiatric cap would have resulted in a de facto recognition

²¹ It is intriguing that on its website providing information to foreign-trained practitioners, Health Force Ontario makes no mention of the podiatric cap and, in fact, clearly creates the impression that one may still register to practise in Ontario as a podiatrist, viz:

"To practise chiropody and podiatry in Ontario, internationally educated chiropodists and podiatrists must hold a Certificate of Registration and meet the requirements set out by the College of Chiropodists of Ontario....."
http://www.healthforceontario.ca/en/Home/Other_Regulated_Health_Professionals/Training_%7C_Practising_Outside_Ontario/Practice_Requirements/Chiropodists_and_Podiatrists

and relaunch of a podiatry model in Ontario; hence, until the Minister's referral to HPRAC, the resistance to any change in the chiropody scope of practice.

Question 14: *What are the primary issues related to problems with patients accessing foot care: a lack of public funding, the podiatric cap, a lack of practitioners or other issues?*

Response: In doing the research to respond to this Question, the College encountered an interesting philosophical argument. Many healthcare practitioners bemoan the lack, or fragmentation, of public funding for footcare. Some stated unequivocally that funding considerations strongly influence their decisions on to whom they refer. In that context, the absence of public funding does present an obstacle to access, or at least an obstacle to access the right practitioner and to access a seamless continuum of footcare. On the other hand, some health economists and health practitioners asserted that private funding of healthcare is a better regulator of expenditures and is a more effective guard against excessive utilization. In the College's considered judgment, the primary "access" issue in Ontario's current footcare model is access to the right footcare, by the right practitioner, in the right place at the right time, particularly access to surgical procedures.

Because of myriad practitioners, both regulated and unregulated, performing public domain acts in footcare, "access" per se is not the major issue. The issues are the extent to which patients are not receiving the "highest and best" standards of care and the number of patients who are receiving routine, long-term follow-up care of infinite or indeterminate length, rather than finite episodes of care based on effective diagnosis and treatment. Many patients who could be cured with effective diagnosis and treatment are not because the attending practitioners lack the requisite competencies, or authorities.

Wide variations in funding for footcare, both public and private, distort access and care delivery and militate against achievement of the objectives of the right care, by the right practitioner, at the right time, in the right place. Some physicians are known to be reluctant to refer their patients "out of the publicly-funded system". This has the effect of discouraging physicians' referrals to podiatrists, but particularly to chiropodists. Orthopedic surgeons claim that their resistance to expanded surgical authorities for podiatrists is, in part, because doing so would amount to the "privatization" of foot surgery, in that OHIP currently covers an infinitesimal portion of the cost of surgical procedures conducted by podiatrists. Patients who do not have private insurance or the ability to pay out of pocket, will obviously gravitate to publicly-funded delivery venues, such as hospital emergency facilities, physicians' offices, publicly-funded physiotherapy clinics (if the patient fulfills the eligibility criteria) and publicly-funded primary care venues such as home care through CCACs (if the patient is not mobile), Family Health Teams, CHCs, Nurse Practitioner-Led Family Health Teams, Aboriginal Health Teams and the like. Podiatrists are highly unlikely to be found in any of these venues and the representation of chiropodists in such venues is statistically insignificant. For example, in Family Health Teams

there are no FTEs approved for podiatrists and the FTEs approved for chiropodists constitute 1.38% of the total.²²

Accordingly, the funding of footcare in Ontario creates an economic incentive for patients to receive their footcare from publicly-funded practitioners such as physicians, nurses and physiotherapists rather than from footcare specialists, namely chiropodists and podiatrists. Given that nearly 60% of chiropodists' and podiatrists' patients are seniors and given that seniors are unlikely to have private insurance or the ability to pay out of pocket, funding impacts are particularly felt by that sector, which incidentally is most likely to experience foot and ankle issues.

In Ontario there are currently 630 long-term-care homes, in which approximately 77,000 residents reside. Subsection 35. (1) of Ontario Regulation 79/10 under *the Long-Term Care Homes Act* requires every home to ensure that each resident receives preventive and basic footcare services, including the cutting of toenails, to ensure comfort and to prevent infection. Resident care is funded through the per resident per diem provided by the Ministry of Health and Long-Term Care, although Ministry funding is often topped up by charitable and municipal homes. Individual residents who have the means may also obtain footcare through private sources. The methodology varies from home to home, but Ministry-funded footcare would be provided by a range of regulated (primarily nurses) and unregulated providers through any of the following programs required pursuant to the regulations under the *Long Term Care Homes Act*: Nursing and personal support services, Medical Services, Infection, prevention and control, Skin and wound care, Pain management and perhaps Restorative care. The results of a College survey indicate that about 150 chiropodists and podiatrists provide services to residents of long-term-care homes on a part-time basis, but the vast majority of medically-necessary footcare is provided by the homes' nursing staffs. The practice of most long-term-care homes is to send any resident with a serious foot issue to the nearest hospital emergency department.

As discussed and documented elsewhere, the podiatric cap certainly has an impact on Ontarians having timely access to bone and the more complex soft tissue surgical procedures of the foot and ankle that are within the scope of practice and authorized acts of members of the podiatrist class. The structural problems pertaining to Ontario's chiropody model (e.g. limited scope of practice and authorized acts, the absence of inter-jurisdictional mobility, the capacity of the educational program) clearly limit the number of chiropodists practising in Ontario, that in turn limits patients' access to the specialized knowledge they have and the footcare services they provide.

Question 15: *Demonstrate that Ontarians are having problems accessing the foot care that would be provided under an expanded scope of practice.*

²² Data provided by the Interprofessional Programs Unit of the Primary Care Branch of the Ministry of Health and Long-Term Care as of September 24, 2014. Out of a total of 2377 approved FTEs, 32.71 were allocated to chiropodists, of which 28.51 had been "allocated" or filled. 0 FTEs were allocated to podiatrists because podiatrists are partially covered by OHIP.

Response: It may be necessary to emphasize that the new and expanded authorized acts are being proposed by the College, not only to enhance access, but also to improve the timeliness and continuity of care in both the current chiropody and the proposed podiatry scopes of practice.

The College points out that, although the solutions proffered may vary, many of the submissions to HPRAC in the context of HPRAC's footcare model consultation demonstrate that Ontarians are having problems accessing the footcare that would be provided under an expanded scope of practice. For example: Submitters 13, 19, 20, 32, 43, 47, 57, 58, 59, 60, 62, 138, 165, Feet for Life Foot Care, the North East LHIN, the North Shore Family Health Team, in Ontario CCAC (name not specified), the Ontario Medical Association Sport & Exercise Medical Division, the Ontario Physiotherapy Association, the Ontario Podiatric Medical Association, the Ontario Society of Chiropodists and the Canadian Federation of Podiatric Medicine.

A report by the Canadian Institute of Health Information (CIHI) found that only 51% of Ontarians 18 years of age and older with diabetes had their feet checked by a health professional over the past 12 month period.²³ CIHI concluded that "there is room for improvement in (diabetic) care provision for adults with diabetes in all jurisdictions".²⁴ It is noteworthy that CIHI also found a correlation between income group and treatment viz:

"The percentage of adults with diabetes receiving all four recommended care tests (an HbA1c test, a urine test for protein, a dilated eye exam and a foot exam) by health care professional was highest in the highest household income group (42%) and lowest in the lowest household income group (21%), age standardized."²⁵

Following is a list to illustrate the surgical procedures podiatrists may not currently perform, but would be authorized to perform under the proposed scope of practice. These are procedures that podiatrists are qualified to perform and are authorized to perform in Alberta, British Columbia and throughout the United States: biopsy and/or excisional procedures of the soft tissues and bone, debridement of the soft tissues and bone, reconstructive procedures of the midfoot and rearfoot, including but not limited to procedures such as; osteotomies, arthrodesis, tendon transfers, closed/open reduction of fractures with or without fixation.

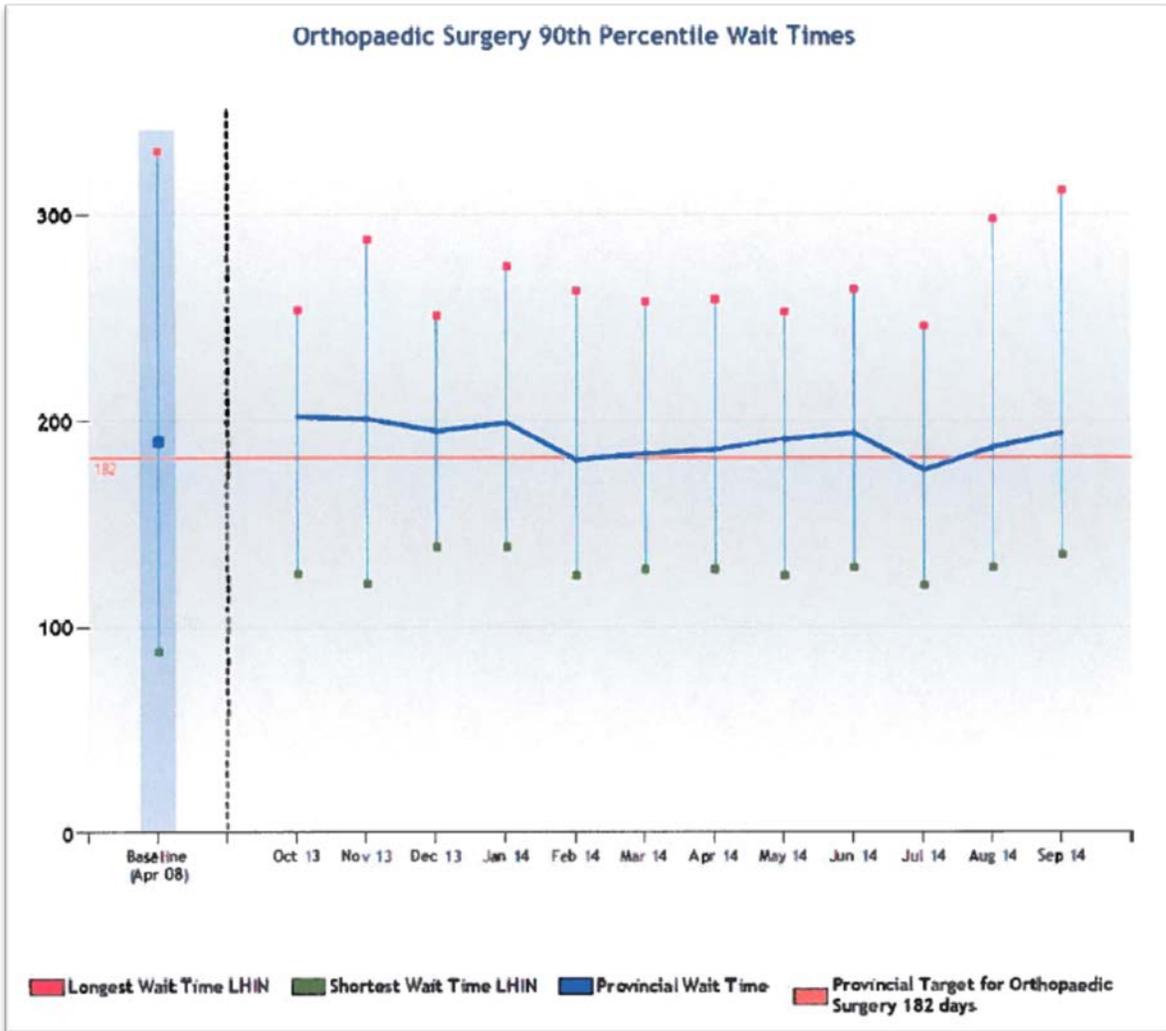
These procedures are currently performed in Ontario primarily by orthopedic surgeons in hospitals.

The following charts demonstrate the wait times for orthopedic surgery on a LHIN-by-LHIN basis. Note the significant variations in wait times across the province. Data to desegregate wait times for foot and ankle surgeries by orthopedic surgeons was not made available.

²³ "Diabetes Care Gaps and Disparities in Canada", Canadian Institute for Health Information, December, 2009, Page 14.

²⁴ Ibid., Page 2.

²⁵ Ibid.



Orthopaedic Surgery	Baseline (Apr 08)	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14
Province	190	202	201	195	199	181	184	186	191	194	176	187	194
Longest	331	254	288	251	275	263	258	259	253	264	246	298	312
Shortest	88	126	121	139	139	125	128	128	125	129	120	129	135

Orthopaedic Surgery LHIN Wait Times - Sep 14	
LHIN	90th Percentile Wait Times
Central	135
Mississauga Halton	150
Central East	160
Waterloo Wellington	160
South West	180
Toronto Central	202
South East	204
Erie St. Clair	208
Champlain	212
North East	221
Hamilton Niagara Haldimand Brant (HNHB)	236
North Simcoe Muskoka	239
Central West	251
North West	312

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Papers prepared by the Ontario and Canadian orthopedic associations in 2009 and 2014 referred to elsewhere in this Submission point to clinically unacceptable wait times for surgical procedures on the foot and ankle. The Ontario Orthopedic Association claims that long wait lists for foot and ankle surgery in Ontario are due to the "shortage of orthopedic surgeons with extensive variation in access across Ontario"; the insufficient number of subspecialist foot and ankle surgeons to meet increasing need; the "limited availability of hospital operating room time"; and "the shortage of family physicians and the cap on physicians' OHIP billings resulting in reduced access to routine footcare and longer waits for consultation with orthopedic surgeons".²⁷

²⁶ http://www.ontariowaittimes.com/SurgeryDI/EN/wt_trend.aspx#13

²⁷ Ontario Orthopedic Association's Submission to the Initial Consultation-Chiropractic and Podiatry Review, Model of Foot Care in Ontario, June 2014, Pages 3-4.

In addition:

The number of Canadians living with diabetes mellitus is increasing in numbers and Northern Ontario has a much higher incidence of foot and lower extremity amputations as a consequence of diabetes mellitus than the provincial average.²⁸ The College heard an abundance of anecdotal evidence that individuals in Northern Ontario, particularly diabetics, who require advanced footcare regularly travel to Manitoba, particularly Winnipeg, to get it. The College suggests that HPRAC might ask the Ministry for out-of-Province OHIP payments pertaining to residents of Northern Ontario to validate this evidence and quantify the phenomenon.

The Southwest LHIN "Diabetes Foot Care Project, Workshop Background Document" (December 10, 2013) reported that

"Interviews with stakeholders revealed that timely access to services is key to increasing client outcomes in diabetic foot ulcers and their prevention. Many of the services associated with diabetic foot ulcer treatment and prevention have limited capacity, for example there are wait times of one month or more at the London Foot Clinic, for diabetes foot care in the FHTs, for specialist appointments. All of these providers agree that delays in access to services adversely affect client outcomes. Often lack of timely access (to) service was stated to be (due) to a lack of provider capacity..." (Page 15-16)

In its "Summary of Community Engagement: Ontario Diabetes Strategy" (conducted in 2009) the Northwest LHIN concluded:

"The need for improved access to footcare services was identified as a common concern during community engagement.

"Footcare services are more or less non-existent and desperately required." (Provider, Sioux Lookout)

..... Many stakeholders shared stories of complex wounds leading to amputations, which might have been prevented with improved footcare. Limited access to advanced footcare training programs and a lack of sustained funding for programs were identified as the two greatest barriers to access." (Page 5)

A study of foot and leg ulcer care in the Peel Region CCAC reported that

"The 2002 surveys indicated that the average new client receiving care at the Wound Healing Clinic had an open ulcer for 10.6 months before being referred to the clinic for a comprehensive assessment and treatment plan. The difficulty in accessing a specialized clinic may account for some of the delays (a few weeks to four to five months or longer), but this averages two to three months in (the Peel Region) clinic." (Woo, Kevin, et al op cit, Page S23)

²⁸ "Workshop Aims To Reduce Amputation Rates In Northern Ontario", Botros, M., Kuhnke, J., Evans, R., & Fusek, B. (2014). Workshop Aims To Reduce Amputation Rates In Northern Ontario. Wound Care Canada, 12(1). Spring 2014 - Volume 12, Number 1.

Question 16: *For foot care surgeries and other treatments that would be provided under an expanded scope of practice, demonstrate how the orthopedic surgeons are not currently meeting the needs of Ontarians. Which treatments have significant wait times?*

Response: We refer HPRAC to the Paper entitled "Proposal for the Development of a Provincial Foot and Ankle Program" by the Ontario Orthopedic Association and the Canadian Orthopedic Association issued in 2009. The findings and recommendations of the Paper are referenced at several points in the College's Application to HPRAC.

It is also important to note the wait times for patients to see an orthopedic surgeon only to be told that the problem does not merit or require surgery, thus requiring the patient to be referred or re-referred to another practitioner.

It is also important to register with HPRAC that orthopedic surgeons do not and are not expected to provide continuous management of patients' foot and ankle conditions.

Question 17: *Do wait times differ for chiropodists and podiatrists? What are the wait times for each profession? Do wait times demonstrate that the public has problems with accessing foot care services that would be provided under an expanded scope of practice? Provide evidence.*

Response: If wait times data is being used by HPRAC to assess supply and demand at least several caveats need to be registered:

- Wait times data for podiatrists are distorted, because many podiatrists are semiretired and are thus limiting their office hours and/or are not taking new patients. According to a survey completed on September 30, 2014, 15% of the podiatrists who responded are semi-retired, in that they no longer practise full-time. Even some podiatrists who are not semi-retired reported that they are not taking new patients.
- A significant number of chiropodists also practise part-time. 25% of survey respondents treated fewer than 1000 patients over the last year.
- Many chiropodists and podiatrists manage or triage their wait lists in order to take emergency (e.g. wound care), high-risk and high-needs patients (e.g. seniors) quickly.
- Survey results indicate that wait times are generally longer for surgical procedures (e.g. bone surgery, nerve surgery, hammer toe correction, bunion surgery) than for nonsurgical treatments. 63% of chiropodists and podiatrists reported significantly longer wait times for surgical procedures.²⁹

With those caveats in mind, according to surveys conducted during the period September-November 2014:

²⁹ The longest wait times were reported for bunions, cheilectomies, hammer toe corrections and any bone surgery.

- Podiatrists tend to treat more patients per capita than chiropractors. The median number of patients treated by podiatrists was 3500 over the past 12 months. The median number for chiropractors was 2500 over the same period;
- 60% of podiatrists reported that their wait lists had increased over the last 12 months and 59% of chiropractors said the same;
- The median wait times for chiropractors and podiatrists was about the same at seven days. However, while chiropractors tend to be clustered around the median, more podiatrists than chiropractors had wait times significantly higher than the median (i.e. outliers).

Question 18: *If available, provide details on which educational institutions would develop and deliver bridging programs. How long would it take to develop these programs? What will be the cost of development and implementation?*

Response: As described in the College's Application, the College reached out to nine Ontario universities with established medical schools or health sciences departments to assess the level of interest in launching a postgraduate degree program in podiatry that would produce the competencies required to perform the proposed new and expanded authorized acts. The College did so on the presumption that the Ontario Government would insist on, or at least prefer, an indigenous education program to support the new scope of practice. The College presumed as well, that any institution that provided the educational program would also provide bridging programs. For the reasons explained in the Application, the College has been unsuccessful in getting any form of a commitment to establish a podiatry program.

The College has given an undertaking to its existing registrants that the College will expend best efforts to have bridging programs offered in Ontario and to have those bridging programs available by the time the new and expanded authorized acts are proclaimed. The Kent State School of Podiatric Medicine has offered its assistance to the College to provide or help an Ontario university provide bridging and upgrading programs and to work with any Ontario university interested in launching a full-scope podiatry program. (Kent State has emphasized that it is interested only in working with an Ontario University.)

The College presumes The Michener Institute could provide some of the bridging programs. In this regard, the College notes that in its submission to HPRAC The Michener said:

"Michener continues to welcome opportunities to support the profession of preparing new practitioners and existing regulated healthcare professionals to continue to meet their continuous education expectations." (Page 73; Part I)

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