RESPONSE

to the HPRAC Report on Chiropody and Podiatry

Submitted by
The College of Chiropodists of Ontario

April 21, 2017

EXECUTIVE SUMMARY

The Wynne Government, Minister Hoskins and the Ministry of Health and Long-Term Care have been presented with an opportunity to reform Ontario's archaic foot care model to truly put Patients First. That opportunity is to allow Ontario's chiropody profession to evolve to a podiatry model of foot care, as has occurred in all comparable jurisdictions.

The scope of practice changes required to fulfill this opportunity are relatively modest: expand the anatomical scope of practice to include the entire foot and the ankle; extend to the entire "podiatry" profession two authorized acts that are currently restricted to the podiatrist class; remove certain restrictions on one controlled act already authorized to the entire profession and authorize the profession to perform two new controlled acts.

The singular prohibition against the registration of new podiatrists that was instigated 35 years ago to protect the nascent chiropody profession from competition is not only no longer needed, its removal is essential.

These actions will quickly launch a more seamless and efficient continuum of foot care that is well within the proven competencies of podiatrists and will have immediate, meaningful and tangible impacts on patients' access to foot care, patient outcomes, patient satisfaction and patients' experience. The impacts will be substantial and will be particularly felt in important areas such as more effective prevention and treatment of diabetic feet and reducing the incidence of amputations as a consequence of Diabetic Foot Ulcers (DFUs).

The College wishes to assure all those concerned that no registrant, grandparented or otherwise, will be allowed to perform any of the new or expanded authorities without first demonstrating to the College that they have the competencies to do so, safely and effectively. The competency thresholds will be no less than those of any other Ontario College administering the same controlled acts.

Two Ontario Health Ministers in succession were sufficiently concerned about the functioning of Ontario’s current foot care model to order a review by HPRAC. After waiting eight years for the review to get underway and 18 months for the review to be conducted, the results could not have been more disappointing. Despite major changes since the current foot care model was launched over 35 years ago, despite overwhelming stakeholder support for converting to a podiatry model, despite major advances in technology, education and training, despite major scope of practice expansions granted to other professions and despite HPRAC expressing grave concerns about the current foot care model, HPRAC concluded that residents of Ontario should be satisfied with a simple rebranding of the chiropody profession; nothing more.

Section II of this Submission includes a critique of the HPRAC report, designed primarily to set the record straight and to demonstrate why HPRAC's recommendations deserve and need to be set aside. For purposes of this Executive Summary, the comment of a major association stakeholder, representing neither chiropody, podiatry, nor any other foot care profession, will suffice:

"Re-HPRAC Report on Chiropody and Podiatry

We are dumb-founded [sic]. We thought this was one of the most compelling scope arguments we've ever seen."

Prior to the commencement of HPRAC's review, the College met with a number of other Ontario health care regulatory Colleges. We did so to apprise them as to why the College strongly believes conversion to a podiatry model is in the public interest and to learn from those Colleges' experience in regulating the new or expanded authorized acts recommended by the College. We also took very serious note of the stakeholder comments to HPRAC.

As a consequence, we have modified the proposals originally made to HPRAC. In particular, and in light of the opioid crisis facing the province, we no longer request that podiatrists be authorized to dispense or sell drugs. We have modified our proposals

to limit the anatomical scope of practice definition. With respect to title, we have modified our proposal in response to stakeholders' concerns about the potential for confusion among the public, patients and members of other health care professions. We now recommend that every new or expanded authorized act, including "communicating a diagnosis", will require a competency test for registrants and we now recommend that the performance of certain of the new or expanded authorized acts be limited to the proposed specialty.

The College's modified proposals follow:

1. **Anatomical Scope of Practice:** The College recommends that the anatomical scope of practice be restricted to the foot (forefoot, midfoot and rear foot) and the ankle. This corresponds with the competencies taught to podiatrists and with the podiatric scope of practice in Alberta, British Columbia, 50 US states, the District of Columbia and the UK.

2. **Clarity in Professional Titles:** The College persists with its proposal for a unitary podiatry profession and a single title "podiatry", but undertakes to use the Colleges' existing authorities under the RHPA to create a specialty for those who have demonstrated to the College that they have the competencies to perform surgical procedures on the bones of the forefoot, midfoot, rear foot and ankle. The College further proposes that, by regulation, only members of that specialty would be allowed to perform those procedures and to perform certain of the controlled acts authorized to the profession, such as casting or setting fractures, ordering or administering certain forms of energy and prescribing and administering certain drugs. This is analogous to the UK model.

3. **"Communicating a Diagnosis":** The College wishes to remind the Minister that the controlled act of "communicating a diagnosis" was granted to members of the podiatrist class in 1993 and has been regulated by the College since then, without evidence of any issues or concerns. The College proposes that the controlled act be available to the entire podiatry profession, with the new Podiatry Act expressly limiting the performance of the authorized acts to diagnoses within the podiatry scope of practice. As with all the new or expanded authorized acts, grandparented and new registrants would be required to demonstrate to the College that they had acquired the necessary competencies to perform the authorized act in patients' best interests. Otherwise terms, conditions and limitations would apply prohibiting their performance of the controlled act.

The College's misconduct regulation would require that practitioners authorized to "communicate a diagnosis" must have and exhibit the knowledge, skill and judgment to do so on a case-by-case basis and, for greater certainty, would expressly prohibit the communicating of diagnoses pertaining to systemic diseases. In this regard, the College notes that it has been waiting for six years for the Ministry to consider the revised Misconduct Regulation proposed by the College.

4. **Radiographs and "Forms of Energy":** The College points to the fact that members of the podiatrist class and chiropodists who have completed four years of instruction in chiropody have been authorized to order and take x-rays since 1984. The College persists with its recommendation that the entire profession be enabled to order and take x-rays of the foot and ankle and that individual registrants who demonstrate requisite competencies be allowed to perform the authority. Current practice is for registrants who already have this authority to own and operate their own equipment licensed under xRIS. The College expects this practice to continue, thereby having a positive impact on system capacity and no net impact on utilization.

   The College also points to the fact that the profession is currently authorized to perform the prescribed forms of energy, electrocoagulation and fulguration. The College persists with its recommendation that the profession be granted the "forms of energy" controlled act, or be exempted from the controlled acts provision by regulation, for the purposes of ordering or administering MRIs (of bony tissues only and reserved for members of the specialty), electromyography and diagnostic ultrasound within the podiatry scope of practice.

5. "**Setting or Casting a Fracture":** To relieve pressures on hospital emergency facilities and operating rooms, to enhance patient experience and convenience and facilitate timely and effective treatment, the College persists in its recommendation that the controlled act of "setting or casting a fracture of a bone or dislocation of the joint in the foot" be authorized for the podiatry profession, but restricted to members of the specialty class. Members of the podiatrist class may now set or cast a surgical fracture, but may not do so for an acute fracture

6. **"Injecting a Substance Other Than In The Foot":** For the reasons indicated earlier in this Submission, the College persists in its recommendation that the current restriction – that applies to chiropodists and members of the podiatrist class – that injections be made only into the feet be removed for members of the specialty, so that injections (e.g. anesthetic blocks and tetanus shots) can be injected as per best clinical practices.

7. "**The Podiatric Cap":** The College remains committed to revocation of the podiatric cap, without reservation. It is simply nonsensical to kill a regulated health profession by public policy, particularly a profession that caters to a growing and vulnerable demographic such as the seniors cohort.

8. **"Clinic Regulation":** The College persists with its original request that the Proposed College of Podiatrists be granted statutory authority to regulate clinics in which podiatric surgery (both soft and bony tissue) is performed.

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SECTION I

INTRODUCTION

In June 2007, the Minister of Health and Long-Term Care (Mr. Smitherman) asked HPRAC to review issues related to the regulation of chiropody and podiatry and to provide advice about making legislative changes. Three years later, he asked that the work be deferred until regulations for other professions have been completed. The chiropody and podiatry review was resuscitated at the request of Minister Matthews in 2013. The review finally got underway January 1, 2014. After a scope of practice review that took an unprecedented 20 months, HPRAC transmitted its report to Minister Hoskins in August, 2016. In March, 2017 Minister Hoskins ordered the report be released for public and stakeholder review and comment.

It is noteworthy that two Ministers in succession were sufficiently concerned about the functioning of Ontario's foot care model to order a review by HPRAC. Yet, despite the passage of a decade since the review was first ordered, despite very strong and widespread stakeholder support for reform, despite major developments within the health care sector over that time (including role evolution for multiple professions such as naturopathy, physiotherapy, kinesiology, registered nurses and midwives), despite delivery model changes such as the widening implementation of Family Health Teams with non-physician health provider roles, despite the government's aging at home and patients first strategies and the government's drive to move care to non-institutional settings whenever practicable and despite substantial demographic changes and technological advances, HPRAC concluded that Ontarians should be satisfied with the status quo.

In June, 2008, the College was invited to make a presentation to the HPRAC Chair, Council members and staff in Niagara-on-the-Lake. The presentation was explained as an opportunity for HPRAC to begin to think about and get ready for the commencement of the chiropody and podiatry review, which was then expected to be launched within the year. They expressed considerable interest in getting to know what chiropodists and podiatrists do in Ontario and in other jurisdictions, the education of the professions, particularly podiatrists and, in general, expressed support for conversion to a podiatry model. The existence of the "podiatric cap" came as a surprise to them and they signaled that they thought it should be removed. They also provided direction and advice as to how the College should develop and formulate its submission when the review actually got underway by HPRAC.

With this historical background, it should be understandable to all that the College was astounded by HPRAC's recommendations to make only cosmetic changes to the practice and regulation of foot care in Ontario. The HPRAC report failed to even acknowledge, let alone deal with, fundamental and pervasive problems with Ontario's current foot care model and the regulation of chiropody and podiatry.

By this submission, the College aims to provide to the Minister evidence that is updated, new or was ignored or discounted by HPRAC indicating clearly that the current model of foot care delivery falls far short of the Minister's "Patients First" objectives and that the adaptation of a podiatry model, with a scope of practice and authorized acts as recommended by the College (and supported by the preponderance of stakeholders), is best suited to serve those needs.

SECTION II

CRITIQUE OF HPRAC'S ANALYSIS, FINDINGS & RECOMMENDATIONS

The HPRAC report clearly demonstrates that HPRAC's approach and analysis were seriously flawed in a number of material respects.

Procedural flaws committed by HPRAC include:

Bias in selection of key stakeholders:

Despite their requests to meet with HPRAC and despite HPRAC meeting with 36 other groups, organizations and individuals, HPRAC never met face-to-face with representatives of the chiropody or podiatry professions in Ontario, namely the Ontario Society of Chiropodists and the Ontario Podiatric Medical Association. Both the OSC and the OPMA support the College's recommendations to launch in Ontario a podiatry model that corrects gaps and defects in the current chiropody model and removes at least some of the obstacles their members see every day to timely and appropriate patient care. It is at least remarkable that HPRAC apparently could not find the time or did not feel it necessary to consult directly with the associations representing the professions that were the subject of the HPRAC review. On the other hand, HPRAC apparently did have time to meet with organizations and individuals known to support the status quo, or marginal changes to it.

Disregard for stakeholders' comments & expertise:

We appreciate that HPRAC conducted multiple stakeholder consultations. Nevertheless, HPRAC largely ignored stakeholder feedback, or did not appropriately or equitably weigh it. Worse still, on several occasions HPRAC materially misrepresented stakeholder feedback. For example, at numerous points, HPRAC noted the very high level of stakeholder support for the various components of conversion to a podiatry model of foot care--often in the 87-93% range. Nevertheless, HPRAC consistently took out of context or cherry-picked stakeholder comments in support of continuation of the status quo. As but one example, in the section pertaining to "Prescribing, Dispensing and Selling a Drug", HPRAC notes that the CPSO raised concerns about the “misuse, diversion and abuse of prescription narcotics", with the clear implication or inference that the CPSO was opposed to any expansion of podiatrists' authority in this regard. In doing so, HPRAC neglected to reference the CPSO's introductory statement on this topic, namely

> "***The CPSO does not object to the proposal*** *that podiatrists who have the requisite knowledge, skill and judgment be permitted to prescribe, dispense, and sell narcotics to patients, where clinically indicated.*" [Our emphasis added].[1]

Unfounded criticism of the College:

At numerous points HPRAC is brutally critical of the College, alleging that it did not "demonstrate" this, or "explain" that, or "provide information" or "clarification" relating to this or that. At one point (page 87) HPRAC stated that it

"… *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."* [2]

This statement begs the question: "Why didn't HPRAC contact the College and ask?" In fact, throughout the review the College consistently asked HPRAC if it required any more information, data, clarification or explanations and was consistently told "no". In fact, it was the College that took the initiative again and again to contact HPRAC. HPRAC-initiated contacts with the College, on the other hand, were rare.

Furthermore, at several points HPRAC states that the College's application "seems to suggest" something or other. In many cases HPRAC's' inference was faulty. Once again, if HPRAC was not 100% clear on what the College's intentions, why didn't HPRAC follow up with the College for clarification? After waiting 10 years for the review, one would have expected a thorough job in ensuring a complete understanding of the Applicant's position.

The College was greatly dismayed and offended to read that HPRAC considered any aspect of its submission to reflect, in HPRAC's words, "…a lack of thoughtful consideration about implementation that may ultimately put the public at risk." Rather, the College endured a decade-long wait for HPRAC to address the issues that the College itself raised with the government and HPRAC, with the express and sole purpose of improving the safety, effectiveness and accessibility of foot care in this Province.

The College would like to draw the Minister's and Ministry's attention to the submission made to HPRAC by the CPSO wherein the CPSO stated:

"Therefore, the CPSO supports, in principle, COCOO's submission to HPRAC. The CPSO feels that a podiatry model of foot care has the potential to offer substantial benefits to both patients and the health care system due to podiatry's expertise in this important, and growing field of clinical care and has the potential to improve access to foot care in Ontario. ***The CPSO also commends COCOO for its comprehensive list of requirements for referral or consultation with other health care professionals whenever a "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" (pages 63-65 of COCOO's application). The CPSO believes these requirements to be a commendable standard of practice to: protect patient safety, encourage inter-professional collaboration, and ensure the best possible clinical outcomes.*** (Our emphasis added.)[3]

Thematic flaws committed by HPRAC include:

1.0 Writing that is often obscure and opaque.

For example:

- The Minister's 2006 referral to HPRAC refers to the professions (i.e. chiropody and podiatry) using the plural form. HPRAC consistently refers to "the profession" without indicating to which profession it is referring, or whether it is referring collectively to both. Accordingly, HPRAC attributes characteristics to "the profession" that do not, in fact, apply to one or other of chiropody and podiatry - and sometimes to neither. For example, (page 65) HPRAC asserts that "The applicant did not demonstrate, with evidence, that the profession [*sic*] has the qualifications and competencies to perform the controlled act of communicating a diagnosis". HPRAC failed to note that members of the podiatrist class were deemed competent and were granted the authority to perform that controlled act in 1993 by the *Chiropody Act,* 1991 and the PES Report provided to HPRAC judged DPM graduates (both chiropodists and members of the podiatrist class) to be fully competent to do so.

- HPRAC's recommendations as written (page 93) would result in the podiatric cap applying to "podiatrists" and not "podiatric surgeons", which if implemented would result in the complete withering away of the profession in Ontario. Is that really HPRAC's intention?

- In the section of the HPRAC report dealing with procedures on tissues below the dermis (pages 73-75), HPRAC engages in a discussion pertaining to the Applicant's request that the anatomical scope be extended to include the ankle. The section concludes with a complete non sequitur, namely a paragraph alleging that the College "failed to ensure proper application of prescribed forms of energy".

1.1 Terminological confusion:

As stated in its submission to HPRAC, the College fully recognizes the completely understandable terminological confusion around the titles "chiropody/chiropodists" and "podiatry/podiatrist". In many jurisdictions around the world, the profession is called "podiatry" and the practitioners are called "podiatrists", but in reality the model in terms of scope of practice and entry-level competencies is a chiropody model. For example, the UK has a unitary chiropody and podiatry profession where practitioners may call themselves either or both " chiropodists" and " podiatrist", but the scope of practice is a chiropody scope of practice that is, in fact, more limited than the chiropody scope of practice that exists in Ontario today.

As a consequence, there were many errors in the interjurisdictional review prepared for HPRAC. The jurisdictional review assumed that if the profession is called “podiatry", it had a "podiatry" scope. So, by way of illustration, HPRAC justified continuing the restrictions on "podiatrists" prescribing drugs by noting that "podiatrists" in many other jurisdictions had no or similarly restricted prescribing rights. In doing so, however, HPRAC's net included jurisdictions, such as Manitoba and the United Kingdom, that are, in actuality, chiropody models. HPRAC did not note that every US state and the District of Columbia, Alberta and British Columbia authorize podiatrists to prescribe drugs. Nor, despite the references in the College's submission, did HPRAC acknowledge that Health Canada and the Government of Canada concluded that podiatrists (including chiropodists in Ontario) are sufficiently competent to be enabled by the Government of Canada to "prescribe, administer and provide controlled substances" (with certain exemptions) pursuant to the *New Classes of Practitioners Regulations*. These shortcomings in the jurisdictional

review were pointed out by the College in its submissions to and communications with HPRAC, but were evidently overlooked or ignored.

In fairness, the author of the jurisdictional review conducted for HPRAC stated that such a review necessarily creates further levels of complexity, since the nuances, titles and model differences in each country make direct comparison challenging at least and impossible at worst. The essential conclusion from the jurisdictional review is that there are multiple permutations and combinations of "podiatry" models around the world. These warnings were apparently overlooked by HPRAC. Nevertheless, the jurisdictional review clearly confirms that what the College is seeking in the public interest is well within the boundaries of safe and effective foot care practised elsewhere.

In a similar vein, HPRAC categorizes as "podiatrists" individual stakeholders who are not registered or licensed as either chiropodists or podiatrists and, if registered under current Ontario legislation, could be registered only as "chiropodists".

As part of its rationale for recommending that "the profession" not be granted the controlled act of communicating a diagnosis, HPRAC cites an article from *Diabetic Medicine* (2005) indicating troubling variations in diagnoses by "podiatrists". Aside from the fact that the article cited is more than 10 years old and speaks to the activity of making a diagnosis rather than communicating one, *Diabetic Medicine* is a UK Journal and the research related to experience with practitioners within the UK model, which (as noted above) is a chiropody model which the College wishes to abandon, not a podiatry model to which the College aspires.

Terminological confusion rears its head oftentimes in the HPRAC report itself. For example, on page 67 HPRAC refers to practitioners in Alberta and British Columbia as "chiropodists". This was particularly astounding because the College (and other stakeholders) had frequently referred to Alberta and British Columbia as the podiatry model proposed to be adapted to Ontario.

1.2 Unfounded confidence in the current model:

The College fully recognizes the value of IPC for patient care. In fact, the results of a Survey conducted by the College in April, 2017 for purposes of this submission ascertain that over 50% of current College registrants practise in an IPC environment, such as hospitals, CHCs, long-term care homes, Family Health Teams and Nurse Practitioner-Lead Teams, home care and multidisciplinary private clinics. This compares very well to most other regulated professions in Ontario. The College is also fully aware that scopes of practice and authorized acts of multiple professions intersect and overlap in Ontario. Nevertheless and despite stakeholder comments and abundant evidence to the contrary, HPRAC made the fundamental error of concluding that the Province's foot care needs are being met by multiple professions, such as physicians, orthopedic surgeons, physiotherapists, chiropractors, massage therapists, nurses and kinesiologists. There is no argument that members of these professions play an important role. Nevertheless, what HPRAC fails to recognize is that chiropody and podiatry are the only professions whose training and scope of practice focus exclusively on the lower extremities. HPRAC also fails to acknowledge that some Colleges, such as the College of Nurses, actually prohibit their members from diagnosing and treating diabetic and other conditions of the foot. The implication of the HPRAC report that the foot care needs of Ontarians can be, or are being met, by other professions overlooks the facts brought forward in the College's and other stakeholders' submissions that under the current model of foot care the needs of Ontarians are not being met, especially in venues such as long-term care homes, rural and remote areas, in home care and for the seniors cohort.

Data provided by the American Podiatric Medical Association demonstrates the natural progression of the profession to multidisciplinary practice. According to APMA data, the later one graduates from a DPM program, the more likely that graduate is to work in a multidisciplinary environment.[4]

1.3 Fundamental misunderstanding or mischaracterization of the podiatry model:

HPRAC somehow reached the conclusion that the podiatry model the College proposes for Ontario is all about surgery. In fact, before HPRAC commenced its review it signaled that it intended to conduct a "new professions review", rather than a "scope of practice review" as if the podiatry model being proposed is new and different and a departure from the chiropody model. As HPRAC's own literature review explained, however, podiatry models of care have evolved, over time, from chiropody models of care. A podiatry model is an extension of the chiropody model in terms of expanded authorities and the competencies to perform them. Podiatrists provide a continuum of foot care from prevention through to soft tissue surgery and ultimately some types of bone surgery. What the College recommended and continues to recommend in the public interest is an expansion of the current chiropody scope of practice so that practitioners may provide a more extensive and seamless continuum of care in order for patients to receive high-quality foot and ankle care that is safe, reasonably accessible and is provided in a timely fashion, without the need of wasteful circular referrals.

Substantive errors committed by HPRAC include:

2.0 HPRAC's reliance on "grey literature"

The College was surprised with HPRAC's reliance on seriously outdated literature. This submission has already referred to HPRAC's reference to a 2005 UK study in support of its recommendation against podiatrists being authorized to communicate a diagnosis. HPRAC was also evidently impressed with the model put forward by the Canadian and Ontario Orthopedic Surgeons, but that case was formulated for the Ministry in 2009 (and neither endorsed nor implemented by the Ministry) and relied on data from 2003-2004.

The College appreciates the candour of the authors of the literature review commissioned by HPRAC pertaining to the 29 documents that were included from the so-called "grey literature". As noted by the authors, "grey literature" includes non-scientific and opinion-based sources such as newsletters and conference proceedings. The descriptions of chiropody and podiatry models in other Canadian and international jurisdictions referred to and relied upon by HPRAC were obtained largely from this grey literature. Naturally, in a context such as the regulation of health care professions, an abundance of opinions and commentaries and a dearth of studies that meet peer-reviewed scientific standards are not unprecedented. The challenge is to appropriately weigh these different levels of evidence in order to make sound recommendations and public policy.

As noted in the Oxman, Lavis *et al* (2009) article referenced in Volume 1, well-informed policy decisions require evidence that informs judgments about the risk of harm, costs and benefits. The authors of HPRAC's jurisdictional review warned that

"….the studies, programs and findings presented….may originate from jurisdictions with health systems that are significantly different from Ontario's. If there is intent to draw heavily from one or more sources presented….we recommend that you contact the lead author of this review for assistance with evaluating the local applicability." [5]

Oxman and Levis emphasize "… all evidence is context-sensitive". The College agrees. While jurisdictional reviews are useful in highlighting the advantages and risks of alternate models of foot care delivery, the College's approach was and is to adapt a model that is specifically integrated with and aligned to the health care regulatory and delivery paradigm as it exists in Ontario today and for the foreseeable future in order to put patients first.

2.1 Failure to acknowledge the College's experience and regulatory effectiveness:

HPRAC concluded that the College had failed to acknowledge the risk of harm associated with the controlled acts it requested, particularly related to "communicating a diagnosis", performing ankle and midfoot and rear foot surgery, ordering and applying x-rays and administering or ordering the administration of forms of energy. HPRAC erred by apparently not understanding that the controlled act of "communicating a diagnosis" was granted to the podiatrist class of members in 1993 and has been regulated by the College for the 25 intervening years since then. The authority to order and apply x-rays (as well as be Radiation Protection Officers) was statutorily granted to podiatrists in 1984 and has been regulated by the College and its predecessors during the 32 intervening years since then. Chiropodists have been authorized by regulation to order and administer the forms of energy of electrocoagulation and fulguration since 1996. HPRAC also failed to note that members of the podiatrist class in Ontario have been authorized to prescribe and administer the federally-regulated class of drugs known as benzodiazepines in Ontario since 2008. HPRAC did not cite and the College is not aware of any claims whatsoever that the College has not regulated the performance of those controlled acts and authorities effectively and in the public interest in the intervening decades. Accordingly, there were no reasonable grounds for HPRAC to conclude that the College does not fully appreciate the risks and did not demonstrate that it could mitigate those risks and ensure that practitioners have the requisite knowledge, skill, training and judgment to perform the additional authorities recommended by the College.

HPRAC not only expressed concern that the College did not grasp the risks associated with "communicating a diagnosis", but also that authorizing the profession to "communicate a diagnosis" would enable podiatrists to diagnose and treat systemic diseases that cause manifestations in the foot or lower limb and would also enable podiatrists to communicate diagnoses beyond their competencies. HPRAC noted that several jurisdictions specifically prohibit any treatment by podiatrists of systemic diseases. HPRAC not only erred by ignoring the fact that the College has regulated the controlled act for 25 years without incident, but also erred by not acknowledging that the *Regulated Health Professions Act* requires that the actual performance of an authorized act be within the profession's scope of practice and the knowledge, skill and judgment of the individual practitioner. Furthermore, other professions not competent to diagnose systemic diseases are authorized to perform the controlled act of communicating a diagnosis. Do HPRAC's concerns apply equally to those professions and, if not, why not?

The College's commitment to safe and effective regulation was clearly demonstrated by the College's commissioning of the PES Report to ascertain competency gaps within the professions related to the performance of each of the proposed authorities and to obtain advice as to how those competency gaps should be addressed. The College made it abundantly clear that no grand-parenting registrant would be allowed to perform any of the new or expanded authorized acts without first demonstrating that he/she had acquired the competencies to perform them safely and effectively. As will be discussed in Section 3, the College also canvassed other regulatory bodies in Ontario and podiatry regulatory bodies across North America to identify the best Standards of Practice, policies and guidelines pertaining to the performance of those authorized acts.

In a related point, HPRAC failed to note that the very competencies that HPRAC questions in chiropodists and podiatrists have been verified by other authorities. For example, Health Canada after a review that took the better part of a decade, added podiatrists (and chiropodists in Ontario) to physicians, dentists, nurse practitioners and midwives as practitioners enabled under the (federal) *Controlled Drugs and Substances Act* to prescribe, possess, administer and provide certain drugs designated under the *Controlled Drugs and Substances Act* and the *Food and Drug Regulations*. Health Canada's rationale is perhaps instructive. Health Canada determined that the New Classes of Practitioners Regulation (NCPR) that added podiatrists, midwives and nurse practitioners to the list of "practitioners",

> *".... would benefit patients as they would not need to seek treatment from more than one health professional in order to be prescribe controlled substances. In so doing, the (NCPR) would support flexible and timely health care service delivery in Canada";*
>
> *" ..... support(s) flexibility and timeliness in health care service delivery"; and*
>
> *"..... benefits patients in so far as they would no longer need to be referred to a physician to obtain a prescription for medication containing a controlled substance".*[6]

The NCPR has been successfully implemented by provincial legislation for podiatrists in British Columbia and Alberta, but not in Ontario.

Finally, HPRAC is critical of the College for its regulatory supervision of clinics in which members of the podiatrist class perform surgery. In the first place, the College was surprised by this criticism, because the HPRAC staff who visited the clinics reported that they were impressed by what they saw. In the second place, HPRAC failed to acknowledge that the College pointed out that it has the authority to regulate individual registrants, but does not have the authority to regulate clinics *per se*, particularly those in which non-registrants are employed. The College asked for statutory authority to do so. It is ironic that HPRAC did not endorse this recommendation.

2.2 The public/private dichotomy:

Throughout the report, HPRAC demonstrates an ideological preference for foot care to be remunerated within the publicly-funded system. HPRAC's clear preference for public funding is a major factor in its opposition to converting to a podiatry model. In this respect, HPRAC erred in a number of ways.

HPRAC errs in the contention or assumption that all surgery performed on the foot and ankle by orthopedic surgeons is conducted in public hospitals within the publicly funded system. A growing number of foot and ankle surgeries are being performed in private clinics (e.g. Centric, Cleveland) and much, if not most, of the foot care provided by other professions (e.g. chiropractic, massage therapy, kinesiology, even physiotherapy) is remunerated privately.

The services rendered by ALL members of the podiatrist class are partially covered by OHIP. The extent of coverage is determined by the Ministry. As of April, 2017, about 30% of members of the professions provide their services (full or part-time) in publicly funded venues. This compares favourably to physiotherapy, kinesiology, massage therapy and chiropractic, among others.

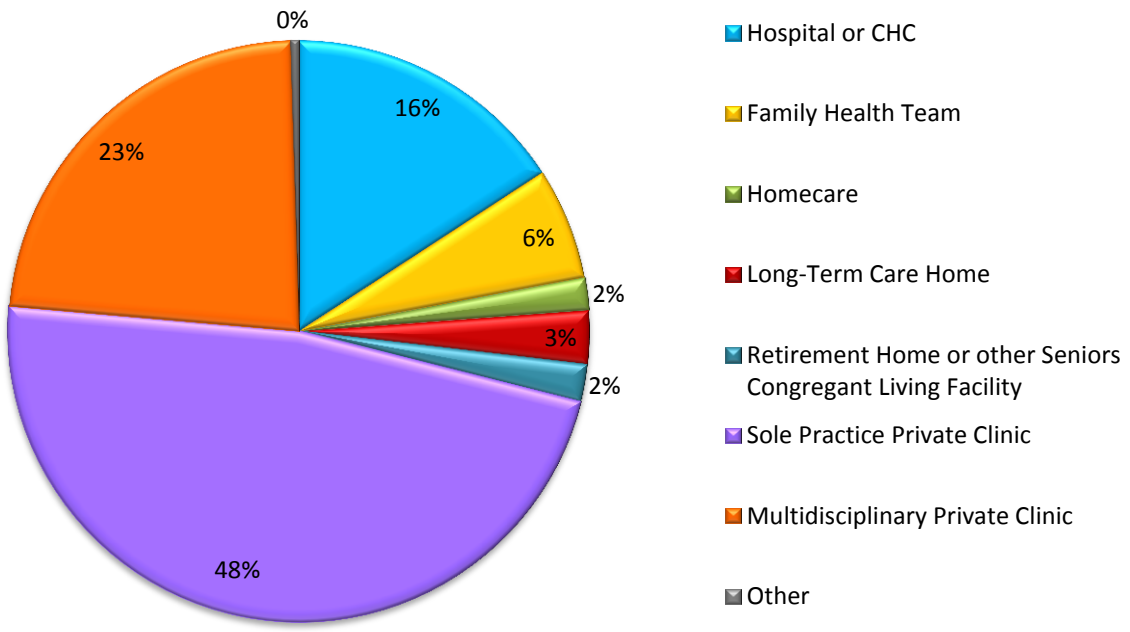


Figure 1: Practice Venue of COCOO Registrants; data obtained from COCOO survey of members, April 17, 2017

The Ministry of Health made substantial investments in the 1980s to fund chiropody clinics in hospitals. Nevertheless, as discussed in the College's original submissions to HPRAC, those clinics have been largely closed down or downsized by the hospitals concerned in order to address patient preferences and real or perceived global budget funding constraints.

Despite requests from the podiatry profession over the years, the Ministry has also been disinclined to authorize podiatrists to be granted hospital privileges under the *Public Hospitals Act,* to include podiatrists in publicly-funded venues such as Family Health Teams, or to expand coverage under OHIP. In fact, in other jurisdictions podiatrists frequently practise in hospitals, veterans' clinics and in other publicly-funded venues. In actuality, there is no correlation between podiatry models and private funding and the extent and nature of public funding for chiropody and podiatry in Ontario is primarily a function of government policy.

HPRAC is critical of the College for not indicating whether or how the services to be performed would be funded. How foot health care is to be remunerated was not part of the Minister's referral. Furthermore, HPRAC's implication that the current situation reflects the professions' desire to be in the privately funded system is simply wrong.

Furthermore, the College informed HPRAC multiple times that the College did not see the discussion of remuneration alternatives or advocating for a particular remuneration model, whether public or private, to be within its regulatory mandate. Put another way, the College has no say or influence --and properly so-- as to how the professions should be remunerated for the services they render.

Finally, the College was advised by the Ministry that remuneration alternatives would be addressed by the Ministry after the Minister decided what to do as a consequence of the HPRAC review. [7]

The College believes that the evidence is clear and irrefutable: The entire HPRAC review was conducted to reach a predetermined conclusion and only that evidence and only those individuals, organizations and documentation that supported that predetermined conclusion were used.

SECTION III

This Section contains an evaluation of the risk of harm, benefits and costs to patients and Ontario's health care system associated with adaptation of the podiatry model proposed by the College in the context of the exigencies and realities of health care delivery and regulation in Ontario. First, however, we reiterate a realistic evaluation of Ontario's current foot care delivery model.

A REALISTIC EVALUATION OF ONTARIO'S CURRENT FOOT CARE DELIVERY MODEL

The *Chiropody Act* has not been significantly amended since it was first presented to the Ontario Legislature in 1991. Since then multiple professions have gone through significant scope of practice changes and multiple professions have obtained regulated status under the RHPA. It goes without saying that the environment and context in which the *Chiropody Act* was drafted have changed dramatically since 1991.

Yet, there is very little in the way of a real evaluation of Ontario's current foot care delivery model in HPRAC's report. Nevertheless, in recommending continuation of the status quo, HPRAC at least implicitly, found no fundamental failings with the current model. Part of Colleges' mandate is to work in consultation with the Minister to ensure "that the people of Ontario have access to adequate numbers of qualified, skilled and competent regulated health professionals."[8] A principal motivation behind the College's request for a review relates to the obvious difficulties all professions are having in providing reasonable access to patients' foot and ankle care needs. Speaking for chiropody and podiatry alone, in the case of members of the podiatrist class the podiatric cap constitutes an obvious obstacle. Rather than growth, the numbers decrease every year and the profession will ultimately cease to exist in Ontario. In the case of chiropody, the current educational and practice models are generating and retaining too few practitioners to satisfy demand. Every year the College receives, on average, approximately 30 applications for registration and loses approximately 7 registrants who have decided to leave the profession for one reason or another. A net increase of 20-25 registrants per year is far below the threshold required to provide reasonable access to foot and ankle care, particularly in light of the growing seniors' cohort and its demands on the health care system. Furthermore, the current model has many obvious illogical or nonsensical characteristics that the College and many stakeholders pointed to in their submissions to HPRAC. The model as launched in the early 1980s and as it exists in Ontario today was designed for chiropodists to practise in hospitals, or in similar institutions, as part of multidisciplinary teams where other members of the team could supervise, delegate or assign care, order diagnostic tests, communicate diagnoses and so on. Yet, today, nearly 80% of chiropodists (and nearly 100% of podiatrists) practise in non-institutional settings. Put simply, the institution-based model launched nearly 40 years ago is out of sync with the realities of the preponderantly private practice model that exists today, largely, if not entirely, as a result of Ministry policies. In addition, today's foot care model is also out of sync with government policies that seek to move health care delivery into non-institutional settings whenever possible.

The logical disconnects in the current practice model that detracts from safe and effective patient care include:

- Chiropodists and podiatrists are legally authorized to prescribe antibiotics, but cannot take a culture or order a laboratory test to determine the right antibiotic to use in each case, or to

measure the effectiveness of the antibiotic prescribed. As one podiatrist put it, without the legal authority to order laboratory tests practitioners have to guess which antibiotic is best for each patient's condition and have to use 19th-century techniques to gauge whether an antibiotic is actually proving effective. For example, chiropodists and podiatrists will mark the limits of an infection on a patient's foot and then monitor whether the infection expands or retreats from that mark.

- The excision of a soft tissue mass in the foot is within the scope of practice and authorized acts of chiropodists and podiatrists, but in treating a soft tissue mass chiropodists and podiatrists cannot obtain a biopsy of that same soft tissue mass and order the laboratory tests (pathology specimen identification) necessary to determine the mass' nature.
- Podiatrists are lawfully authorized to cause a surgical break in the bones (osteotomy) in performing certain surgical procedures in the forefoot, but if a patient presents with a simple fracture of that very same bone, the podiatrist may not perform the controlled act of setting or casting that fracture.
- Podiatrists may lawfully surgically straighten a toe that is deformed or malaligned (Hammer Toe) by a combination of soft tissue and osseous bone surgery, but if that same toe becomes dislocated and malaligned by misadventure (e.g. stubbing the toe), the podiatrist is not able to cast the foot to address the identical deformity of the very same toe.

CLINICAL SCENARIO 1.0

CLINICAL SCENARIO: LABORATORY TESTS

1. **Once the antibiotic was amended, the clinical presentation quickly improved.**
2. **Uric acid levels were within normal limits.**
3. **Urinalysis demonstrated proteinuria.**

A 60 year old female presents to a podiatrist's office with a painful, swollen left foot and ankle. The symptoms arose three days prior without known cause. Over the ensuing period, there has been an increase in pain to the point that she is now forced to walk with a cane. One week ago she attended a "girl's weekend away" during which she attended a salon where she received a "foot spa treatment". She has been taking Advil to manage the pain. She is an alcoholic with a history of hypertension. She has no GP. She takes Hydrochlorthiazide.

Upon examination by the podiatrist, the left foot and ankle are erythematous, hot and swollen around its entire perimeter. The area was exquisitely painful to palpation. The erythema and swelling extended from the forefoot, predominately along the lateral- dorsal border to approximately 2 cm above the malleoli. Scant serous drainage was noted emanating from the 4th interdigital space.

….Continued

CLINICAL SCENARIO: LABORATORY TESTS CONTINUED

UNDER CURRENT SCOPE:

The patient is advised that several possible diagnoses exist for this presentation. The first and most pressing being that we are dealing with a deep space infection of her foot that is advancing into the lower leg (cellulitis). Furthermore, she is at risk of developing septicemia (blood poisoning). Because of the advanced state of the presentation, the patient was advised that she should proceed immediately to the local ER for appropriate intervention.

The differential diagnosis is that of acute gout/CPPD (calcium pyrophosphate disease-Pseudogout).

UNDER PROPOSED SCOPE:

The interdigital space drainage specimen was collected and sent for culture and sensitivity stat. A finger-stick blood specimen demonstrated an elevated random glucose reading. Arrangements were made with the local hospital to receive the patient along with a requisition to initiate IV infusion of the antibiotic Ancef stat. She was given a prescription for Tylenol III to address her pain along with crutches to assist with herambulation. She was given a lab requisition to obtain a CBC with differential, urinalysis, fasting blood glucose and uric acid testing at the hospital.

The lab test results were consistent with infection. The wound culture and sensitivity demonstrated that the organism was Methicillin Resistant Staph. Aureus (MRSA). The patient was notified and the IV team at the hospital was advised to change the antibiotic to Vancomycin.

Fasting blood glucose was elevated. The patient was referred to the endocrinologist on staff to follow up accordingly on the suspected underlying medical concern of Diabetes.

To address these idiosyncrasies and to provide a more seamless and extended continuum of care for patients, in its original submissions to HPRAC, the College recommended scope of practice changes that fall into three categories:

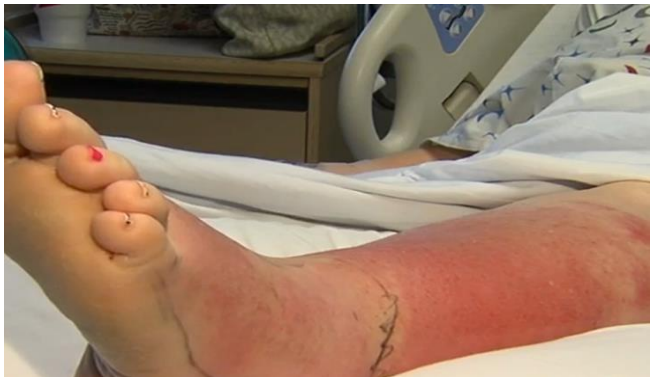
1. Extending to the entire profession, controlled acts and other authorities already authorized to a subset of the chiropody profession and/or to all members of the podiatrist class, namely communicating a diagnosis and ordering and taking x-rays.

2. Expanding, or reducing restrictions placed on, controlled acts already authorized to the entire profession, namely dispensing and selling drugs, "forms of energy" and removing the prohibition against making injections into anatomical locations other than the feet.
3. Authorizing a new controlled act to the profession, namely administering and ordering the administration of forms of energy.
4. Expanding the anatomical scope of practice of the profession to include the ankle and structures affecting the foot and ankle.

In response to comments made by stakeholders during the HPRAC review and also in response to changes in the health care environment since the HPRAC review was ordered in 2006, the College has modified its proposals. Those modifications will be explained in this Section along with real-life case scenarios illustrating the benefits to patients achieved by adopting the College's proposals.

The College wishes to make abundantly clear to the Ministry that in ALL cases, the College will ensure that each of its registrants not currently authorized to perform any controlled act authorized to the profession will have to demonstrate to the College his/her competency to do so before being allowed to perform the controlled act. The competency thresholds will be at least equivalent to those applied by other Colleges who have the same authorized acts and authorities. Prior to commencement of the HPRAC review, the College of Chiropodists initiated extensive consultations with other Colleges in order to understand what those thresholds are and to identify regulatory best practices pertaining to those authorized acts for the College of Chiropodists to adapt should those controlled acts be authorized to the profession.

For those Ontarians who, as suggested by HPRAC, rely on estheticians for foot care, it is reasonable to believe that such ‘consumers’ would be considered simple , no-risk cases by health professionals and do not typically require a health intervention. One hopes that they are not relying on aestheticians for foot care because they cannot access the professional foot care they require. One also hopes that were an aesthetician to come upon any condition that required referral to a health care practitioner, the aesthetician would do so. Nonetheless, data provided in the College's first submissions about the incidence of foot infections originating from aestheticians' care is worrisome, as is the anecdotal information pertaining to the extent to which aestheticians are treating seniors' foot conditions in, for example, long-term care homes. Reproduced below is a picture of the lower leg of a patient who contracted cellulitis by being nicked by an aesthetician during a spa visit. The patient presented at a podiatrist’s clinic, was immediately sent to emergency and spent four days in hospital.



1: http://www.self.com/story/a-woman-got-a-nasty-foot-infection-from-a-pedicure-what-you-need-to-know

High quality, evidence-based preventive foot care is critical for 'patients' who are at risk due to foot problems that could have devastating health consequences, and treatment for those patients who present with complex foot conditions based on factors including age, medical conditions such as diabetes, and poor living conditions such as marginalized populations. There should be no dispute that these patients require the best possible foot care. The College's fundamental disagreement with HPRAC is around the need for meaningful change to better meet these growing populations' needs - a change HPRAC has deemed unnecessary and the College deems essential. Following from that is disagreement regarding the ability of the chiropody profession in Ontario to fulfill the HPRAC criteria for a scope change.

The case for change can be considered within two overarching themes: Scope of practice changes that are specifically patient-centered and those that are directed toward the health system in Ontario, or system-centered objectives. Together, the scope of practice changes at the patient level and at the system level satisfy the ten criteria for recommending a scope of practice change as set out by HPRAC. (p.40, vol.1)

CASE FOR CHANGE

I. PATIENT-CENTRED OBJECTIVES

II. SYSTEM-CENTRED OBJECTIVES

I. THE KEY PATIENT-CENTRED OBJECTIVES OF RECOMMENDED REGULATORY AND SCOPE OF PRACTICE CHANGES:

The current functioning of the foot care model, insofar as it involves chiropodists and podiatrists, does not put patients first. Patients are subjected to circular referrals for diagnostic tests and treatment that delay or frustrate timely diagnosis and treatment, are inconvenient for patients and detract from the patient experience and patient satisfaction ---- not to mention adding unnecessary costs to Ontario's health care delivery system. Since the ordering of many of these diagnostic tests and the delivery of many of these treatments are within the competencies of podiatrists and a growing number of chiropodists, these referrals are often completely unnecessary. This will be illustrated graphically at various points in this Section.

Foot care is a label for such a wide range of services that it inherently creates complexity and misunderstanding. As HPRAC described in answering the question "What is Foot Care?", the majority of procedures performed in so-called 'routine' foot care are not controlled acts and HPRAC identifies that foot care providers include unregulated individuals such as estheticians, personal support workers as well as regulated and, highly specialized physicians such as orthopaedic surgeons, and many other regulated and unregulated professionals in between, including chiropodists and podiatrists. (vol. 1 p.8)[9]

The College wishes to put to rest any concerns that it wishes the podiatry profession to have exclusivity in any aspect of the assessment, diagnosis or treatment of diseases, disorders and

dysfunctions of the foot and ankle. The College fully acknowledges the important role that many other professions play in a continuum of foot and ankle care and the importance of interprofessional collaboration. What the College is proposing in no way restricts – and aims to enhance-- both.

The College application sought not only to simplify this confusing, provider/not patient-centric/suboptimal provider landscape, but also sought to improve patient foot outcomes and thereby improve overall health outcomes. Through an expanded scope of practice for a unified regulated health profession of podiatry with its singular focus on the foot and ankle, its focused knowledge and training with respect to the foot and ankle and an expertise developed through specialized education, the College is confident that patient-centred objectives for preventive care, foot and ankle assessments and treatment including bone surgery, that are essential for excellence in and less fragmented patient care will be achieved.

The College is gratified that HPRAC agreed with the College's recommendation to change the title of "chiropodist" to the title of "podiatrist", which will reduce existing confusion among other health professionals when making a referral for foot and ankle care, and simplify the provider landscape for patients. This confusion was amply evidenced during the stakeholder consultation. The College also acknowledges and accepts HPRAC's aim to distinguish between general practice podiatrists and those podiatrists who have additional, specialized training to provide an extended continuum of care that involves surgery. But these initiatives alone fall far short of achieving the results that the College aims for in the interests of patients, including those that HPRAC identified.

One protected title of podiatrist, with a specialty subset of College members who have additional training who may also perform surgery EXCEPT (for example) in cases where an expected and/or prolonged hospitalization is required (for example) the patient's entire limb is threatened by infection, there are other acute life-threatening comorbidities or spine injuries, there is an ascending necrotizing infection requiring aggressive debridement, open fractures of the leg, the patient is medically unstable and the procedure can otherwise be conducted safely and effectively. The College will invoke its existing authorities under Subsections 95(1) (e), (h) and (h.1). of the RHPA to create a specialty for those who have demonstrated to the College that they have the competencies to perform surgical interventions in addition to those in the current chiropody scope. The College further proposes that, by regulation, only members of that specialty would be allowed to perform these procedures and to perform certain of the controlled acts authorized to the profession, such as casting or setting fractures, ordering or administering certain forms of energy and prescribing and administering certain drugs. College members who have acquired and demonstrate the requisite competencies would then be recognized as having moved from podiatry into the podiatry specialty. This is analogous to the transition of registered nurses to the registered nurses extended class, referred to as Nurse Practitioners, or to the specialty of oral and maxillofacial surgeons within the dentistry profession.

CLINICAL SCENARIO 2.0

CLINICAL SCENARIO: FRACTURE

A 20-year-old healthy male sustained an injury to his left forefoot while mountain biking earlier in the day. He currently feels quite well in general; however, is concerned about the foot due to significant pain and bruising. The patient presents to the office of his chiropodist who he has previously seen for other unrelated sports injuries.

Upon presentation the patient is noted to have great difficulty bearing weight on the left forefoot and examination reveals swelling, bruising and pain to palpation of the third and fourth left metatarsal structures. The exam is otherwise normal.

….Continued

CLINICAL SCENARIO: FRACTURE CONTINUED

UNDER CURRENT SCOPE:

[**Note**: "Chiropodists" other than those having graduated from a four-year "chiropody" program cannot order or take x-rays or fluoroscopes to diagnose a fracture and neither chiropodists nor podiatrists may set or cast a fracture.]

The patient is given a protective surgical boot and crutches and advised to rest, ice, and elevate the foot. A letter is written and faxed to the patient's primary care physician indicating the patient's condition and recommending x-rays. The patient returns to the primary care physician who then sends the patient for x-rays that reveal fractured metatarsals and results in the following: a referral to the emergency room, subsequent consultation with an orthopaedic surgeon, and a final decision to schedule surgery in the hospital operating room.

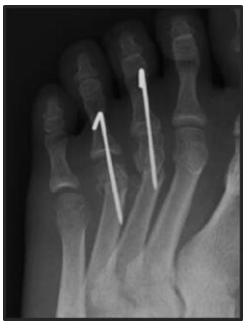
Time elapsed: 5-7 days or longer, depending on orthopedic specialists and operating room availability.

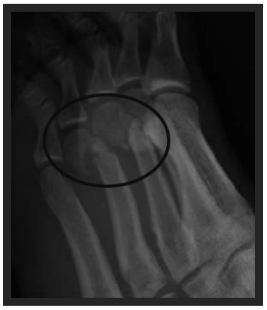
UNDER THE PROPOSED EXPANDED SCOPE:

Weight-bearing fluoroscope or x-rays are taken immediately in the Podiatrist's office and interpreted by the Podiatrist revealing fracture dislocations of the third and fourth left metatarsals (see below).

This diagnosis is communicated to the patient. All treatment options are reviewed with the patient. Due to the nature of the injury, closed manipulation/reduction under x-ray guidance with percutaneous fracture fixation are specifically recommended. It is explained to the patient that if appropriate reduction cannot be achieved with these techniques, open reduction with internal screw fixation (ORIF) of the metatarsal fracture(s) would then be performed. The patient indicates he fully understands his options and schedules to have these procedures performed within the next several days by the Podiatrist in the office surgical suite utilizing oral sedation and/or nitrous oxide, mid-calf tourniquet, and regional local anesthetic techniques. A letter is written and faxed to the patient's primary care physician indicating the patient's condition and the recommended treatment plan. The procedure is successfully performed as planned.

Post-operative care including serial dressing changes and x-rays are all performed by the Podiatrist in the office. The patient is referred to a physiotherapist for physiotherapy to be initiated at four weeks as deemed necessary by the physiotherapist. The patient returns to full activity within two months after the initial injury. The Podiatrist advises the patient on the best shoes and fits the patient with an orthotic device to protect this area in the future.





The discussion that follows utilizes the title “podiatrist” as encompassing of today’s chiropodists and members of the podiatrist class reflecting this anticipated change and providing the simplicity for readers that this change will have for patients.

Preventive foot care

An expert foot assessment goes well beyond nail care. When a patient presents to a podiatrist for assessment, the podiatrist will assess for complicating medical factors that may require a referral to a physician or specialist, such as the family physician or an orthopedic or vascular surgeon or dermatologist. This is a critical aspect of preventive foot care – the expertise to know when a foot symptom is indicative of a systemic disease or disorder that requires diagnosis and treatment by a physician, or in some cases a Nurse Practitioner. The foot assessment by a podiatrist may uncover foot pathology that requires treatment within the scope of practice of the podiatrist and the assessment may also lead to patient education about proper foot hygiene and foot care. Paradoxically, today’s chiropodist is authorized to formulate a foot-related diagnosis, but is not authorized to communicate that diagnosis to the patient. It is difficult to imagine a patient encounter where the professional develops a treatment plan to prevent, for example, further exacerbation of a foot ulcer and provides treatment such as wound debridement, but cannot tell the patient the diagnosis on which the treatment plan is based, nor communicate the diagnosis to the patient’s primary health care provider or to other practitioners within the patient's circle of care. It is also difficult to imagine how the patient can give informed consent to treatment under these circumstances. Norms and paternalism within the health sector have evolved since these prohibitions were introduced over two decades ago. Today, patients can have electronic access to their lab results and obtain their personal diagnostic information and diagnoses digitally. Diagnostic information belongs to the patient and prohibiting a regulated health professional from communicating the diagnosis that the professional is competent to make and on which the treatment plan is developed and provided, is simply outdated and not in patients' best interests.

The controlled act of "communicating a diagnosis" was granted to members of the podiatrist class in 1993 and has been regulated by the College since then, without evidence of concerns for patient welfare. In seeking authority to communicate a diagnosis within the podiatry scope of practice for its members who have demonstrated the requisite competencies, not only does the College anticipate improved patient understanding of their foot conditions and the expected outcomes of treatment, but also better communication between the podiatrist and the other professionals involved in the patient’s care. All members of the patient’s health team can be informed about the podiatrist’s diagnosis, limited of course to diagnoses within the podiatry scope of practice, thereby enabling a comprehensive care plan, as well as an understanding of the rationale for the podiatrist’s treatment plan to prevent further medical complications. Contrary to HPRAC, the College believes that the risk of harm to patients is actually reduced by the communication of a diagnosis by qualified podiatrists.

For today’s chiropodists, before this new controlled act is granted on an individual basis each member will be required to demonstrate to the College that the necessary competencies to communicate a diagnosis have been acquired. Communication of diagnoses pertaining to systemic diseases would be prohibited for all College members, except, of course, by lawful delegation. Those College registrants who have been authorized to communicate a diagnosis would be identified as such by rostering on the College's public website as per, for example, the College of Physiotherapists of Ontario.

HPRAC noted that foot assessment is not occurring with the required frequency to maintain a healthy foot. (p. 13 vol. 1) In the context of diabetic patients, the HPRAC report states that approximately 14-24% of patients with leg and foot ulcers require amputation, and 69% of these

patients will not survive beyond five years after amputation. The incidence of foot amputation is highest in Northern Ontario, particularly in First Nations Communities, in rural and remote areas and for patients who do not have a primary care provider.

PATIENT-CENTRED ISSUE | ABORIGINAL HEALTH

The incidence of diabetes and resultant amputations is highest among Aboriginal communities. The Truth and Reconciliation Commission found that First Nations peoples 45 years of age and older have nearly twice the rate of diabetes as non-aboriginals.[18] Indigenous peoples with diabetes also experience disparities in diabetes-related complications and mortality. Higher prevalence rates of microvascular disease, including chronic kidney disease, lower limb amputation foot abnormalities and more severe retinopathy, are found in Aboriginal peoples with diabetes than in the general population with diabetes. The expansion of the numbers of foot care specialists and authorizing them to provide a more extensive and seamless continuum of care are entirely consistent with the Premier's and her government's commitment to improving the welfare of First Nations peoples in Ontario.

Expert preventive foot care is critical for the prevention of amputation and death for persons with diabetes. Of the 1.5 million people with diabetes in Ontario, between 16,600 and 27,600 are expected to have a diabetic foot ulcer in one year alone. According to the Canadian Diabetes Association (CDA), in 2015 there were an estimated 1,954 amputations related to diabetic foot ulcers in Ontario. A 2016 study found that 85% of these amputations are preventable. The CDA estimates that costs related to diabetes in Ontario amounted to $4.9 billion direct and indirect costs in 2015 – of which diabetic foot ulcers accounted for $407.5 million; and this cost is expected to rise as the population ages. This cost burden related to diabetic foot ulcers could be reduced with adequate preventive foot care by reducing the rate of costly amputation surgeries.

The **Canadian Agency for Drugs and Knowledge in Health** stated:

> *"The integration of podiatric surgery into an (sic) usual limb-salvage service (i.e. vascular surgery with medicine and allied patient care services) has been shown in a retrospective study to have positive impact on diabetic foot care, such as significantly reduced urgent surgeries, reduced below-knee amputation rates. In another retrospective study, the addition of a limb preservation team (LPT, which includes podiatric and vascular surgery, wound care nurse, orthotic laboratory, and research unit) was shown to decrease the rate of major amputations, and the rate of death in patients with diabetic lower-extremity ulcerations, as compared to the non-LPT group."*[12]
>
> A study aimed at preventing amputations in cases of foot diabetes described in the Journal of Vascular Surgery by Rogers *et al.* states:
>
> "*…the podiatrist's role is often that of "gatekeeper" to the diabetic foot team, because the foot ulcer is often the entry diagnosis. A simple foot ulcer is often a manifestation of a much larger underlying nexus of problems whose complete management crosses multiple disciplines. The podiatrist's primary duty is to evaluate the foot ulcer, exclude or treat foot infections, rule out PAD or refer to vascular surgery and create a comprehensive wound healing plan that uses the*

other members of the team. Podiatric surgeons include foot surgery in their treatment plan, when necessary, to heal a wound or prevent its recurrence. ***The podiatrist has particular expertise in biomechanics and pressure off-loading unique to the profession. The podiatrist also performs a critical role in identification and management of diabetic patients at highest risk for ulceration. Podiatric prevention clinics are a key component of comprehensive diabetic foot care****." [Our emphasis added.]*

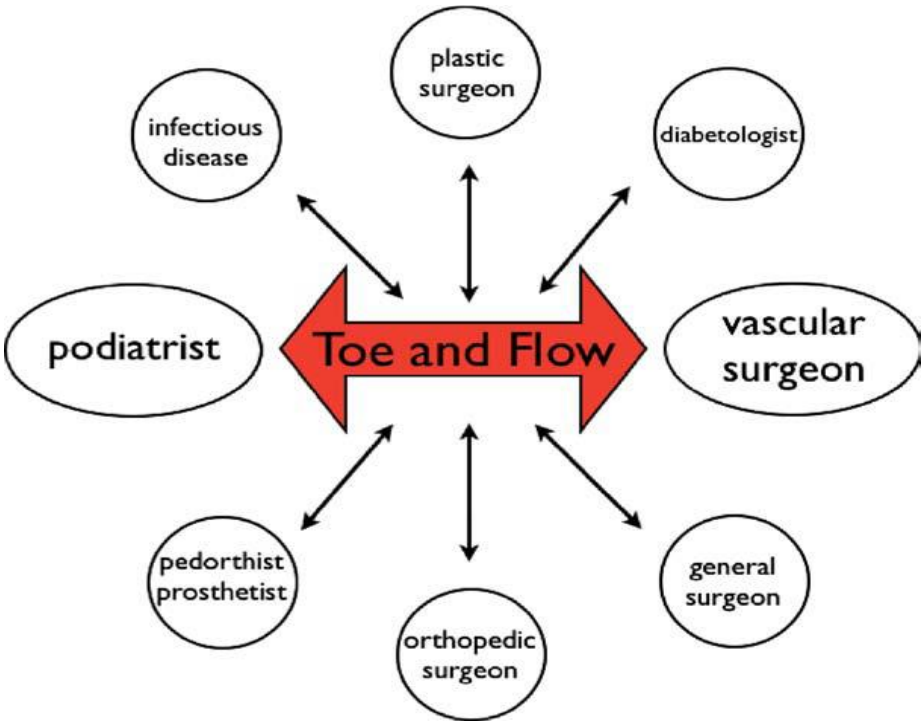
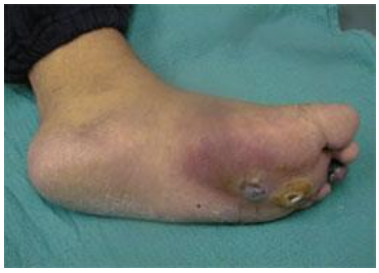


Figure 2: Illustration of the optimal inter-professional circle of care recommended by Rogers et al. for the diagnosis and treatment of diabetic feet.

As referenced in submissions to HPRAC, when the State of Arizona delisted Medicaid for podiatrists, the State encountered a 37.5% increase in hospitalization rates for diabetic foot treatments and the incidence of sepsis, amputation and death from diabetic conditions of the foot rose by 50%.

Despite HPRAC's conclusion that the criterion of public need for a scope of practice change had not been satisfied, a significant public need would in fact be met through the proposed change in scope of practice and the College's motivation in seeking these changes is unequivocally to improve the public's foot health and overall health…. clearly in the public interest.

CLINICAL SCENARIO: DIABETIC FOOT ULCER



This diabetic patient presented with an open ulcer on the bottom of the left foot. The patient does not relate any trauma and tells clinician that her blood sugar is poorly controlled.

Physical exam reveals palpable pulses with swelling to the left arch. There is redness around the wound, but the wound does probe to bone.

UNDER CURRENT SCOPE:

If there is a clinical suspicion of bone infection or the wound probe to bone, the role of the podiatrist is limited to the extreme. The Podiatrist may debride the soft tissue around the wound and start the patient on a broad-spectrum antibiotic, but is unable to obtain a proper culture prior to beginning antibiotic therapy. This may result in an inaccurate culture obtained from subsequent clinician. Under the current scope the podiatrist is unable to coordinate care with the primary care physician, radiologist or infectious disease specialist. The podiatrist is unable to obtain a piece of the infected bone for biopsy and culture in order to direct appropriate therapy, because the talus is infected and the podiatrist does not have access to laboratory testing. The podiatrist is unable to order a bone scan or MRI to determine the extent of the infection.

The patient must be referred to the GP (if there is one) or the Emergency Department of the hospital. This delay in care lead to inappropriate therapy and the likelihood of an advancing infection that will require prolonged antibiotic therapy and perhaps even amputation.

PROPOSED SCOPE:

X-rays do not demonstrate any bony changes consistent with a bone infection, but the clinical suspicion remains high as the wound probes to the talar neck which is in the foot portion of the ankle joint. The podiatrist takes a deep culture of the soft tissue and sends it to the laboratory for culture and sensitivity. The patient is started on a broad spectrum oral antibiotic by the podiatrist pending follow-up clinical evaluation and return of the culture results.

Blood work is ordered and demonstrates an increase in blood glucose, slight elevation in the white blood cell count and an increase in CRP and ESR (both markers of inflammation that are monitored for improvement as the infection resolves). The patient does not have a fever and there does not appear to be any signs of sepsis (infection in the blood stream), joint involvement or advancing infection so there is no need for the patient to be hospitalized at this point.

…Continued

CLINICAL SCENARIO: DIABETIC FOOT ULCER CONTINUED

The patient returns for a follow up appointment with no clinical improvement. A bone biopsy and bone culture is performed at the talus by the podiatrist. A white blood cell labeled bone scan is ordered by the podiatrist in order to determine the extent of bony involvement and confirm clinical suspicion of osteomyelitis. The bone scan involves taking the patient's blood and tagging the white blood cells with a radioactive tracer and re-injecting it into the patient. The results of the bone culture and bone scan are coordinated with an INFECTIOUS DISEASE SPECIALIST who requests an MRI and begins IV antibiotic therapy.

The podiatrist practising in the EXPANDED SCOPE has helped the patient avoid unnecessary delays and lowered the overall risk of advancing infection and subsequent amputation.

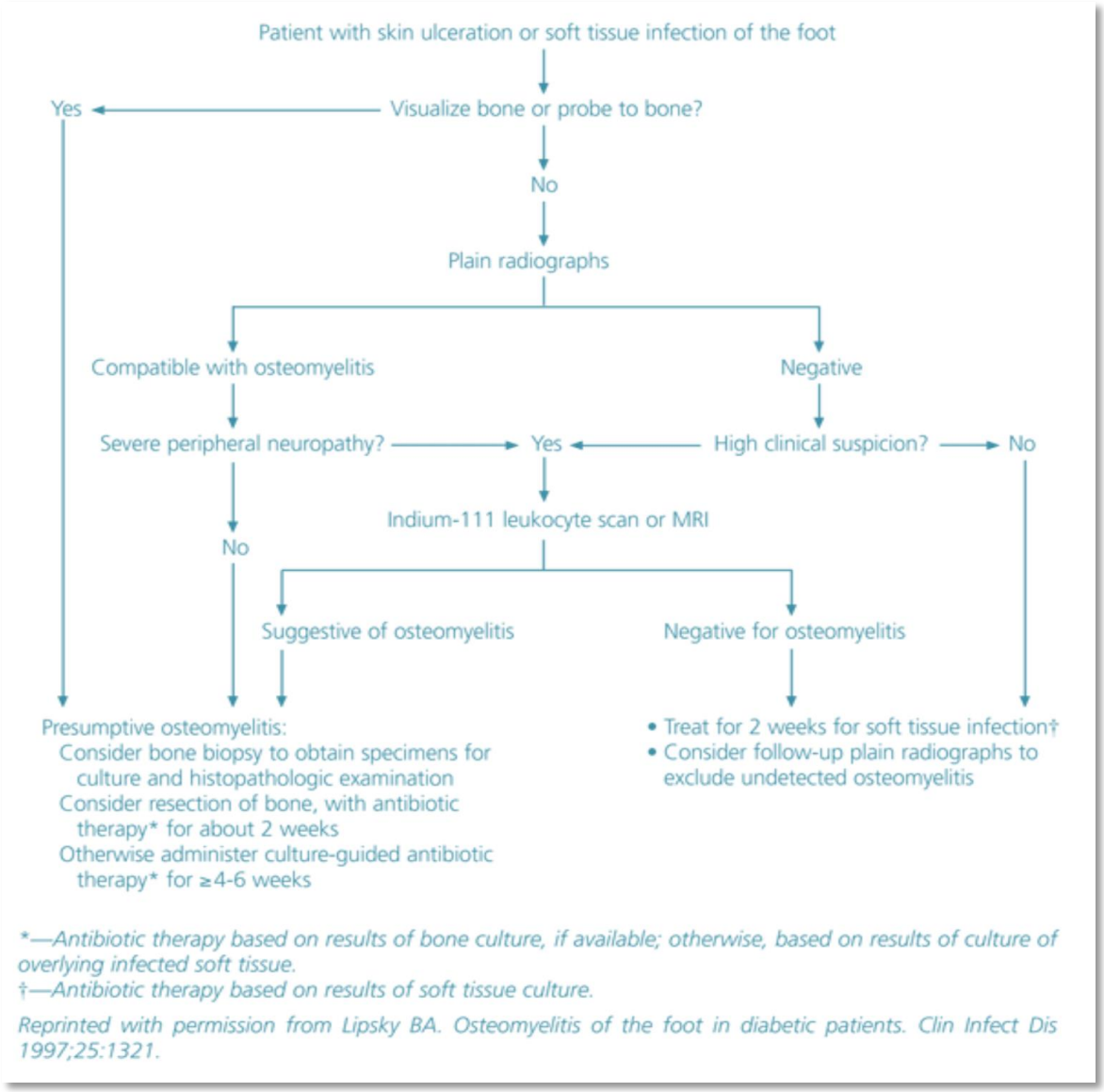


Figure 3: Treatment of a skin ulceration of the foot

A more extensive and seamless continuum of foot and ankle care

A major and persistent criticism of Ontario's health system is its fragmentation, professional silos, professional turf battles and lack of integration. Unfortunately, these criticisms are deserved within the current regulatory regime for the delivery of foot care. The College seeks to address unnecessary patient hand-offs and circular referrals with their inherent increased potential for patients 'falling through the cracks'. The College propose to accomplish this by authorizing qualified registrants to order a more extensive suite of diagnostic tests within the scope of practice and practitioners individual competencies.

Today's podiatrists must refer patients back to their Primary Care Provider for most of the diagnostic tests required to adequately formulate diagnoses within their existing scope of practice. In addition to patient inconvenience, 84% of registrants report that they experience delays and other difficulties when they request a Primary Care Provider to order a diagnostic test. In 30% of the cases, the test isn't ordered at all; in 33% of the cases the tests are ordered, but the podiatrist does not receive the results; and in 37% of the cases the podiatrist does receive the results, but not without an unacceptable passage of time.[13] Although distressing, these results are not at all dissimilar to the experience of other professions in analogous situations, for example oral and maxillofacial surgeons ordering MRIs, or physiotherapists ordering diagnostic tests.

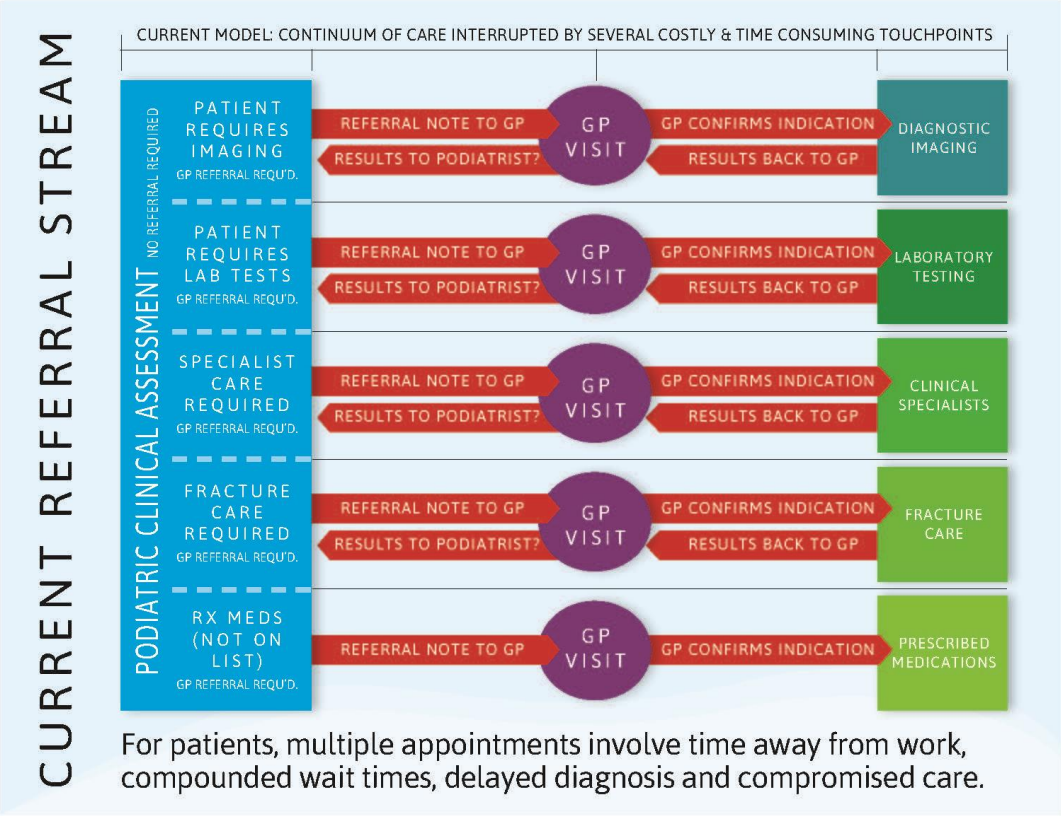


Figure 4: Current Referral Stream in the foot care model

Access to a fuller suite of diagnostic testing will contribute to a seamless patient experience by reducing unnecessary referrals to other health care providers. This in turn will improve patient convenience, expedite diagnosis and treatment and reduce wait times and system-wide costs.

Since its inception, the *Healing Arts Radiation Protection Act* has authorized any registrant of the College of Chiropodists who satisfies the following criteria to order and take x-rays:

> "……*who has been continuously registered as a chiropodist under the Chiropody Act (1944) and the Chiropody Act, 1991 since before November 1, 1980 or who is a graduate of a four-year course of instruction in chiropody."*

In its HARP Guidelines, the Ministry of Health (as it was then known) made the case for chiropodists (podiatrists) ordering x-rays:

> *"X-ray evaluation of the foot and related structures [sic] is essential if the chiropodist (podiatrist) is to determine a diagnosis and/or confirm a clinical diagnosis. Of particular importance to the chiropodist (podiatrist) are x-rays taken to determine biomechanical function and these investigations entail weight-bearing views utilizing specialized techniques and interpretation."*

Accordingly, the podiatrist class of College members and those who have completed a four-year course of instruction in chiropody have been authorized to order and take x-rays for decades. Not only have safety issues not arisen, there is no evidence that members have contributed to the unnecessary use of x-ray that has plagued other diagnostic areas such as low backs. To improve continuity of care, this authorization needs to be extended to the entire profession and granted by the College to those who have demonstrated the competencies to order x-rays safely and effectively. This will be beneficial for patients who require an x-ray to establish biomechanical function through weight bearing views and will no longer have to wait for a family physician appointment. Since the vast majority of authorized registrants have obtained XRIS licenses to own and operate their own x-ray equipment, the costs for Ontario's health care system will be negligible.

The College persists in its recommendation that the profession be granted the controlled act of administering and ordering the administration of forms of energy (RHPA subsection 27 (2)7). As noted in Section 2 of this Submission, Ontario Regulation 107/96 has authorized the profession to perform a portion of the controlled act, specifically "to apply electricity for electrocoagulation or fulguration", for two decades. Nevertheless, given that the formerly-proposed expansion of performing diagnostics to include MRI would not only require a significant learning curve for two thirds of College members, the College proposes that the forms of energy authorized to the profession include only diagnostic ultrasound and electromyography within the podiatry scope of practice, as well as ordering MRIs of bony tissues; AND that the authorized act be restricted to members of the specialty. Once again, to reduce unnecessary circular referrals and provide seamless and efficiently delivered care, providing patients direct access to these diagnostics will improve the patient experience; facilitate timely diagnosis and treatment and continuity of care.

The College recommends that the profession be authorized to set or cast fractures of a bone or dislocation of the joint in the foot (RHPA, subsection 27 (2) 3.). As indicated earlier in this submission, members of the podiatrist class currently perform osteotomies and other surgical procedures on the forefoot that require the fixation or setting of bones, but are not authorized to do the same for simple, acute fractures. Performance of the authorized act will be restricted to members of the specialty. Granting this authority will also contribute to more efficient and seamless care by reducing the need to send a patient from a podiatry clinic to a hospital emergency department merely to set any kind of foot fracture. These services are well within the competence of the members of the proposed specialty class. Regulatory recognition will be welcomed by those patients who must needlessly travel, sometimes long distances, for a foot x-ray and then casting.

The current authorization for injections into the foot is another foundation for seamless care delivery. Podiatrists' education (confirmed by the Professional Examination Services report which we included in our prior submission) provides them with the competencies to inject substances beyond the anatomical limits of the lower limb. In practice, there are often cases where effectiveness and best clinical practices require injections of a substance into another area of the anatomy, for example, a tetanus toxoid booster administered in the deltoid muscle of the arm/shoulder. This can arise where, for example, individuals living in remote areas with limited access to a physician particularly if they are economically disadvantaged, have a mental illness or have a history of drug/alcohol abuse, present to a podiatrist with an infected foot wound and without verifiable tetanus protection status. Providing that injection reduces the risk of harm rather than increasing it. With approved expansion for injections, the College will develop an accompanying standard for its members to match the new authorizations prior to the implementation date to ensure podiatrists have the required knowledge, skill and training. Although the College believes that access to the highest quality and seamless care for patients would be enhanced through podiatrists being authorized to prescribe, dispense and sell drugs, we appreciate that drug-related developments, since our 2014 submission, may now create additional risk of harm. In particular, we are concerned about the current opioid crisis and that access to opioids dispensed at podiatry offices may have unintended harmful consequences, for example, increased polydoctoring and polypharmacy. Therefore, the College agrees that the drugs prescribed by podiatrists must be dispensed only at pharmacies. Where these drugs are over-the-counter topical medicines fabricated specifically for conditions of the foot, for example, to treat ganglions, instead of dispensing these drugs themselves, podiatrists will need to make special arrangements with local pharmacies to carry a supply of these drugs for podiatry patients. The College believes this addresses concerns expressed by some stakeholders, such as the CPSO, around the risk of harm with respect to drug dispensing.

For regulatory simplicity, the College suggests that the drugs that are eligible for podiatry prescription be described in regulation in such a manner (i.e. by "classes") that will not require ongoing updating because of the regulatory specificity, but rather be described in broader language that will enable perpetual currency.

Improving patient access to foot and ankle care today and in the future

The College and the overwhelming majority of stakeholders who commented during the course of the HPRAC review find the so-called "podiatric cap" incomprehensible and indefensible. Continuation of the cap would constitute a huge obstacle to the Minister's duty specified in Section 3 of the RHPA, namely to ensure that "individuals have access to services provided by the health professions of their choice." It is also incomprehensible why the Government of Ontario would interfere with the ability of any profession to respond to the natural forces of supply of and demand for its services. As laid out in more detail in the College's original submissions to HPRAC, the cap is also inconsistent or in conflict with at least the spirit, if not the letter, of the *Fair Access to Regulated Professions Act*, the reciprocal recognition provisions of NAFTA (Chapter 16), the new Canadian Free Trade Agreement (Section 7) and the Ontario-Québec Accord. The combination of Ontario's idiosyncratic chiropody model and the podiatric cap have created obstacles and caused frustrations for other jurisdictions. This includes the absence of chiropody and podiatry from the professions listed in Chapter 16 of NAFTA and the absence of an interprovincial/territorial MRI under the AIT applying to either chiropody or podiatry. The cap has also stunted and warped the natural evolution of the chiropody profession in Ontario in that, no matter their competencies, chiropodists are very limited in being able to use those competencies.

The podiatric cap was instituted largely to mute competition for the chiropody profession that the Ontario government decided to adopt in the late 1970s. With a unitary profession that rationale, as questionable as it was at the time, no longer applies and is even more questionable now. In a society and government whose aim is transparency, openness and welcoming, how can the Ontario government maintain a cap that effectively tells the podiatric world that they are not welcome in the Province? We cannot claim transparency and openness on the one hand and prevent podiatrists from practising their profession here on the other hand.

In practical terms, despite government initiatives to increase access to health providers across the province through, for example, incentives such as the Rehabilitation Professionals Incentive Grant Program that offers taxable incentive grants to chiropodists, it is acknowledged that there is uneven access to foot care in Ontario. Access to orthopedic surgery on the foot and ankle is also problematic in Ontario. The Ministry's own data clearly demonstrates that although wait times for orthopedic foot surgery have trended downwards since 2013, wait times still exceed Ministry targets in 9/10 LHINS. Furthermore, the downward trend in wait times reversed itself during the last quarter of 2016. Finally, and in many ways more importantly, published wait times data tell only part of the story. Wait times between referral to and the first consultation with an orthopedic surgeon for foot surgery indicate a serious and growing problem. A survey conducted by the College to update information for purposes of this Submission indicates that a preponderance of patients currently referred to orthopedic surgeons (via GPs if the patient has one) wait 6 to 12 months for the first consultation. [See the pie charts at Figures 5, 6, 7 & 8] This does not include abundant anecdotal information about orthopedic surgeons turning away patients who require relatively minor foot surgery that could be performed by podiatrist under the proposed scope of practice.

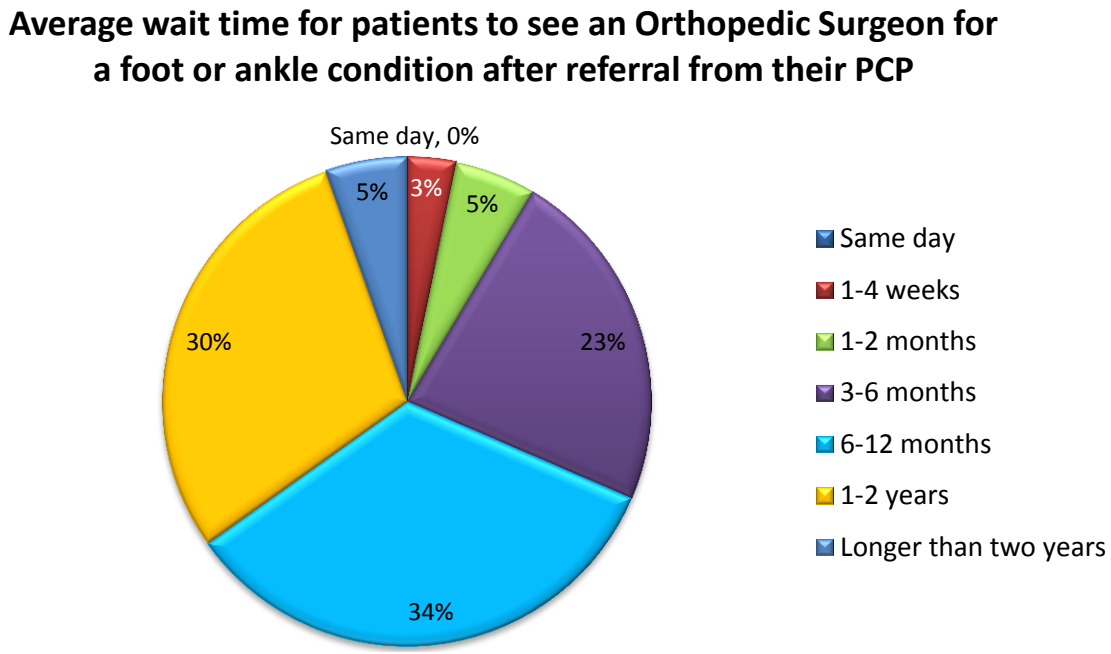


Figure 5: **Average wait time data obtained from survey of COCOO members April 17, 2017**

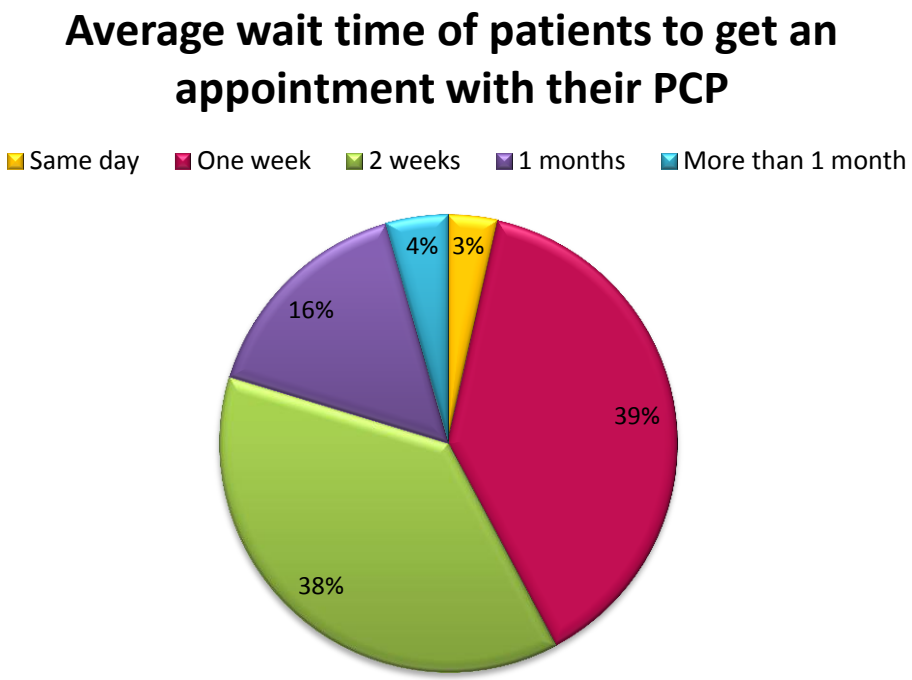


Figure 6: Average wait time data obtained from survey of members of the COCOO, April 17, 2017

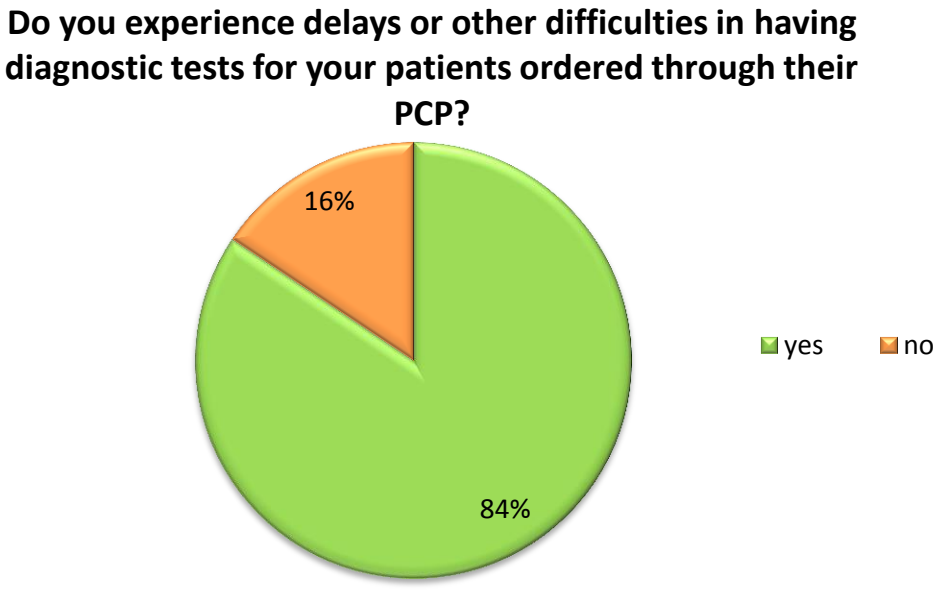


Figure 7: Primary care physician delays - data obtained from survey of members of the COCOO, April 17, 2017

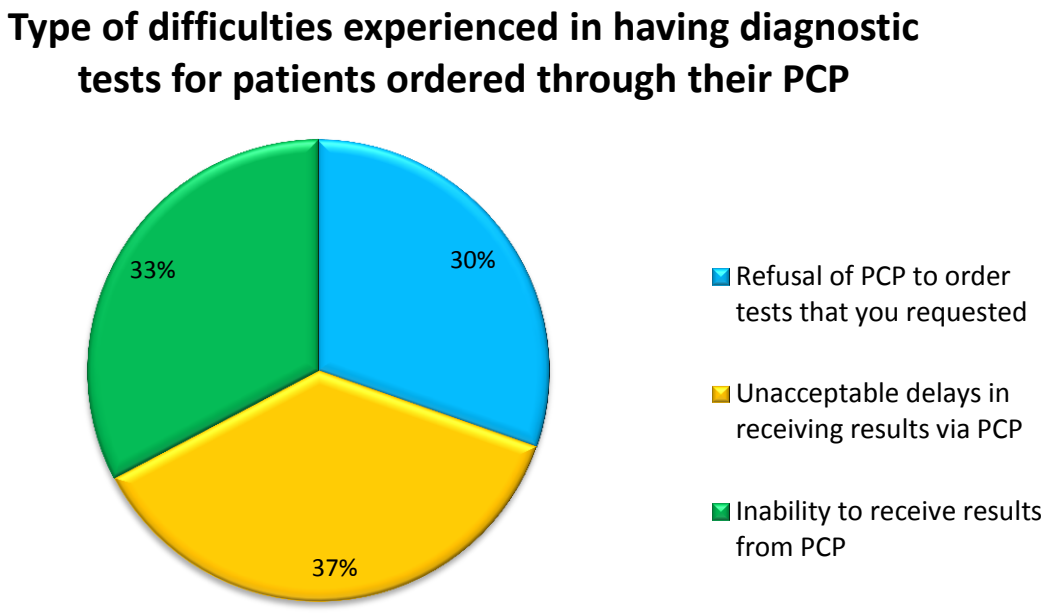


Figure 8: Types of difficulties dealing with primary care physicians, data obtained from survey of members of the COCOO, April 17, 2017

We are fortunate that there is an available solution. Access to foot care, including foot surgery, will be enhanced and foot surgery wait times significantly reduced through the removal of the current restriction on the registration of new podiatrists, as the title currently exists. In addition to the positive impact of improved access for patient outcomes through timely, expert preventive and treatment services, it will also enhance access to family physicians, medical specialists and nurse practitioners whose time would otherwise be spent with foot care patients who could be treated by podiatrists. To ensure a viable and dynamic profession today, and in the future, and to attract foreign trained clinicians with diverse backgrounds and Ontario residents who have been educated elsewhere who are now excluded by the Act from becoming podiatrists in our province, the cap on the number of College registrants must end.

Given that the aging population is increasing, and thus the demand for podiatric services is increasing, the continuation of a decade-long restriction that precludes the profession from meeting patient need and has interfered with its natural evolution in response to patient need that has occurred with all other professions is indefensible. As noted by MOHLTC author Dr. S.K. Sinha in 2012, the majority of seniors have at least one chronic disease or condition which increases the risk of foot complications and seniors account for nearly half of total health care expenditures, in light of the fact that seniors constitute nearly 60% of podiatrists' and chiropodists' patients, the podiatric cap makes no public policy sense.

HPRAC identified the aboriginal population as having an increased risk of serious foot conditions because of the high incidence of diabetes, coupled with remote geographical locations where access to care is a barrier. The incidence of foot infections is the highest in north eastern communities where both primary care provider and podiatry supply our insufficient. Certainly, to provide podiatric care within Ontario's aboriginal communities under the current Act and its restriction of 69 podiatrists whose scope includes cutting into the bony tissue of the foot, a number that is decreasing, but by the Act can never increase, we are missing an opportunity to expand foot care access in these communities. Also, rather than enable and encourage aboriginal candidates to join the podiatry profession and practise within their home communities, the regulation thwarts

interest. Podiatry students are similar to other health discipline students; they join a profession with the intention to practise to the top of their registration. A patient-centred Act must support that interest.

Central to the regulation of health care is the protection of the public. The College considers ensuring its members are fully competent to practise safely, delivering evidence-based care and mitigating risk of harm as paramount and it is proud of its long history of effective regulation. A former Minister of Health and Long Term Care's (Deb Matthews') written recognition has affirmed the College's regulatory effectiveness.

As already indicated, the College has examined the practices and standards of podiatry regulators in other jurisdictions and the practices of other Ontario regulatory Colleges charged with regulating the same or analogous controlled acts. The College will continue those consultations and will use that experience, those practices and standards as thresholds and guidance in the development of its own Standards of Practice, Guidelines and Policies for the performance of the new and expanded authorized acts.

II. THE KEY SYSTEM-CENTRED OBJECTIVES OF RECOMMENDED REGULATORY AND SCOPE OF PRACTICE CHANGES:

A continuum of foot and ankle surgery

HPRAC indicated that its decision not to recommend an expanded scope of practice or expansion of controlled and authorized acts was influenced by its observation that the College did not provide clear anatomical boundaries for surgery or limitations on diseases that would be diagnosed. It is unfortunate that HPRAC interpreted the College recommendations as including the lower leg or diseases that are not restricted to the foot and ankle. The College provides assurance that it does not recommend a scope of practice inclusive of a systemic disease or disorder, or a disease or disorder beyond the foot and ankle.

Today's podiatrists are legally authorized to perform bony surgery of the forefoot. The College recommends expansion to include the remainder of the foot and the ankle, as exists in 50 US states, plus the District of Columbia and in Alberta, British Columbia, the United Kingdom and other jurisdictions. Anatomical boundaries were raised by HPRAC as an insurmountable problem. These are largely clinician-driven challenges. The definition of foot and ankle will be understood by a lay person and the College seeks simplicity for patients through these scope changes. The College recognizes that the advocacy bodies for orthopedic surgery have fought and continue to fight tirelessly against any scope change for chiropody and podiatry. This fight appears to be more about professional turf protection than about putting patients first. In Ontario there are approximately 30 orthopaedic surgeons who identify themselves as 'foot and ankle' surgeons and may thereby consider podiatric foot and ankle surgery as either encroaching on their practices. As noted earlier, there is a continuum of foot care and that continuum includes a podiatrists and orthopaedic surgeons, preferably working together in the best interests of patients.

Having said that, there are clearly surgical procedures that are beyond the scope of practice of members of the proposed specialty and the College would prohibit the performance of those procedures to any member of the profession. Examples are provided later in this submission.

The economic benefit to Ontario's health care system

In Ontario, members of the podiatrist class are limited to a scope of practice that exists nowhere else in podiatry models. The educational model and scope of practice for chiropody that exists in Ontario, exists nowhere else. Those factors, coupled with the impact of the podiatric cap and the small size of the chiropody profession, have militated against investigation, research and analysis of either profession, including the economic and fiscal costs and benefits. Accordingly, the principal source of data on the cost effectiveness and economic impacts of podiatry is the United States. One likely externality of launching a unitary podiatry profession in Ontario with a scope of practice similar to other podiatry scopes is the promotion of clinical research, the development and sharing of clinical best practices and the study and publication of economic and fiscal impacts and health system cost benefits.

As discussed earlier in the Submission, the important role that podiatrists play elsewhere – and have the potential to play in Ontario – in the diagnosis and treatment of diabetic feet of feet is exceedingly well-documented and quantified:

"Many studies have shown that a team approach to diabetic foot conditions is effective in amputation prevention. Zyed et al reported results of a retrospective analysis of 312 patients with diabetes and critical leg ischemia and demonstrated a reduction in the amputation rate in a multidisciplinary setting. The team was composed of a vascular and podiatric surgeon, dietary specialists, tissue viability nurse, interventional radiologist and radiology coordinator."

"A prospective study of US population showed that podiatric surgery-vascular surgery collaboration resulted in 83% limb salvage at five years."

"Prevention and prophylactic foot care has been advocated to decrease patient morbidity, the utilization of expensive resources, as well as the risk for amputation (Pinzur et al., 2005). These interventions that include the identification of risk factors, patient education, and intensive podiatric care (Moreland et al 2004; Singh et al 2005) have been shown to be cost-effective or even cost-saving".[14]

SUMMARY OF THOMSON REUTERS STUDY

- Single Podiatrist Visit per patient generates $3.5 billion in US health-care savings per year.
- The study compared health and risk factors for those who had seen a podiatrist for care to those who had not over the three year study period
- The commercial insurance group saved, on average, $19,696 per patient over a three –year time period. The Medical group saved, on average, $4,271 per patient over the same three years.
- Conservatively projected, these per-patient numbers support an estimated $10.5 billion in savings over three years (3.5 billion a year)
- Including podiatrists in the diabetes management team has proven to be a vital step in preventing ulcers and amputation.

An article in Diabetes Care[15] studied results of cutting podiatric services from Medicaid in several States, and concluded:

"*In Arizona's Medicaid, the volume of admissions with DFUs has climbed to their highest recorded level; the development appears to be at least temporally related to the elimination of low-cost preventive services provided by podiatric physicians.*"

Figure 9, from the same article, illustrates what happens when podiatric services are delisted.

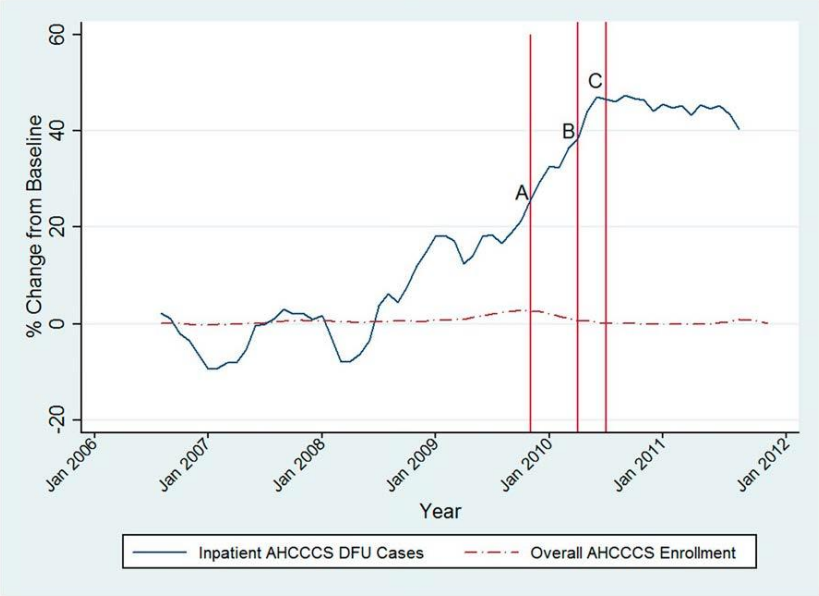


Figure 9: Unadjusted, overall DFU hospitalizations among AHCCCS beneficiaries (6-month moving average). Time point A: Announced recommendation to eliminate reimbursements to podiatrists within AHCCCS; Arizona 49th Legislature SB1003 and HB2003 (October 2009). Time point B: Arizona 49th Legislature SB1003 and HB2003 legislation signed (March 2010). Time point C: Official date of podiatric service coverage elimination (June 2010)

Bridging and podiatric educational programs

In its report to the Minister, HPRAC was critical of what it perceived as a lack of specificity and detail in the College's submissions pertaining to the bridging programs for grand-parented registrants and the lack of specificity about what a podiatry program would look like and where it would be offered. Once again, the College feels this criticism is misplaced. The College specifically asked HPRAC how far HPRAC expected the College to go down these particular avenues. The Chair of HPRAC (Mr. Corcoran) indicated that it would be "up to others" to determine what educational infrastructure would be required to address whatever scope of practice expansion was determined by the Minister, the government and eventually the Legislature. The College was also aware that HPRAC had received a submission from and had consultations with the Michener Institute. Finally, the College explained in its submissions to HPRAC that it is difficult to engage in meaningful discussions with any educational institution without knowing with some precision what the scope of practice of the profession is going to be and without assurances that the podiatric cap would be revoked.

The College understands that the Michener Institute of Education at UHN intends to make a submission to the Ministry in response to the HPRAC report. Nonetheless, the College has been advised by the Michener Institute of Education at UHN that:

- As confirmed by the PES Report, various cohorts of Michener graduates over the years have the competencies required to perform all of the new and expanded authorized acts proposed by

the College, with the exception of "setting or casting a fracture of a bone or a dislocation of a joint".

- The Michener Institute of Education at UHN envisions an Ontario podiatry program that satisfies the entry to practice criteria of all regulatory jurisdictions in Canada

- The Michener is prepared to offer whatever bridging and educational programs may be necessary to support and assess the competencies required for graduates to practise in whatever scope of practice is agreed to by the Minister, subject of course to Ministry approval and funding. The recent integration of Michener Institute with UHN (which occurred after completion of HPRAC's review) substantially increases the Michener's ability and capacity to do this.

- The Michener Institute is concerned about the inadequacy of the numbers of practising chiropodists to meet the foot care needs of Ontarians, particularly in Northern Ontario.

SECTION IV

CONCLUSIONS AND RECOMMENDATIONS

In the late 1970s, the assumption was made that the foot care needs of Ontarians could be satisfied by orthopedic surgeons and hospitals. Today, fewer and fewer hospitals have foot care clinics and the wait times to be served by the 30 or so orthopedic surgeons specializing in the foot and ankle persistently exceed Ministry targets. That is why, in 2006, then-Minister Smitherman (subsequently confirmed by Minister Matthews) determined that a review by HPRAC of Ontario's foot care model and the chiropody and podiatry professions was in order.

The College's original submissions to HPRAC, the preponderance of stakeholders and this submission demonstrate that the current chiropody model as it exists in Ontario does not function in patients' best interests.

While the HPRAC report itself is pervasively defective, the stakeholder comments and the extensive discussions, triggered by the HPRAC review that the College has had have enabled the College to sharpen, update and modify its proposals. The College remains 100% committed to the introduction of a podiatry model in Ontario that will be significantly better for patients.

The components of that model follow and are illustrated in Figure 10:

Figure 10: Components of current and proposed foot care models

SCOPE	CURRENT		PROPOSED*	
	CHIROPODY	PODIATRIST CLASS	PODIATRY	SPECIALTY
"Communicating a Diagnosis"		✓	✓	✓
Entire Foot (Bone Surgery)				✓
Ankle Soft Tissue & Bone Surgery				✓
Ordering & Taking X-Rays	✓ (4 yr. grads)	✓	✓	✓
Setting or Casting Fracture & Dislocations of the Foot and Ankle				✓
"Form of Energy"	✓ Electrocoagulation & Fulguration	✓ Electrocoagulation & Fulguration	✓ Add Diagnostic Ultrasound & Electromyography	✓ Add Diagnostic Ultrasound, Electromyography, MRI (for bone examination)
"Injecting a Substance"	✓	✓	✓ Remove restriction to the foot	✓ Remove restriction to the foot

*For those with demonstrated competencies

1. **Anatomical Scope of Practice:** Even though the terminology "structures affecting the foot and ankle" are used to describe the podiatry scope of practice in over 50 regulatory jurisdictions, the College has heard the concerns expressed by stakeholders and recommends that the anatomical scope of practice be restricted to the foot (forefoot, midfoot and rear foot) and the ankle.

2. **Unitary Profession:** The College appreciates the concerns expressed by many stakeholders that a single title for all members of the profession still risks creating confusion for patients, other health care practitioners making referrals to "podiatrists" and the public generally. Accordingly, the College persists with its proposal for a unitary podiatry profession and a single title "podiatry", but undertakes to use the Colleges' existing authorities under the RHPA to create a specialty for those who have demonstrated to the College that they have the competencies to perform the proposed new authorized acts and authorities. The College further proposes that, by regulation, only members of that specialty would be allowed to perform those procedures and to perform certain of the controlled acts authorized to the profession, such as casting or setting fractures, ordering or administering certain forms of energy and prescribing and administering certain drugs. Practitioners who subsequently acquire the requisite competencies to the College's satisfaction must be allowed to move from general practice podiatry into the specialty.

3. **"Communicating a Diagnosis":** The College wishes to remind the Minister that the controlled act of "communicating a diagnosis" was granted to members of the podiatrist class in 1993 and has been regulated by the College since then, without evidence of any issues or concerns. The College proposes that the controlled act be available to the entire podiatry profession, with the new Podiatry Act expressly limiting the performance of the authorized acts to diagnoses within the podiatry scope of practice. Grandparented registrants would, however, be required to demonstrate to the College that they had acquired the necessary competencies to perform the authorized act in patients' best interests, otherwise terms, conditions and limitations would apply prohibiting their performance of the controlled act. As it currently does, the College's misconduct regulations would require that practitioners authorized to "communicate a diagnosis" must have and exhibit the knowledge, skill and judgment to do so on a case-by-case basis and, for greater certainty, would expressly prohibit the communicating of diagnoses pertaining to systemic diseases. In this regard, the College notes that it has been waiting for six years for the Ministry to consider the revised Misconduct Regulation proposed by the College.

4. **"Dispensing and Selling Drugs":** A major difficulty created by the decade-long wait to commence and complete the HPRAC review is that things changed in the health care and public policy environments during the intervening years. The opioid crisis that currently faces Ontario is one of those changes. In that light, the College is no longer proposing that podiatrists (including members of the specialty) be authorized to dispense and sell drugs. As indicated earlier in this submission, the associations have undertaken to work with the pharmaceutical manufacturers and pharmacies to ensure the reasonable availability of those drugs that hitherto for have been difficult for patients to access because of their special nature and limited demand.

5. **Radiographs and "Forms of Energy":** The College points to the fact that members of the podiatrist class and chiropodists who have completed four years of instruction in chiropody have been authorized to order and take x-rays since 1984. The College persists with its recommendation that the entire profession be enabled to order and take x-rays of the foot and ankle and that individual registrants who demonstrates requisite competencies be allowed to perform the authority. Current practice is for registrants who already have this authority to own

and operate their own equipment is licensed under xRIS. The College expects this practice to continue, thereby having a positive impact on system capacity and no net impact on utilization.

The College also point the fact that the profession is currently authorized to perform the prescribed forms of energy, electrocoagulation and fulguration. For the reasons set out earlier in this Submission, the College also persists with its recommendation that the profession be granted the "forms of energy" controlled act, or be exempted from the controlled acts provision by regulation, for the purposes of ordering or administering MRIs (of bony tissues only and reserved for members of the specialty), electromyography and diagnostic ultrasound within the podiatry scope of practice.

6. **“Setting or Casting a Fracture”:** To relieve pressures on hospital emergency facilities and operating rooms, to enhance the patient experience and convenience and facilitate timely and effective treatment, the College persists in its recommendation that the controlled act of “setting or casting a fracture of a bone or dislocation of the joint in the foot” be authorized for the podiatry profession, but restricted to members of the specialty class.

7. **“Injecting a Substance Other Than In The Foot”:** For the reasons indicated earlier in this Submission, the College persists in its recommendation that the current restriction – that applies to chiropodists and members of the podiatrist class – that injections be made only into the feet be removed for members of the specialty, so that injections (e.g. anesthetic blocks and tetanus shots) can be injected as per best clinical practices.

8. **"The Podiatric Cap":** The College remains committed to revocation of the podiatric cap and will continue to work to achieve revocation until it's done. It is simply nonsensical to kill a regulated health profession by public policy, particularly a profession that caters to a growing and vulnerable demographic such as the seniors sector.

9. **"Clinic Regulation":** The College persists with its original request that the College of Podiatrists be granted statutory authority to regulate clinics in which podiatric surgery (both soft and bony tissue) is performed.

ENDNOTES

[1]"Second Consultation" Submission to HPRAC by CPSO, March 31, 2015, P2.

[2]HPRAC page 87. http://www.hprac.org/en/resources/Chiropody-report-Final-AODA- approved-2015-08-26.pdf

[3]"Second Consultation" Submission to HPRAC by CPSO, March 31, 2015, P1.

[4]"Year of Graduation from Podiatric Medical College by Practice Type", APMA, 2015.

[5]"HPRAC's jurisdictional review. Pages 65/138 - A 36. http://www.hprac.org/en/resources/Chiropody-AODA-Volume-2-English-version-with-cover-v2-3-FINAL-s.pdf

[6]Controlled Drugs and Substances Act and the Food and Drug Regulations.

[7]The College was advised by the Ministry that remuneration alternatives would be addressed by the Ministry after the Minister decided what to do as a consequence of the HPRAC review

[8]Subsection 2.1, Health Professions Procedural Code.

[9]HPRAC (vol. 1 p.8) http://www.hprac.org/en/resources/Chiropody-report-Final-AODA-approved-2015-08-26.pdf

[10]Truth and Reconciliation Commission of Canada, Winnipeg, Manitoba 2015. Web, page 108

[11]http://guidelines.diabetes.ca/browse/chapter38.

[12]Rapid Response Report, November 6, 2013

[13]COCOO Survey of Registrants April 17, 2017

[14]Wu, Stephanie, C, et al. "Foot ulcers in the diabetic patient, prevention and treatment", Vascular Health Risk Management, February, 2007, Page 2/14.

[15]Foot-in-Wallet Disease: Tripped Up by “Cost-saving” reductions Volume 37, September 2014