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

Re: Review of the Chiropody and Podiatry Professions

Enclosed please find:

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

We have provided both in hard copy and electronic formats.

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

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

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

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

These remain our objectives.

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

Yours sincerely,

Peter Stavropoulos, DCh, DPM,
President
REVIEW
of the Chiropody and Podiatry Professions

Application to the
Health Professions Regulatory Advisory Council

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

Submitted by
The College of Chiropodists of Ontario

November 28, 2014
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GLOSSARY OF TERMS

"APPLICANT" means the College of Chiropodists of Ontario.

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

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

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

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

"COLLEGE" means the College of Chiropodists of Ontario.

"DCh" means "Diploma in Chiropody"

“DSc” means “Doctor of Surgical Chiropody”

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

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

"OSC" means the Ontario Society of Chiropodists, a voluntary professional association for chiropodists registered to practise in Ontario.
FORWARD

History of the Chiropody & Podiatry Professions in Canada and Ontario

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

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

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

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

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

¹ Kippen, David; foottalk.blogspot.ca/2008/12/potted-history-of-podiatry/HTML.
³ The National Association of Podiatry, subsequently was renamed the American Podiatry Association and is now the American Podiatric Medical Association.
degree in the sciences as a prerequisite to entry. One of the distinguishing characteristics of the US podiatry education programs was their incorporation of the "medical teaching model" and their affiliation or association with medical schools. This transition was completed by all the US podiatry programs by the early 1970s when all graduates of US podiatry programs received the DPM degree. Hence, the podiatry model of footcare was and is often referred to as the "DPM model".

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

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

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

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

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

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

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

- Chiropodists and diploma or first-degree trained podiatrists diagnose diseases, deformities and injuries of the human foot and treat patients using braces, casts, shields, orthotic devices, physical therapy and subcutaneous soft-tissue foot surgery."  

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

"Doctors of Podiatric Medicine (DPM)"

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

- A medical residency is required in Alberta and British Columbia.

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

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

Chiropodists and podiatrists

• A three-year diploma program in chiropody (DCh) obtained in Canada 
or
  A first-degree program in podiatric medicine (D.Pod.M.) obtained abroad (United Kingdom) is usually required.

• A licence (sic) is required in New Brunswick, Québec, Ontario, Manitoba, Saskatchewan, Alberta and British Columbia”.10

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

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

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

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

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

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

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

Titles and Scopes of Practice

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


Regulation of the Profession and Changing Scopes in Ontario

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

That strategy achieved success in 1944. The Chiropody Act, 1944 came into force and effect and chiropodists began to be regulated by the Board of Regents, Chiropody. In 1950 and 1955 the Board of Regents amended its registration requirements to require a DSc degree as a condition of registration. This resulted in the exclusion of nearly every British-trained chiropodist. In retrospect, the strategy that resulted in the Chiropody Act, 1944 focused too much on obtaining a separate Act and too little on putting in place a scope of practice that reflected practitioners’ competencies and health system needs.

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Accordingly, the *Chiropody Act* and subsequent amendments continued to reflect the UK chiropody scope of practice.

This exclusion of most British practitioners, combined with a limited scope of practice and the absence of any education program in Ontario meant that the number of chiropodists remained low in Ontario from the 1940s onward. Throughout the 1950s there were never more than 67 registered chiropodists in Ontario, increasing to only 69 by 1969. The resultant ratio of practitioners to population was 1:100,000 versus 1:30,000 in the United States and 1:20,000 in the United Kingdom.

In 1966, the Government of Ontario commissioned the Committee on the Healing Arts (CHA) and in 1972 and 1973 the Ontario Council of Health (OCH) issued sequential reports on chiropody. Both the CHA and the OCH recommended a chiropody model of footcare delivery based on the scope of practice and training for chiropodists in the UK. The Report of the Committee on the Healing Arts stated that “the Committee regards chiropody primarily as the British regard it, as supplementary to medicine.” Furthermore the Committee recommended that a course in chiropody, similar to the training programs for British chiropodists, be set up in Ontario at a College of Applied Arts and Technology or equivalent and be no longer than three years. The Committee also recommended that anyone trained to the level of a British practitioner be allowed to practise in Ontario to augment the number of existing practitioners. Additionally, the Committee recommended that chiropodists’ scope of practice not include surgery involving subcutaneous tissue, although it noted that the Courts had twice ruled such surgery to be within the existing chiropody scope of practice. Similarly the Committee recommended that nothing beyond local anesthetics and no drugs be authorized for administration by chiropodists.

*The Report of the Ontario Council of Health Task Force on Chiropody (1972)* took largely the same tack as the CHA with some minor variations and additional recommendations. The CHA and the Report of the OCH shared the same views on surgery, anaesthetics and drugs, with the notable exception by the OCH that chiropodists be allowed to use keratolytic agents, fungicides and antibiotics. Additionally, the OCH recommended chiropodists work with physicians and other health personnel and that hospitals, community health centres and other health delivery institutions be encouraged to include chiropodists in their health teams. Both the OCH and the CHA agreed that chiropodists should be licensed practitioners.

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In 1980, the Ontario government announced the introduction of a chiropody model adopted from the chiropody model that existed in the United Kingdom at the time. The intention was for chiropodists to be located in hospitals and other community health facilities as salaried employees. The Ministry of Health took a very active role in promoting the profession by funding new chiropody clinics in hospitals across the province, particularly in areas of the province that were underserviced in footcare. The objective was to achieve a provider-to population ratio of 1:30,000 and equitable province-wide coverage.

Another objective was also to have practitioners trained in Ontario and to that end the Ministry funded a chiropody education program. British-trained chiropodists were recruited initially to augment the number of “podiatrists”, as were Ontario nurses who had completed additional training in footcare.

In March, 1980 the Ontario government introduced a Bill (Bill 167, “The Chiropody Amendment Act”) to make two amendments to the Chiropody Act, 1944. Those amendments were represented as bringing the Chiropody Act into line with the Health Disciplines Act that governed a number of other healthcare professions. The amendments increased lay representation on the Board of Regents and authorized the Lieutenant Governor in Council to make regulations under the Act. At the same time the government announced that "podiatrists" (sic) practising in Ontario, as well as Ontario residents training in podiatry in the United States who return to Ontario to practise, would continue to be covered by OHIP.24 It is noteworthy that the Legislature was presented with a clear choice at the time. The Liberal Opposition had already brought forward a private member's Bill (Bill 149) proposing amendments to the Health Disciplines Act to adopt a US style podiatry model and to bring the regulation of podiatrists under the Health Disciplines Act. Bill 149 died on the Order Paper after passage of Bill 167.

The historical record indicates the decision to adopt a chiropody model in 1980 came about for several reasons:

- There weren't enough chiropodists/podiatrists to satisfy the demand for footcare in Ontario. In 1980, there were no more than 75 podiatrists/chiropodists practising in Ontario and large areas of the province were underserviced or had no service at all. On this point, the Parliamentary Assistant to the Minister of Minister of Health (Mr. Turner) said during the debate on Bill 167:

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"Podiatrists have delivered a service that is obviously well received by recipients in the province. The simple fact is there are just not enough of them."²⁵

- There wasn’t an educational program for podiatrists in Canada and no likelihood of one being established in the foreseeable future.

- There were sufficient numbers of physicians and orthopedic surgeons to address the demand for all but routine footcare. As the Minister of Health (Mr. Timbrell) said at the time: "The significant difference between chiropody and podiatry is that the latter includes surgical procedures. In Ontario there are considered to be sufficient surgeons, particularly orthopedic surgeons, to provide surgical management of foot disorders."²⁶

- The UK chiropody model fit better with Ontario's healthcare delivery paradigm of the time, which was hospital and physician-centric.

There have been suggestions that in 1980 the Ontario government aimed to wind-down the podiatry profession. The documentary history does not support that suggestion. In response to an accusation to that effect from a member of the Opposition, the Parliamentary Assistant to the Minister of Health stated: "I want to assure the members there is no plot on behalf of this ministry or the government to terminate the services of podiatrists."²⁷

**The Education Program**

To achieve the government's objective of having chiropodists trained in Ontario, a chiropody program encompassing six semesters over a two-year period was set up and funded by the Ministry of Health at George Brown College. Graduates received a Diploma in Chiropody/DCh. The program was subsequently expanded to seven semesters over three years, with the first intake of "three-year" students in 1986 and the first graduation of "three-year DChs" occurring in 1989. From 1980 to 1989, the Diploma was issued by George Brown. From 1989 to 1996, the Diploma was issued jointly by George Brown and the Michener. From 1997 onwards the Diploma was issued by the Michener.²⁸


²⁶ “Foot-Care Services”. 13 March, 1980.


²⁸ The Michener Institute provided this historical information. In its submission to HPRAC as part of the consultation on Ontario's current footcare model, The Michener claimed that it took over the program in 2003, but that is clearly incorrect.
program were provided from time-to-time at Toronto General Hospital and elsewhere. There were also at least two "gap" years over the last three decades as part of the program's restructuring, wherein there was no intake of new students.

The chiropody education program has gone through a number of iterations over the last three decades and is now characterized as an Advanced Diploma of Health Sciences (Chiropody), is delivered in seven semesters over three years and requires an undergraduate degree for admission. Among current registrants of the College, 64 are graduates of the George Brown two-year program; 87 are graduates of the George Brown three-year program; and 172 are graduates of some combination of the George Brown and Michener three-year programs from 1989 onwards. The chiropody program at the Michener remains the only chiropody educational program offered in North America and one of the very few diploma-level chiropody programs left in the world.

**The Health Professions Legislation Review (HPLR)**

The Health Professions Legislation Review was commissioned in 1983 as an independent review of the regulation of Ontario's healthcare professions and the appropriate regulatory framework. In the matter of the chiropody and podiatry professions, the Review essentially accepted the Ministry's recent decision to adopt the UK chiropody model. On April 30, 1986 the Minister of Health (Mr. Elston) indicated that eight professions, including chiropodists and podiatrists, would be clustered or jointly regulated under one governing body. The professions thus grouped were to share a common governing council under a single professional act. The Minister provided several reasons for this "clustering", but did not indicate which applied to chiropody and podiatry, although the persistent, small size of the podiatry profession was probably a major factor.

Late in its work, the Review recommended the recognition of podiatrists as a class of members within the chiropody profession with additional authorized acts. The Review did so in order to acknowledge and utilize the additional competencies that currently-practising podiatrists possessed. This "bifurcation" was resisted by the Board of Regents, Chiropody, but was ultimately entrenched in the **Chiropody Act, 1991**.

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Under the *Chiropody Act, 1991*, chiropodists registered with the Board of Regents who had graduated with a US DSc or DPM were grand-parented into the podiatrist class of members. Members of the podiatrist class have the same legislated scope of practice as chiropodists, but have additional authorized acts namely "communicating a diagnosis" and performing surgery on the bones of the forefoot. Podiatrists also have access to a few drugs in addition to those authorized for chiropodists.

Members of the podiatrist class and any chiropodists who have graduated from a four-year chiropody education program are also authorized to order and take radiographs, to own and operate radiographic equipment and be radiation protection officers under the *Healing Arts Radiation Protection Act (HARP)*. At this time, among the chiropodist members only members of the podiatrist class and those DPM graduates who have registered in Ontario as chiropodists have registered under HARP.

The College had a total of 637 in-province registrants at the conclusion of 2013; 568 chiropodists, including a number of who have DPM degrees; and 69 members of the podiatrist class. In addition the College has received 23 requests for applications to apply to the College and register from DPM graduates.
### The Ontario-Wide Distribution of Chiropodists and Podiatrists:

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<td>9</td>
<td>0</td>
</tr>
</tbody>
</table>

*Figure 3. The Distribution of Chiropodists and Podiatrists by 14 LHIN.*

Notes:
1. Does not include registrants with out-of-province address.
2. Chiropodists who do not have an address on file with the College.
The “Podiatric Cap”

Subsection 3. (2) of the *Chiropody Act, 1991* reads as follows:

"No person shall be added to the class of members called podiatrists after the 31st day of July, 1993."

This prohibition against the registration of new members of a regulated profession is unique and unprecedented in Ontario. The Minister's referral letter has asked HPRAC to conduct "an analysis of... whether the existing limitations on the podiatrist class of members should continue."31

The podiatric cap originates from the Ontario government’s decision in the late 1970s to adopt the UK chiropody model. Until 1993, however, the Board of Regents, Chiropody continued to register US-trained podiatrists to practise in Ontario and the Ministry of Health continued to issue OHIP registrations to them. US-trained podiatrists were also registered by the Ministry during this period to operate radiographic equipment and order x-rays under the *Healing Arts Radiation Protection Act* and were appointed as Radiation Protection Officers.

The Health Professions Legislation Review endorsed the implementation of the podiatric cap through legislation. Its official reason for doing so was that the podiatry profession had failed to fulfill the four criteria set by the HPLR to justify independent regulation under the new regulatory framework. The absence of an educational facility in Ontario also appeared to be a major consideration behind the cap. Podiatrists in Ontario had also developed something of an antagonistic relationship with physicians and had positioned podiatry as an alternative to mainstream medicine, while chiropody had positioned itself as being complementary to mainstream medicine. One explanation for the podiatric cap, therefore, was that those professions that directly challenged the medical monopoly were less likely to succeed with regulation than those who positioned themselves as complementing it.32

In the workup to the *Regulated Health Professions Act* and the *Chiropody Act, 1991*, the Board of Regents and the chiropody profession advocated for a prohibition against the registration of US-trained podiatrists, who were the real target of the prohibition against the registration of new "podiatrists".33 34


17
Because of free trade obligations, a prohibition against US-trained podiatrists alone would almost certainly have been challenged as discriminatory treatment. Accordingly, the government decided to put a universal prohibition in place effective July 31, 1993 against the registration of any new members of the podiatrist class.

The College of Chiropodists believes it self-evident that the podiatric cap must disappear with the move to a North American podiatric model. The Ontario Society of Chiropodists, the Ontario Podiatric Medical Association, the Canadian Federation of Podiatric Medicine and the Canadian Podiatric Medical Association are all in agreement. No current College registrant has expressed opposition to removal of the cap. During the stakeholder consultations, no stakeholder has expressed opposition to removal of the podiatric cap. In fact, a number of stakeholders found the cap peculiar and counterintuitive in an environment of increasing scarcity of healthcare practitioners.

The cap has been the most obvious impediment to the natural evolution of the chiropody profession in Ontario in response to health system changes and health system demands. While other jurisdictions have evolved to a podiatry model, Ontario persists with a model of footcare delivery and regulation that was adopted in the late 1970s and has evolved in most comparable jurisdictions.

The cap is the only reason that a Mutual Recognition Agreement for chiropody and podiatry under the Agreement on Internal Trade has not been agreed to amongst the Canadian provinces and territories. Chiropody/podiatry is the only RHPA profession that does not have an interprovincial/territorial MRA in place and the only obstacle to doing so has been the cap. The cap is the principal reason that podiatrists are not recognized with other healthcare professions for purposes of mutual recognition under Chapter 16 (Appendix 1603 .D1) of the North American Free Trade Agreement (NAFTA) (See Part II, General Duty). The cap is also in conflict with the spirit, if not the letter, of the Fair Access to Regulated Professions Act.

As such, the existence of the cap has substantially complicated College operations, because the College has no option but to deny applications for registration as podiatrists from Ontario residents who are graduates of DPM programs in Québec and the United States and from podiatrists from other provinces and from foreign jurisdictions.

More importantly, in the College's view, the cap neither serves nor protects the public interest. Despite the growing gap between the demand for the footcare services provided by podiatrists, the supply of podiatrists cannot be increased. The most highly-qualified group of podiatrists in Ontario must practise as chiropodists and within the limited chiropody authorized acts (See Case Study 1). The waste or

misapplication of these competencies is difficult to justify, particularly in the current environment where the demand for footcare far outstrips the supply.

Case Study of an American trained DPM Practicing in Ontario

James Hill holds a B.Sc. in Biology from Wayne State University and a Doctor of Podiatric Medicine/DPM degree from the Dr. William M Scholl College of Podiatric Medicine in Chicago, Illinois. From 1996 to 1998 he completed a podiatric surgical residency in the medical and surgical treatment of the foot, rear foot and ankle, including diabetic limb salvage and trauma at the Columbia North Houston Medical Center in Houston Texas. He is a fellow of the American College of Foot and Ankle Surgeons and is Board certified by the American Board of Podiatric Surgery (ABPS) in Foot Surgery. James is also Board certified by the ABPS in Reconstructive Rearfoot and Ankle Surgery.

He is licensed as a podiatric physician and surgeon in Michigan. Several days a week he performs complex surgical procedures on the foot and ankle at the Oakwood Southshore Medical Center, the Henry Ford Wyandotte Hospital and Beaumont Hospital in Michigan and at a community-based clinic in Troy, Michigan. Procedures he routinely performs as a licensed podiatric physician and surgeon in Michigan include surgeries for limb and life threatening diabetic foot infections, and traumatic injuries including calcaneal fractures and complex ankle fractures. He also performs elective procedures for complex forefoot, midfoot, rearfoot and ankle deformities including surgery involving diabetic Charcot reconstruction, rheumatoid forefoot reconstruction, flatfoot repair and ankle replacement.

In 1999 he was registered by the College of Chiropodists of Ontario to practise chiropody in this province where he is resident. Like approximately 20 other DPM graduates, because of the “podiatric cap” and despite his education and training, the College could not admit him to the podiatrists class of members. Accordingly, his ontario practice is restricted to the more limited chiropody authorized acts and he is unable to perform any of the podiatric procedures for which he is trained and that he performs regularly in Michigan.

The Applicant recommends the removal of the podiatric cap. In fact, achievement of the fundamental objective of this Application, namely transitioning to a podiatry model of footcare delivery and regulation, is premised on the removal of the podiatric cap.

Overview of the Recommendations by the College

As will be articulated in greater depth and detail in this Application, the College is recommending an adaptation of the North American podiatry model of care and regulation to better reflect Ontario’s present healthcare delivery paradigm, the government’s stated policy objectives and to implement a model that will better address the public interest by closing the gap between the demand for advanced footcare and the supply of competent practitioners. This gap exists primarily among seniors (who compromise about 58% of chiropodists’ and podiatrists’ patients) and among patients with chronic disease such as diabetes. There are multiple reasons for the gap. One is the increased incidence of chronic debilitating conditions of the foot and ankle associated with chronic systemic diseases such as diabetes, arthritis and cancer. Furthermore, and despite the government’s intentions in adopting a chiropody model three decades ago, orthopedic surgeons acknowledge that they cannot fill the gap for
higher-end medical care. There are no more than 25 orthopedic surgeons specializing in the foot and ankle in Ontario. According to a submission to the Ministry of Health and Long-Term Care funded by the Ontario and Canadian Orthopedic Associations, general orthopedic surgeons have stopped performing many foot and ankle surgeries and the number of foot and ankle surgeons has not increased enough to fulfill the needs of Ontario citizens.\textsuperscript{35} The same report noted that some foot and ankle specialists are reducing the number of less specialized foot and ankle surgeries they perform, in some cases because operating time is limited for such procedures.\textsuperscript{36} The report also notes that the performance of less complex foot and ankle surgeries is not an efficient use of highly-specialized orthopedic surgeons.\textsuperscript{37} Adaptation of the North American podiatry model will allow podiatrists to provide a more seamless continuum of care to patients and some components of the North American podiatry model are essential for podiatrists and chiropodists to provide safe and effective care and the highest and best standards of care in the CURRENT scope of practice.

"Wait times data clearly demonstrates that the volumes of patients being treated within the health care system at the present time is not managing the surgical need for forefoot or ankle surgery within the province of Ontario. As many patients are currently unable to access care within the health care system the absolute volume of surgeries required is not known"

- (Daniels et al, 2009.20).

Chiropody’s evolution, coupled with changes in the healthcare delivery system, has already taken the practice of the profession towards the North American podiatry model. For example, whereas the government anticipated that chiropodists would practise primarily in hospitals, CHCs and public health units, in 2012 less than 20\% of registrants reported that they practised full or part-time in a hospital or in an analogous healthcare delivery institution. The education programs at the Michener have gone through a series of enhancements and have equipped chiropodists with competencies far in excess of those required for the chiropody scope of practice and authorized acts.

One of the reasons the government of the day may have had for the "clustering" of podiatrists with the chiropody profession as a class of members was to "avoid public confusion".\textsuperscript{38} If that in fact was an objective, it has clearly failed. Few members of the public -- and not many more members of other healthcare professions --understand what a chiropodist is or does. Nor do they understand the differences between chiropodists and podiatrists. Because of international adoption of the podiatry

\textsuperscript{35} Daniels, Dr. T, et al. “Proposal for the Development of a Provincial Foot and Ankle Program”. Ontario Orthopaedic Association and the Canadian Orthopaedic Association, May 2009. 9
\textsuperscript{37} “Proposal for the Development of a Provincial Foot and Ankle Program”. May 2009. 11.
\textsuperscript{38} “Striking a New Balance: a Blueprint for the Regulation of Ontario’s Health Professions”. 1989. 11.
nomenclature, in particular the close proximity to the US, the recognition of podiatry and the podiatry profession is substantially higher.

The adoption of a North American podiatry model will also allow practitioners, both chiropodists and podiatrists, to practise to the full extent of the competencies they have acquired. The conversion to a podiatry model is also consistent with practices elsewhere in Canada - namely British Columbia and Alberta - and in many comparable foreign jurisdictions.

This is not to say that the government's decision in 1980 to adopt the UK chiropody model was ill-advised. It is simply that Ontario's healthcare delivery paradigm and government policy have since moved in different directions. Furthermore the anachronisms and rigidities of the *Chiropody Act, 1991* have limited the professions’ and the College's ability to adapt and evolve in response to changes in healthcare policy, funding and healthcare delivery, patient demand (due largely to the growth of the seniors demographic), inter-jurisdictional labour mobility requirements and education and to promote clinical best practices and interprofessional collaboration.

The College, therefore, applied for an HPRAC scope of practice review in 2006, recommending a conversion to a podiatry model that reflects the most extensive podiatry scopes of practice now existing in Canada, namely those of British Columbia and Alberta, and adapted to Ontario's health policy, regulatory and health system frameworks. The following is the College’s submission to HPRAC, complete with supplementary documentation and materials.
College of Chiropodists’ (Applicant’s) Questionnaire

Q 1: "Does your current scope of practice accurately reflect your profession's current activities, functions, roles and responsibilities?"

Response: No. As will be explained in greater depth and detail in this Application, the history of the chiropody and podiatry professions in Ontario and the models of healthcare delivery and regulation selected by the Government of Ontario three decades ago led to regulatory and delivery models that have become seriously outdated and have resulted in a mismatch with Ontario’s present healthcare delivery paradigm, government policy, patient demand, the competencies that podiatrists and chiropodists have acquired and the venues in which chiropodists and podiatrists now practise.

The current scope and authorized acts reflect an institution-based delivery model. At that time, the vast majority of chiropodists worked in hospitals and similar institutions as salaried employees within multidisciplinary teams. Less than 20% of chiropodists work full or part-time in institutional practice today and most work as sole practitioners in private practice. The scope of practice and authorized acts from members of the podiatrist class were never designed to support, accommodate or promote the podiatry practice model, which is a non-institutional, community-based, practice model.

Q 2: “Name the profession for which a change in scope of practice is being sought, and the professional Act that would require amendment.”

Response: The chiropody and podiatry professions are currently regulated in Ontario under the Regulated Health Professions Act (RHPA) and the Chiropody Act, 1991. The College proposes the replacement of the Chiropody Act with a Podiatry Act.

This Application proposes the creation of a unitary "podiatry" profession that reflects the North American podiatry model in terms of scope of practice and practice model. The podiatry profession is currently regulated by the College of Chiropodists as a class of members of the chiropody profession. For purposes of this Application, the proposed expanded scope of practice and new or expanded authorized acts are built on the current podiatry authorized acts as stipulated in subsection 5. (2) of the Chiropody Act, 1991 and on the authorities granted to podiatrists under other legislation.

Consistent with practices in other jurisdictions and in line with the scope of practice and authorized acts herein proposed and to avoid public and interprofessional confusion, the College proposes that the chiropody profession no longer be recognized for purposes of regulation under the Regulated Health Professions Act (RHPA), although the "chiropodist" title would continue to be a protected title under the RHPA to avoid public confusion.
Q 3: "Describe the change in scope of practice being sought."

Response: The current scope of practice statement reads as follows:

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

The proposed scope of practice statement reads as follows (the changes from the current scope statement are underlined):

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

As such, the College is seeking an anatomical expansion of the scope of practice to include the ankle and structures affecting the foot or ankle and additional controlled acts to enable qualified podiatrists to provide highest and best clinical treatment within the current and within a proposed expanded continuum of care.

Q 4: “Name the College/association/group making the request, or sponsoring the proposal for change.”

Response: The Applicant is the College of Chiropodists of Ontario, established and operating under the Chiropody Act, 1991.

Q 5: "Address/website/e-mail."

Response:
College of Chiropodists of Ontario
180 Dundas Street West, Suite 2102
Toronto, Ontario
M5G 1Z8
General’s Email - slefkowitz@cocoo.on.ca
Registrar’s Email – Fsmith@cocoo.on.ca

Q 6: "Telephone and fax numbers."

Response: (416) 542-1333 or Toll Free in Ontario at 1-877-232-7653. Fax: (416) 542-1666
Q 7: “Contact person (including day telephone numbers).”

Response: Don Gracey: dgracey@cggroup.com; 905-946-1515 extension 227.

Q 8: “List other professions, organizations or individuals who could provide relevant information with respect to the requested change scope of practice of your profession.

Response: The College prepared a list of identifiable stakeholders, including those organizations and colleges whose members’ scopes of practice and authorized acts would overlap with those being proposed by the College. The College also identified other stakeholders that could be expected to have an interest in this review. That list grew incrementally as the stakeholder consultations proceeded.

Dear 
As you may know, the Health Professions Regulatory Advisory Council (HPRAC) is scheduled to at least begin a review of the chiropody and podiatry professions this year. Specifically, the Minister has asked HPRAC “to review issues relating to the regulation of chiropody and podiatry and provide advice as to whether and how there should be changes to existing legislation regarding these related professions” and analyze “the current model of foot care in Ontario, issues regardong restricted titles, and whether the existing limitations on the podiatrist class of members should continue.”

The College of Chiropodists of Ontario will recommend to HPRAC that Ontario adopt a podiatry model of footcare, coincident with trends in other jurisdictions and to better address the growing and increasingly unmet demand for footcare across Ontario, particularly by seniors, diabetics and other populations. The scope of practice and new or expanded authorized acts that will be proposed by the College are attached to this letter. Additional information, including the College’s original letter to the Minister requesting the HPRAC review, is available through the College’s website at [URL].

We anticipate that [Name of Organization] will wish to be kept advised and consulted during the HPRAC process and may wish to be directly engaged in the HPRAC review itself. Accordingly, we would appreciate the opportunity to meet with you at your earliest opportunity to discuss the College’s position and to hear whatever comments and suggestions you would like to offer.

We will follow up with your office shortly.

Yours sincerely,

Figure 4. Template of the Stakeholder Letter sent to all Stakeholders
In February, 2013 the College began to send letters to the identified stakeholders informing them of the anticipated HPRAC review and what the College intends to recommend to HPRAC for purposes of the review. Each stakeholder was also offered the opportunity to be fully briefed by the College and was sent a letter to inform them of their opportunity to participate (See Figure 5 below).

The list below identifies those stakeholders who were contacted as well as those who expressed an interest in having a briefing and when such briefings occurred (Stakeholder Contact Information has been provided to HPRAC separately by letter.)

<table>
<thead>
<tr>
<th>Stakeholders – Current as of January 28 2014</th>
<th>Letters Sent (Y/N)</th>
<th>Response Received (Y/N)</th>
<th>Interest Expressed (Y/N)</th>
<th>Meeting Arranged (Date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ontario Society of Chiropodists (OSC)</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Multiple, ongoing meetings</td>
</tr>
<tr>
<td>Ontario Podiatric Medical Association (OPMA)</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>2013/11/21</td>
</tr>
<tr>
<td>Canadian Association of Foot Care Nurses</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>“I did forward your email request to the provincial advisor for Ontario and after further reflection realize that CAFCN although a nursing footcare association may not be your best source at this point in time. We are hopeful that CNO, RNAO or RPNAO might be able to assist in education and scope of practice questions.” -Pat MacDonald</td>
</tr>
<tr>
<td>Canadian Federation of Podiatric Medicine (CFPM)</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>2013/05/24 -14:00</td>
</tr>
<tr>
<td>Canadian Podiatric Medical Association (CPMA)</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>2013/05/24 –15:30</td>
</tr>
<tr>
<td>American Podiatric Medical Association (APMA)</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>2013/05/07</td>
</tr>
<tr>
<td>American Association of Colleges of Podiatric Medicine (AACPMAS)</td>
<td>Y</td>
<td>N</td>
<td></td>
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<tr>
<td>Council on Podiatric Medical Education (CPME)</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>2013/05/07</td>
</tr>
<tr>
<td>The College of Physicians and Surgeons of Ontario (CPSO)</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>2013/06/20 -10am</td>
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<tr>
<td>College of Medical Laboratory Technologists (CMLTO)*</td>
<td>Y</td>
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<td>N</td>
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<tr>
<td>Ontario Medical Association (OMA)</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>2013/04/11</td>
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</table>
There has been continuous follow-up with the OMA

<table>
<thead>
<tr>
<th>Organization</th>
<th>Y</th>
<th>Y</th>
<th>Y</th>
<th>Date/Details</th>
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<tr>
<td>Ontario Chiropractic Association (OCA)</td>
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<td></td>
<td>2013/06/13 – Teleconference + follow-ups.</td>
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<tr>
<td>The College of Kinesiologists of Ontario</td>
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<td></td>
<td>Y</td>
<td>2014/04/15 + follow-ups</td>
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<tr>
<td>The College of Family Physicians of Canada (CFPC)</td>
<td></td>
<td>Y</td>
<td>N</td>
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<tr>
<td>Ontario College of Pharmacists (OCP)</td>
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<td>Y</td>
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<tr>
<td>College of Physiotherapists of Ontario</td>
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<tr>
<td>Ontario Physiotherapy Association (OPA)*</td>
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<tr>
<td>College of Nurses of Ontario (CNO)</td>
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<td>N</td>
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<td>Registered Nurses’ Association of Ontario (RNAO)</td>
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<td>Y</td>
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<tr>
<td>Registered Practical Nurses’ Association of Ontario (RPNAO)</td>
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<td>Y</td>
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<td>Ontario Orthopedic Association (OOA)</td>
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<td>College of Optometrists</td>
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<td>N</td>
<td></td>
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<tr>
<td>LHINC Council (LHIN Collaborative)</td>
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<td>Y</td>
<td>N</td>
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<tr>
<td>Ontario Association of Community Care Access Centres (OACCAC)</td>
<td></td>
<td>Y</td>
<td>N</td>
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<tr>
<td>Ontario Association of Non-Profit Homes &amp; Services for Seniors (OANHSS)*</td>
<td></td>
<td>Y</td>
<td>Y</td>
<td>2013/03/27 + follow-ups</td>
</tr>
<tr>
<td>Ontario Long-Term Care Association (OLTCA)</td>
<td></td>
<td>Y</td>
<td>Y</td>
<td>2014/07/08</td>
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</table>

The meeting was not viewed as a consultation but a one-way briefing in which information was provided to them. They gave no comments or feedback. The Association has not responded to subsequent contacts by the College.
Ontario Hospital Association (OHA) | Y | N
Ontario Retirement Communities Association (ORCA) | Y | Y | N
Canadian Association of Retired Persons (CARP) | Y | Y | N
Ontario Retirement Communities Association (ORCA) | Y | Y | N
Canadian Association of Retired Persons (CARP) | Y | Y | N

“Although we will not be involved directly, it would be great to see the end results of your efforts. We wish you all the best.”

–Sarah Park

Ontario Retirement Communities Association (ORCA)

Ontario Society of Senior Citizens’ Organizations (OSCO) | Y | N

Canadian Life and Health Insurance Association (CLHIA) | Y | Y | Y

Workplace Safety and Insurance Board (WSIB) | Y | Y | N

The Michener Institute for Applied Health Sciences | Y | Y | Y

June 21, 2013 + follow-ups

Q 9: "What are the exact changes that you propose to the profession's scope of practice (scope of practice statement, controlled acts, title protection, harm clause, regulations, exemptions or exceptions that may apply the profession, standards of practice, guidelines, policies and bylaws developed by the College, other legislation that may apply the profession and other relevant matters)? How are these proposed changes related to the profession and its current scope of practice?"

Response: The College is proposing the creation of a unitary podiatry profession in Ontario with a scope of practice and authorized acts that reflect the podiatry scopes of practice in British Columbia, Alberta and in other comparable jurisdictions; and that are adapted to Ontario's healthcare policy, regulatory and healthcare delivery frameworks. The current College of Chiropodists of Ontario would be replaced by a College of Podiatrists of Ontario. As such, the College is recommending the replacement or wholesale revision of the Chiropody Act, 1991, the regulations thereunder, plus all College policies, guidelines and By-Laws that are currently in force and effect, plus coincidental amendments to other statutes and regulations.

Protected Titles: Continuation of statutory protection for the titles "Podiatrist" and "Chiropodist", variations or abbreviations thereof, or equivalents in another language. In addition, statutory protection of the two titles (as per current practice in comparable jurisdictions):
"Podiatric Surgeon", a variation or abbreviation thereof, or an equivalent in another language.

"Foot Surgeon", a variation or abbreviation thereof, or an equivalent in another language.

**Inter-jurisdictional Comparison:** In Alberta, the protected titles for the podiatry profession are: a) "podiatrist"; (b) "podiatric medical practitioner"; (c) "podiatric surgeon"; (d) "podiatric orthopedist"; (e) "podiatric physician"; (f) "doctor of podiatric medicine"; (g) "doctor"; (h) "DPM"; and (i) "Dr". 39 In British Columbia, the protected titles for the podiatry profession are: (a) "podiatrist"; (b) "podiatric surgeon"; (c) "surgeon"; and (d) "doctor". 40 "Podiatric Surgeon" is a protected title in most US states and in jurisdictions such as the UK and Australia.

**Proposed Scope of Practice for the Podiatry Act:** "The practice of podiatry is the assessment or diagnosis of the foot and ankle and the treatment and prevention of diseases, disorders or dysfunctions of the foot, ankle and structures affecting the foot or ankle by therapeutic, orthotic or palliative means" (Additions to the current scope of practice statement are underlined for ease of reference).

**Proposed New or Expanded Authorized Acts for the Podiatry Act:**

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

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

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

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

5. Applying or ordering the application of a prescribed form of energy (Not currently authorized for either chiropodists or podiatrists).


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

**Proposed New or Expanded Authorities Under Other Acts:**

7. Order prescribed laboratory tests (Not currently authorized for either chiropodists or podiatrists) under the *Laboratory and Specimen Collection Center Licensing Act and Regulation 682 thereunder* and the *Medical Laboratory Technology Act and regulations*.

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

**General Regulation 203/94:** Major revisions are required to this Regulation in order to remove references to "members of the podiatrist class", "podiatry class", "chiropody class" and "chiropodist" in order to implement and reflect a unitary podiatry profession.

Additional revisions to other regulations will be required to reflect the new scope of practice statement and the new and expanded authorized acts.

The College also proposes changes to the list of drugs that may be prescribed and administered by podiatrists and the competencies required to do so in order to support several of the new and expanded authorized acts and also to reflect the New Classes of Practitioners Regulations (NCPR) under the (federal) *Controlled Drugs and Substances Act* (CDSA). The NCPR includes "podiatrists" within the definition of "practitioner" for purposes of that regulation.41

**Q 10:** "How does current legislation (profession-specific and/or other) prevent or limit members of the profession from performing to the full extent of the proposed scope of practice?"

**Response:** The current legislation does not allow practitioners to perform to the full extent of the proposed scope of practice. The current scope of practice also entails mismatches between what chiropodists and podiatrists are allowed and not allowed to do; for example the authority to perform a range of surgical procedures, but an inability to order laboratory tests to ensure those surgical procedures and the follow-up can be conducted safely. Furthermore, the current legislation does not

41 Note: for purposes of the NCPR, “podiatrist” is defined as “a person who is registered and entitled under the laws of a province to practise chiropody or podiatry and who is practising chiropody or podiatry in that province”, SOR/2012-230. Web: <http://laws-lois.justice.gc.ca/eng/regulations/SOR-2012-230/page-1.html>.
allow many chiropodists and podiatrists to practise to the full extent of their acknowledged competencies. The competency of podiatrists to perform the proposed authorized acts has been amply demonstrated in other jurisdictions.

To begin with, the current scope of practice and authorized acts do not include the ankle and are limited to the foot for purposes of diagnosis, assessment, treatment and the performance of procedures such as injecting substances and ordering or taking radiographs. In the case of bone surgery, the current legislation limits podiatrists to the bones of the forefoot (i.e. the metatarsals and the phalanges of the toes).

More specifically, with respect to the individual proposed authorized acts (the proposed expansions of current authorized acts are underlined):

“Communicating a diagnosis identifying a disease or disorder of the foot or ankle as the cause of a person's symptoms”:

Members of the podiatrist class may currently communicate a diagnosis identifying a disease or disorder of the foot as the cause of a person's symptoms.

It has long been acknowledged and documented that the selection of those professions authorized to "communicate a diagnosis" under the RHPA was arbitrary. Since then, a number of additional professions, such as physiotherapy, nurse practitioners and naturopathy, have been granted the controlled act within their respective scopes of practice.

Notwithstanding their competencies to do so, no chiropodist is authorized to perform the "communicating a diagnosis" controlled act, despite chiropodists' authority to perform surgical procedures below the dermis. The Ministry of Health and Long-Term Care maintains that chiropodists may formulate a diagnosis, but may not communicate that diagnosis to a patient or to the patient's representative. It is anomalous for any profession that is authorized to perform surgical procedures and to prescribe drugs not to be able to communicate a diagnosis to patients explaining the disease or disorder that the surgery or drugs are designed to address and to obtain informed consent to treatment. Extended health benefits insurers and other practitioners routinely ask chiropodists to provide a diagnosis of their patients, which they are technically not authorized to provide. It is particularly anomalous for DPM graduates who are limited to the chiropody authorized acts not to be able to communicate a diagnosis in Ontario when they are obviously as competent as members of the podiatrist class to do so and are authorized to do so when practising in other jurisdictions.
Inter-jurisdictional comparison: "Communicating a diagnosis" as defined by the RHPA is not a restricted act in either British Colombia or Alberta. In both provinces, the scope of practice for podiatry includes the ankle.42 43

According to a survey conducted by the Applicant during the summer of 2013, 98% of registrants intend to perform this controlled act and 82% believe they already have the competencies to do so.

2. "Performing a procedure on tissues below the dermis to treat conditions of the ankle or foot":

Both chiropodists and podiatrists are currently authorized to perform the authorized act of “cutting into subcutaneous tissues of the foot”. Podiatrists are authorized to cut into “subcutaneous tissues of the foot and bony tissue of the fore foot.” The addition of the reference to the "ankle" is consistent with practice in comparable jurisdictions (i.e. 48 US States and the District of Colombia, Alberta and British Columbia) and is recommended in order to acknowledge the interconnectedness between the ankle and the foot and to reflect the expanded anatomical boundaries of the proposed scope of practice for all appropriately-qualified practitioners to perform bone surgery on the foot and ankle.

Inter-jurisdictional comparison: In British Columbia, Alberta, in 48 states, plus the District of Colombia and in several European countries podiatrists are authorized to perform surgical procedures on subcutaneous tissues of the ankle and foot (i.e. both soft and bony tissue).44 45 "Podiatric surgeons" in the United Kingdom and Australia are also authorized to perform surgical procedures on the foot and ankle.

According to a survey conducted by the Applicant during the summer of 2013, 63% of registrants already perform or intend to perform this controlled act and 34% believe they already have the competencies to do so.

3. "Setting or casting a fracture of the bone or dislocation of the joint, in the foot or ankle":

Currently, neither chiropodists nor podiatrists are authorized to perform this controlled act. This creates a severe impediment to performance of both the current and the proposed scopes of practice. In the current scope of practice podiatrists perform osteotomies and arthroplasties and would do so under the proposed scope of practice as well. In performing osteotomies (surgical cuts into bone) and arthroplasties (a joint remodeling surgical procedure), podiatrists surgically “fracture” bones and dislocate joints and need the companion authority to set or cast them in order to provide an appropriate continuum of care and to comply with the clinically-accepted standard of care for these procedures.

Being authorized to set and cast fractures and dislocations in the foot or ankle will enable podiatrists to treat abnormalities of bony structures in both the acute and planned surgical reconstructive settings.

The inability to "set fractures" also prohibits podiatrists from responding to emergency situations, leaving an emergency room visit the most likely alternative.

**Inter-jurisdictional comparison**: In neither British Columbia nor Alberta is this defined as a restricted act. In both provinces, setting fractures is deemed to be part of the scope of practice of podiatry.\(^{46}\)\(^{47}\)

According to a survey conducted by the Applicant during the summer of 2013, 63% of registrants intend to perform this controlled act with respect to the foot (once they acquire or demonstrate the competencies necessary to do so) and 24% believe they already have the competencies to do so.

According to a survey conducted by the Applicant during the summer of 2013, 49% of registrants intend to perform this controlled act with respect to the ankle and 15% believe they have the competencies to do so.

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**Clinical Scenario: ARTHRITIS**

A 55 year old woman with a history of "arthritis" presents to the Podiatrist's office complaining of bilateral forefoot deformity and pain. Her right foot hurts more than the left. This limits her daily activities and is diminishing her overall fitness level. She has tried a variety of pads, shoes and OTC insoles all without significant relief. Her primary care physician has prescribed Celebrex and she takes a daily 81mg ASA. She has no other medical problems or medications. She has no known drug allergies and has had no previous surgery. She does not smoke or drink alcohol other than an occasional glass of wine. Her Family History is positive for deep vein thrombosis (DVT) and subsequent pulmonary embolism (PE) which killed her mother in her fifties after a long flight to Europe.

Physical exam reveals a well-developed middle-aged woman in no apparent acute discomfort or distress. Pedal pulses are palpable. Capillary fill time is "within normal limits" (WNL). Mild diffuse non-pitting ankle edema is noted on both sides. Neurological exam is WNL with deep tendon reflexes, both Achilles and patellar 2/4 on both sides. Babinski and ankle clonus are normal. Pin prick, proprioception and vibratory sensations are normal on both lower extremities. Skin exam reveals that her skin is thin, warm and dry with hair growth present bilateral foot. Hyperkeratosis is noted at the plantar aspect of the second and fifth metatarsal heads on both feet and the dorsal aspect of the proximal interphalangeal joints of digits 2, 3, 4 and 5 bilateral foot. The lesser digits on both feet display pain on palpation, subluxation with dorsal contraction with fibular deviation. There is plantar bony prominence with pain on palpation and distal plantar fat pad atrophy at metatarsal heads one through five on both feet. Severe bunion deformity with pain on palpation and range of motion noted at the first MPJ on both feet. Hypermobility is noted at the first metatarsal cuneiform joint on both feet.

Radiographs were taken at the Podiatrist's office on the initial visit; three views weight-bearing of both feet, AP, oblique and lateral are negative for acute fracture or dislocation. Mild diffuse osteopenia is noted bilateral. There is fibular deviation and subluxation with peri-articular degenerative changes of the lesser metatarsal phalangeal joints on both feet. The lesser digits are dorsally contracted on both feet. There is an increase in the hallux abductus angle, first intermetatarsal angle and tibial sesamoid position on both feet.

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\(^{46}\) *Health Professions Act: Podiatrists Regulation*. 2011.

Clinical Scenario: ARTHRITIS Continued

This same patient returns several months later with a chronic discomfort with prolonged weight-bearing secondary to progressing deformity of both feet. She would like to discuss surgical treatment options.

CURRENT SCOPE:

A letter is written by the podiatrist/chiropodist to the patient’s primary care physician recommending surgical intervention. The patient returns to the primary physician resulting in a delay of care depending on local wait times.

PROPOSED/EXPANDED SCOPE:

The Podiatrist requests routine blood work, electrocardiogram, and urinalysis with medical clearance to be provided by her primary care physician. She discontinued taking ASA five days prior to her scheduled procedure.

Surgery is performed in the office or surgery centre by the Podiatrist utilizing sedation, local anesthetic and an ankle tourniquet. Procedures include pan-metatarsal head resection with correction of hammertoe deformity of digits 2, 3, 4 and 5 on the right foot with first MPJ fusion with internal fixation. An autograft bone graft was obtained by the Podiatrist from the right calcaneus at the same surgical sitting to be placed at the first MPJ fusion site and at the first metatarsal cuneiform fusion. The patient will be non-weight bearing in a below knee cast and crutches or a walker for 6-8 weeks. Serial x-rays to monitor healing will be provided in the Podiatrist’s office. Blood work and ancillary testing will also be provided as needed by the Podiatrist during the post-operative course of treatment.

A prescription was given for acetaminophen with codeine for management of post-operative pain. A prescription was also given for Lovenox (enoxaparin) 30mg subcutaneously by self-injection into the abdomen every 12 hours for 10 days after surgery to decrease the chance of DVT and/or subsequent PE. A referral is made to a Physiotherapist to aid in return to ambulation and assistive daily living care is ordered for at home recovery.

The patient’s past medical history, medications and allergies were reviewed as well as a complete review of systems. Her condition was evaluated and her x-rays and treatment options were discussed in detail. Organized blood work including CBC, Rheumatoid factor, Anti-nuclear antibodies (ANA), erythrocyte sedimentation rate (ESR) and C-reactive protein levels. Debrided hyperkeratotic tissue from both feet in the office and the patient was provided with a temporary pad for comfort. Recommendations were made for orthotics and more supportive shoes. Surgical treatment was recommended only if conservative options fail.

Case Study 2. Clinical Scenario for an Arthritic Patient continued

5. "Administering, by injection, a substance designated in the Regulations":

Currently, both chiropodists and podiatrists are authorized to administer substances by injection, but only into the feet. To function properly and lawfully and in the best interests of patients within the current and proposed scopes of practice, podiatrists need the authority to administer substances by injection elsewhere in the body. For example, as per clinical best practices and for optimal effectiveness, appropriately-qualified podiatrists need to be authorized to perform sublingual, intradermal and subcutaneous IM and IV injections and intraosseous (IO) in the thigh, buttocks, shoulders, arm, abdomen, wrist or hand, as well as in the foot and ankle.
The drugs listed in Figure 6 elicit their actions within the central nervous system and not within the foot. These drugs reach the central nervous system via the systemic circulation. The parenteral routes of administration introduce drugs directly into the systemic circulation (IV) or almost directly into the systemic circulation (IM, SC). The accepted standard for parenteral administration of these drugs is outside of the foot. These parenteral routes of administration are preferred or mandated for the drugs in question as these drugs are either poorly absorbed or unstable in the GI tract (e.g. many of the opioid narcotics) and would not adequately reach the central nervous system. Parenteral administration also provides a rapid onset of action which is imperative for emergency medications such as naloxone and flumazenil.

6. "Applying or ordering the application of a prescribed form of energy":

The *Chiropody Act, 1991* does not grant this controlled act to either chiropodists or podiatrists. Nevertheless, section 2 of Ontario Regulation 107/96 authorizes (by exemption) members of the College of Chiropodists to apply electricity for electrocoagulation or fulguration. The College asserts that it is in the public interest to include this controlled act in the new scope of practise in order for podiatrists to be able to diagnose and treat patients safely, efficiently and effectively in both the current and proposed scopes of practice. In the College's view it is essential that appropriately qualified podiatrists have access to (i.e. authorized to order and/or perform) certain "forms of energy" such as Magnetic Resonance Imaging (MRIs) for bony and soft tissue pathology, diagnostic ultrasound of the foot, ankle and leg to evaluate and/or guide diagnostic procedures within arterial, venous, subcutaneous and musculoskeletal structures, plethysmography to assess vascular pathology, nerve conduction velocity studies and EMGs in order to identify and assess nerve damage.

**Inter-jurisdictional comparison:** Analogous authorities to ordering or applying prescribed forms of energy are not restricted in Alberta or B.C.

According to a survey conducted by the Applicant during the summer of 2013, 61% of registrants intend to perform an electromyography and 21% believe they have the competencies to do so. 77% of registrants intend to perform nerve conduction studies and 31% believe they have the competencies to do so. 78% of registrants intend to perform electromagnetism for MRI and 32% believe they have the competencies to do so. 79% of registrants intend to perform diagnostic ultrasound and 31% believe they have the competencies to do so.

7. "Prescribing, dispensing and selling a drug designated in the Regulations":

Both chiropodists and podiatrists are currently authorized to prescribe drugs designated in the Schedules in Ontario Regulation 203/94. The list of prescribed drugs would have to be consolidated and augmented to reflect the unitary and expanded scope of practice and authorized acts and also to authorize qualified podiatrists to prescribe, dispense and sell drugs and substances regulated under the _Controlled Drugs and Substances Act_. Proclamation of the (federal) New Classes of Practitioners
Regulations enables provincial legislation to authorize chiropodists and podiatrists to use such drugs. See Figure 6 for examples of controlled drugs and substances required to perform the proposed acts.

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Administration Method</th>
<th>Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine</td>
<td>PO</td>
<td>I</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>PO</td>
<td>I</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>PO</td>
<td>I</td>
</tr>
<tr>
<td>Morphine</td>
<td>PO,IV</td>
<td>I</td>
</tr>
<tr>
<td>Meperidine (Demerol)</td>
<td>PO,SC,IM,IV</td>
<td>I</td>
</tr>
<tr>
<td>Nalbuphine (Nubain)</td>
<td>SC,IM,IV</td>
<td>I</td>
</tr>
<tr>
<td>Pentazocine (Talwin)</td>
<td>PO,SC,IM,IV</td>
<td>I</td>
</tr>
<tr>
<td>Butorphanol (Stadol)</td>
<td>IM,IV</td>
<td>I</td>
</tr>
<tr>
<td>Naloxone (Opioid Antagonist)</td>
<td>SC,IV,IM</td>
<td>I</td>
</tr>
<tr>
<td>Flumazenil (Benzodiazepine Antagonist)</td>
<td>IV</td>
<td>IV</td>
</tr>
</tbody>
</table>

Figure 6. Examples of Drugs and Substances Required to Perform the Proposed Acts

Some topical medicines and other drugs are fabricated by pharmaceutical companies and pharmacists specifically for conditions of the foot and ankle (Formula 3, FFN and Clear Nails to treat fungal toenails, Lamisil 2.5% in DMSO, 10 mL, Apply OD. Topical antifungal; 10% Ketoprofen PLO, 30g, Apply to affected area TID. Topical anti-inflammatory; Verapamil 15%, Diclofenac 6%, Bupivacaine 1% in Lipoderm, 50g, Apply to affected area BID. Used for treatment of ganglions.) These drugs are rarely available over-the-counter and are provided directly by pharmaceutical companies to chiropodists and podiatrists for direct dispensing to their patients. Hence, the Applicant is asking for the addition of the "dispensing" authority to the current authorized act, as is currently the case in Ontario with physicians, dentists and dental hygienists.

Inter-jurisdictional comparisons: In Alberta, podiatrists are authorized to prescribe a Schedule 1 drug within the meaning of the Pharmacy and Drug Act. They have full prescribing privileges for drugs listed in Schedule F of the Food and Drugs Act and Regulations; they may prescribe and dispense the benzodiazepine class of drugs, as well as those specified in the Controlled Drugs and Substances Act; and may dispense, compound, provide for selling or sell a Schedule 1 drug or Schedule 2 drug within the meaning of the Pharmacy and Drug Act for the purpose of treating ailments, diseases, deformities and
injuries of the human foot and ankle. In British Columbia, podiatrists are authorized to prescribe, compound, dispense or administer by any means a drug listed in Schedule I or II of the Pharmacists, Pharmacy Operations and Drug Schedule Act.

Authorities beyond the RHPA

The Laboratory and Specimen Collection Centre Licensing Act, Regulation 682:

Currently, podiatrists and chiropodists are not authorized to order any of the laboratory tests they need under the current scope of practice, including those to diagnose, plan and evaluate treatments and to monitor diseases and treatment outcomes. Chiropodists and podiatrists must refer patients back to family physicians to generate required laboratory tests, which delays diagnosis and treatment, inconveniences patients and unnecessarily adds costs for the healthcare system. In particular, podiatrists and chiropodists are not authorized to order laboratory tests or specimen collection for diagnostic pathology and microbiology that are integral to the effective and safe assessment and treatment of their patients. It is anomalous that chiropodists and podiatrists are authorized to perform surgical procedures on the subcutaneous tissues of the foot and podiatrists are also authorized to perform surgical procedures on the bones of the forefoot, yet neither chiropodists nor podiatrists are authorized to order any of the laboratory tests used to identify or quantify, for example, pathogens, viruses and blood clotting times and factors. Accordingly, in the patients’ interests, the Applicant is urging amendments to Regulation 682 (and the regulations under the Medical Laboratory Technology Act) in order to allow qualified podiatrists to order directly laboratory tests within the proposed scope of practice, so that they may provide timely and appropriate diagnoses to patients without the need for circular referrals to family physicians. The laboratory tests that the Applicant recommends qualified podiatrists be able to order include but are not limited to:

- Laboratory evaluations, such as electrolytes, BUN, creatinine, INR/PTT, CBC, platelet count, nicotine, urinalysis, arterial blood gases, urine HCG (pregnancy testing), pulmonary function tests;

- Infection profiles, such as CBC with differential, blood cultures, antibiotic blood levels (for example Vancomycin peaks and troughs); and

- Arthritis panels, such as Rheumatoid factor, erythrocyte sedimentation rate, anti-nuclear antibody profile, HLA-B27 genetic marker, C-Reactive Protein and erythrocyte sedimentation rate.

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• Podiatrists in British Columbia and Alberta are authorized to order these tests.

The Healing Arts Radiation Protection Act (HARP Act):

The HARP Act, as currently written, authorizes any graduate of a "four year course of instruction in chiropody" to order and take x-rays, operate radiographic equipment and to be designated as a radiation protection officer (RPO). As such, only 14% of current College registrants are eligible to perform any of the authorities under the HARP Act (i.e. members of the podiatrist class, DPMs practising as chiropodists and a very few chiropodists). Qualified podiatrists being able to order or take x-rays as part of the proposed scope of practice would obviate the need for circular referrals to family physicians and is also integral to timely and appropriate diagnosis and treatment. The HARP Act and any successor legislation should authorize all appropriately-qualified podiatrists to order and take x-rays of the lower limb, ankle and foot, to own radiographic equipment for that purpose and to be eligible for designation as radiation protection officers.

According to a survey conducted by the Applicant during the summer of 2013, 96% of registrants intend to prescribe x-rays and 73% believe they have the competencies to do so, while 59% of registrants intend to take x-rays and 29% believe they have the competencies to do so.

Q 11: "Do members of your profession practice in a collaborative or team environment where change in scope of practice and the recognition of existing or new competencies will contribute to interprofessional health care delivery? Please describe any consultation process that has occurred with other professions."

Response: In December, 2012, the College circulated a survey to its registrants as part of the registration renewal process for 2013. The survey "closed" on March 31, 2013. This survey was the second survey of this nature and the College intends to continue to conduct similar surveys coincident with registration renewal for the foreseeable future.

The survey results indicated that in 2012:

• 27% of registrants worked in multidisciplinary clinics;
• 12% of registrants worked full or part-time in multidisciplinary, primary care delivery groups, such as Family Health Teams (physician and nurse practitioner-led), or Community Health Centres;
• 10% of registrants worked full or part time in public hospitals; and
• 9% of registrants worked full or part-time in long-term care and retirement homes.

Another noteworthy outcome of the survey is that 20% of registrants provided footcare in patients' homes, other than in the long-term-care homes, retirement homes, assisted and supportive living centres. When providing footcare in patients’ homes, registrants are on their own. It is particularly
important in this delivery venue, given that patients are not ambulatory, or their mobility is at least seriously compromised, that practitioners be able to practise the widest possible scope and provide the most extensive and seamless continuum of care that their competencies allow. Doing this will enable them to provide homebound patients with the full continuum of footcare they require and to minimize the necessity for circular referrals to family physicians, or relying on hospital emergency departments. It is noteworthy, in this regard, that Dr. Sinha's report recommends increased access for seniors to home care by primary care practitioners.  

A further noteworthy outcome of the survey is that only 10% of registrants (entirely chiropodists) worked, full or part-time, in hospitals. Why is this noteworthy? Because when the chiropody program was launched it was the government's expressed intention that chiropody be provided primarily in hospitals by practitioners employed as salaried personnel. The small number of chiropodists currently practising in hospitals demonstrates how far the current chiropody practice model has changed and evolved from the original model in response to patient demand and changes in Ontario's healthcare delivery system.

“Put another way, the natural progression or evolution of the chiropody profession in Ontario has been towards the North American podiatry model.”

In terms of the interprofessional consultation process on which the College embarked:

- The College prepared a list of Colleges and professional associations where the scopes of practice intersected with that being proposed to HPRAC, or whose members refer their patients to or otherwise work with chiropodists and podiatrists.

- The College included in this list stakeholders who might be impacted in other ways by the scope of practice changes being recommended, or who might otherwise be expected to have an interest in the scope of practice changes.

- Organizations were added to this "stakeholder list" as the College's consultation process unfolded.

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51 “Foot-Care Services”. 13 March, 1980.
• The College sent a letter to each identified stakeholder setting out the changes the College intends to recommend to the scope of practice, authorized acts and other authorities and offered a briefing to each.

• 27 stakeholders responded. 19 asked for a briefing and 19 such briefings have been completed.

In some cases, absent a response from the stakeholder, the College proactively reached out to the stakeholder in order to address known or anticipated matters (e.g. Ontario Orthopedic Association, Ontario Long-Term Care Association).

Q 12: "Describe how the proposed changes to the scope of practice of the profession are in the public interest. Please consider describe the influence of any the following factors:"

Response:

a. Gaps in professional services: As explained elsewhere in this Application, primarily because of the growth of the seniors population and the incidence of chronicity associated with that population, there is an expanding gap between the demand for services within the proposed podiatric scope and the supply of practitioners who are authorized and competent to provide those services. One indicator of this gap is the increase in wait times for chiropodists and podiatrists in Ontario (See Figure 7). The gap is caused by a combination of an inadequate number of practitioners and scope of practice restrictions. The fact is that there is no regulated profession in Ontario, other than the 25 or so orthopedic surgeons specializing in footcare, whose scope of practice focuses exclusively on the diagnosis and treatment of diseases, disorders and dysfunctions of the foot and ankle. These gaps are particularly evident in areas of the province that are underserviced in terms of access to primary care practitioners. The gaps are concerning because individuals, primarily seniors, who are caught in that gap are unable to get timely diagnosis and treatment of their foot and ankle ailments. Given the critical role that foot and ankle health plays in mobility, delayed diagnosis and treatment leads to increased levels of chronicity, plus loss of mobility, independence and one's ability to work and perform activities of daily living.

"...limb amputation is largely preventable in people with diabetes. Routine screening for vascular risk factors, foot examination at least annually to assess for peripheral neuropathy or PAD, patient education regarding footcare and referral to a podiatrist or vascular surgeon when needed, are important steps toward lowering the risk of this major diabetes complication."

- Sarah E Capes, M.D., MSc, FRCPC, Diana Sherifali, RN, PhD, CDE, "Assessment and Management of the Diabetic Foot" in Canadian Diabetes, Winter 2010/volume 23/ Number 4.
Another facet of the supply/demand gap is the limited number of venues where foot and ankle services are available. Notwithstanding the small size of the professions in both relative and absolute terms, both chiropodists and podiatrists practise in multiple healthcare delivery venues, including nursing homes, retirement homes, home care and primary healthcare delivery venues such as Family Health Teams (See Figure 8).

Figure 7. Average Wait Times for Patients seeking a Chiropodist
The North American "podiatry model" is more than scope of practice and relevant competencies. It also entails a different model of healthcare delivery. A number of podiatrists do practise in hospitals and in analogous healthcare institutions. Nevertheless, the podiatric model of practice is decentralized and revolves around community-based clinics and surgical centres. As such, the North American podiatry model of practice helps to de-stress institutional models of care by draining off those patients whose conditions can be safely and effectively treated elsewhere. The North American podiatry model of practice is also more accessible and convenient to patients and there is also abundant evidence that it is more cost-effective than institutional models of care (See Appendix B).

b. Epidemiological trends in illness and disease: The increased incidence of and morbidity and mortality associated with chronic diseases such as diabetes, arthritis and cancer that often manifest themselves in the foot and ankle are documented elsewhere.

Diabetes: The Canadian Association of Wound Care claims that there are currently 2.3 million Canadians living with diabetes of whom approximately 345,000 will develop a foot ulcer. A significant minority of diabetic foot ulcers fail to heal and will require limb amputation. Limb amputation is associated with a significant risk of mortality: 30% will die within one year of amputation and 69% will not survive beyond

According to a 2013 Report by the OECD ("Health at a Glance"), Canada's prevalence of Type I and Type 2 Diabetes at 8.7 exceeds the OECD's average of 6.9. There is a particularly substantial body of scientific evidence relating the importance and efficacy of podiatric care for diabetic patients, viz:

- Patients who received simultaneous vascular surgery and podiatric care are much more likely to avoid amputations.\(^{54}\)

- Patients treated by podiatrists have a higher awareness and knowledge of diabetic foot care and self-care that reduce the incidence of foot problems.\(^{55}\)

- Podiatric treatment of diabetic patients with foot ulcers in the multidisciplinary system reduces treatment costs.\(^{56}\)

- The American Diabetes Association recommends that diabetic treatment teams consist of a family physician, an ophthalmologist and a podiatrist.

- Podiatric treatment provided to diabetics is a significant element in preventing foot amputation, thus reducing the heavy cost of hospitalization and other types of treatments.\(^{57}\)

- In its clinical practice guidelines for General Practitioners, the Canadian Diabetes Association recommends that General Practitioners "Look at your patient's feet and know the signs". Among other recommendations, the CDA recommends referral for professional nail and skin care and for professionally fitted footwear if patients present with numb, painful or tingling feet, or present with signs of bony changes or deformities. If patients present with dry, cracked blistered or ulcerated feet, the CDA recommends referral for professional skincare to manage calluses and referral for non-weightbearing footwear. If a patient's feet display dependent rubor, signs of ischemia and/or gangrenous ulcers, the CDA recommends referral for professional skincare to manage calluses.

\(^{53}\) Ibid.


Arthritis: According to the Arthritis Alliance of Canada, 4.6 million Canadians suffer from some form of arthritis. Arthritis is the most common cause of disability in Canada, resulting in poor quality of life and workforce limitations. Osteoarthritis, Rheumatoid Arthritis and Post-Traumatic Arthritis often manifest themselves in the foot. Arthritis cannot be cured. A 2008 study by T. Daniels et al. concludes that patients with advanced-stage ankle arthritis are as disabled as patients with end-stage hip arthritis. For arthritic conditions that are posttraumatic, the majority of patients are in the prime of their lives and require effective treatment outcomes in order to return to productive and enjoyable lifestyles. The treatment objectives are controlling inflammation and preserving joint function, or restoring joint function if it has been lost. Because the foot is a frequent target, chiropodists and podiatrists are often the first practitioners to encounter some of the complaints that identify arthritic conditions— inflammation, pain, stiffness, excessive warmth or injuries. Even bunions can be manifestations of arthritis.

According to the Canadian Arthritis Association,

*Four out of five people experience a foot problem sometime in their lives; some of those problems are the result of arthritic complaints. Most minor foot problems — such as calluses and corns, high and low arches and exotic — sounding (but common) ills like plantar fasciitis — are easily treatable, particularly by podiatrists, chiropodists and occupational therapists. For more serious problems, especially those related to arthritis, you’ll need the services of a podiatrist or medical doctor, particularly if you require surgery. Any major procedure requiring general anesthetic must be performed by an orthopedic surgeon, dermatologist or plastic surgeon, but most minor surgery — and a great deal of non-surgical care — can be done by a foot specialist known as a podiatrist (or, for minor problems, a chiropodist).*

Cancer: Foot melanoma is the deadliest form of cancer. Bob Marley, the noted Jamaican singer-songwriter, died at the age of 36 from an untreated malignant melanoma under his toenail. Early diagnosis and treatment of foot melanomas can avoid their spread throughout the body. Effective diagnosis of foot melanoma requires regular clinical examinations, particularly for patients over 50 and, when a melanoma is suspected, skin biopsies (i.e. laboratory tests).

c. *Changing public needs for services and increased public awareness of available services:* As discussed elsewhere in this Application Ontario’s aging population and chronicity associated therewith prompt increased demand for foot and ankle care that is not being adequately addressed within Ontario’s existing health delivery system.

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d. **Waiting times for healthcare services:** Ontario's wait times for orthopedic surgery of the foot and ankle persistently exceed clinical guidelines and best practices. The Canadian and Ontario orthopedic associations have acknowledged that the current number of orthopedic surgeons specializing in foot and ankle care is limited and that changes have to be made.\(^{61}\) Converting to a podiatric scope of practice would help alleviate wait times for orthopedic surgery in two ways: First, members of the College of Podiatrists could diagnose and treat more patients and provide additional procedures, thereby reducing the demand and wait times for orthopedic surgeons. Second, orthopedic surgeons could utilize more of their time and expertise to concentrate on the more complex procedures and diagnoses and reduce wait times for them.

Current wait times for chiropodists and podiatrists also often exceed clinical guidelines. The proposals made in this Application with respect to enhanced scope of practice and removal of the podiatric cap can be expected to increase the number of podiatric practitioners and, thereby, reduce wait times for their services.

e. **Geographic variation in availability and diversity of healthcare providers across the province:** The current chiropody framework has led to huge disparities in practitioner distribution across the Province. This is particularly the case for podiatrist members. Figure 3 on page 16 illustrates the current distribution of chiropodists and podiatrists among the 14 LHINs. Statistically adjusted rates of foot and ankle surgery conducted by orthopedic surgeons also varies widely across the 14 LHINs. The Ontario-wide statistically adjusted rates of orthopedic surgery were 49 per 100,000 population for foot surgery and 16.7 per 100,000 population for ankle surgery (Subject to updating from WHIS). The lowest adjusted rates of foot and ankle surgery were in the North West, North Simcoe Muskoka and Central West LHINs. The highest rates for foot surgery occurred in the Erie St. Clair, Toronto Central and North East LHINs and the highest adjusted rates for ankle surgery occurred in the Toronto Central, South West and Erie St. Clair LHINs. According to the Canadian and Ontario Orthopedic Associations, these differences can be attributed to the availability, or lack thereof, of practitioners to perform foot and ankle surgery.\(^{62}\)

f. **Changing technology:** There has been a number of innovations that enable podiatrists to obtain good outcomes from procedures that were historically limited to orthopedic surgeons and to hospitals and similar institutions. Advances in surgical and anesthetic techniques, fixation options, portable/outpatient intra-operative imaging technologies, portable/outpatient emergency equipment and crash cart technologies have become available in healthcare delivery in general. More specific to podiatry, technological advances include:

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• Shock wave therapy for heel spurs and plantar fasciitis and Achilles tendinopathy (Requires local anesthetic and diagnostic ultrasound);

• Endoscopy plantar fasciotomy for plantar fasciitis; and

• Endoscopic intermetatarsal nerve decompression for Morton’s neuroma.

g. **Demographic trends:** Statistics and projections pertaining to Ontario’s aging population are well known (See Following Text Box). Nearly 60% of Ontario’s podiatrists’ and chiropodists’ patients are 55 years of age or older. This figure will likely increase as the percentage of seniors in the population increases --- assuming there is a parallel growth in the profession. A major public benefit of conversion to a podiatric model of care is to enhance seniors’ access to more timely, convenient and cost-effective foot and ankle care and to enable a more extensive and seamless continuum of care.

- 1.9 million Ontarians are 65 years of age or older.
- 14.6% of Ontarians are 65 years of age or older.
- The proportion of seniors to the general population is projected to double over the next 20 years.
- Seniors account for nearly half of total healthcare expenditures.
- The vast majority of seniors have at least one chronic disease or condition.


h. **Promotion of collaborative scopes of practice:** Although much of the current and proposed scopes of practice involve public domain activities that can be performed and are being performed by members of multiple regulated and unregulated professions, except for the 25 or so orthopedic surgeons specializing in the foot and ankle, podiatrists and chiropodists are the only regulated professions trained to specialize in the foot and ankle and are the only professions authorized to perform subcutaneous surgical procedures on the foot and ankle. Nevertheless, nurses, physiotherapists, chiropractors and massage therapists do provide important non-invasive treatments of the foot and ankle and will continue to do so, often in collaboration with podiatrists. The advent of a unitary profession with the podiatric scope will facilitate interprofessional collaboration and the College and the professional associations intend to promote enhanced interprofessional collaboration once the new scope of practice and authorized acts are in place. Creating a unitary profession under the single and better-known title "podiatrist" will facilitate interprofessional collaboration by addressing confusion around the "chiropodist" title. (See Response to Question # 5 in HPRAC’s “Additional Questions”.)
i. **Patient safety:** The College is confident that current and prospective registrants will practise safely and effectively and have, or will acquire, the knowledge, skill and judgment to do so. The College will be amending its Standards of Practice to ensure safe and effective performance of the new and expanded authorized acts, by those who have demonstrated the competencies to do so. A concern to the College is the increasing number of unregulated "footcare specialists", "cosmetologists", "aestheticians" and the like who are practising within the current chiropody scope. These practitioners are performing often risky procedures without appropriate training and safeguards and on patients who may not be aware of the risk to which they are being exposed. Expanding the scope of practice and removing the podiatric cap as recommended in this Application will begin to close the supply/demand gap and, thereby, begin to make these practitioners redundant.

"The Ministry needs to build the continuum of care in the community, so there are more options for seniors to get the care they need outside of hospitals and long-term care homes".

- Ministry of Health, Results-Based Plan Briefing Book 2012-2013.

There is no evidence from other jurisdictions in which the podiatric scope has been in operation for substantial periods of time to apprehend an increased risk of harm to patients as a consequence of implementation of either the scope or the podiatric model of care. Nevertheless, the College will be asking for authority to regulate surgery centres and other venues that are owned by podiatrists and in which podiatric surgery is conducted and will devise and implement Quality Assurance requirements and mechanisms analogous to those for Independent Health Facilities administered by the College of Physicians and Surgeons of Ontario.

j. **Wellness and health promotion:** There is a large volume of evidence and advice that maintaining good foot health is instrumental to overall health and is also necessary for mobility, independence, productivity and the normal conduct of activities of daily living. There is also a large volume of evidence that many diseases, disorders and dysfunctions manifest themselves first, or at some point, in the foot. Chiropodists and Podiatrists play an important role in promoting and preserving foot health and wellness. What chiropodist and podiatrist do in foot wellness and health promotion can, however, be accomplished fully and effectively within the current scope of practice and authorized acts.

k. **Health human resources issues:** The Minister's referral asked HPRAC not only to conduct a scope of practice review, but to review and make recommendations on other or related matters such as the podiatric cap. As indicated in the Forward to this Application, in the College's view any cap on the registration of qualified, healthcare practitioners cannot be justified in Ontario's current and
projected health human resources environment. Removal of the cap will facilitate the profession's ability to grow naturally and to respond to patient and healthcare system demands.

Expanding the scope of practice is projected to have beneficial HHR impacts in two respects discussed in more detail elsewhere in this Application and in the College's response to HPRAC's Additional 18 Questions:

1. By allowing podiatrists to perform the more advanced surgical procedures for which they are qualified, reducing the demand and wait times for orthopedic and other surgeons (particularly the 25 or so orthopedic surgeons who specialize in the foot and ankle). This would hopefully have the effect of reducing wait times for the more complex foot and ankle surgical procedures that require the attention of orthopedic and other surgeons.

2. By filling the gaps in the scope of practice, pertaining particularly to diagnostic tests, reducing demand and wait times for general practice physicians.

I. *Professional competencies not currently recognized:* Chiropodists' scope of practice and authorized acts have not changed, in Ontario, to reflect changes in the chiropody educational program and the podiatric cap keeps them from performing any of the controlled acts authorized for podiatrists, regardless of competencies.

There are about 75 Doctors of Podiatric Medicine --three times the number of orthopedic surgeons certified as foot and ankle specialists ---registered to practise in Ontario who are competent to and whose peers in other jurisdictions currently:

- Perform surgical procedures on the foot and ankle;
- Set and cast fractures of bones or dislocations of joints in the foot and ankle;
- Order or apply "forms of energy" such as MRIs;
- Prescribe, dispense, or sell drugs, including controlled drugs and substances, consistent with the podiatric scope of practice;
- Administer substances by injection were clinically indicated in the body; and
- Order laboratory tests.

m. *Access to services in remote, rural or under services areas:* The distribution of chiropodists and particularly podiatrists throughout Ontario is very uneven. Figure 3 on page 16 illustrates the distribution of chiropodists and podiatrists by LHIN District. The lowest ratios of chiropodists and podiatrists to population occur in urban areas of the Province.
As discussed elsewhere in this Submission and in the response to HPRAC’s 18 Additional Questions, access to footcare services, especially advanced footcare services, are particularly compromised in Northern Ontario. The Provider in Sioux Lookout characterized footcare services in the area as "more or less nonexistent and desperately required". The College also hears anecdotal evidence about individuals in Northern Ontario who require advanced footcare having to travel to Manitoba to get it. Impaired access to footcare in Northern Ontario is almost certainly a major factor in the relatively high number of diabetic toe and foot amputations and partial amputations compared to the rest of the Province.

Footcare in Ontario's Aboriginal, First Nations, Métis and Inuit communities is particularly challenged, despite the alarmingly high incidence of diabetes among members of those communities. The incidence of Type 2 Diabetes in such communities is 3 to 5 times higher than the general population. The Sandy Lake First Nations have the third highest incidence of diabetes recorded in the world. One result is a substantially and unacceptably higher occurrence of lower limb amputation and foot abnormalities.

To respond to the supply/demand gap in rural, remote and underserviced areas, some chiropodists and podiatrists have established satellite clinics. Some chiropodists and podiatrists serve on the staffs of clinics that focus on aboriginal health. But such initiatives fall far short of need.

Removal of the podiatric cap will prompt growth of the profession. With additional numbers, market forces will attract podiatrists to underserviced areas. The proposed expanded scope of practice will relieve demand for orthopedic surgeons providing footcare surgery that podiatrists can competently and safely perform and will create a more seamless continuum of care that will reduce the number of circular referrals to general and other practitioners.

Q 13: "How would this proposed change in scope of practice affect the public's access to health professions of choice?"

Response: The principal motivation behind the College's proposal is to enhance the public's access to, and choice among, regulated footcare practitioners and to create an expanded and seamless continuum of footcare. As stated elsewhere in this Application, the gap between the demand for advanced footcare services and the supply of regulated, qualified practitioners continues to grow, primarily (but not exclusively) as a consequence of the growth of the seniors demographic. Individuals 55 years of age and older constitute approximately 58% of chiropodists' and podiatrists' patients. The supply/demand gap is, in part, manifested by long wait lists for diagnosis and treatment by orthopedic surgeons specializing in the foot (of which there are about 25 in Ontario).
The gap in the supply of and demand for chiropodists' and podiatrists' services in Ontario is a function of several factors:

Gaps or mismatches in the current authorized acts that prompt circular referrals that delay diagnosis and treatment and compound wait lists and wait times

- The limited scope of practice and authorized acts for chiropody and podiatry in Ontario for which most chiropodists and podiatrists are overqualified and that, thereby, discourage practitioners from entering or staying in the profession in Ontario;

- The limited scope of practice and authorized acts that restrict chiropodists' and podiatrists' ability to respond to patient and health system demand; and

- The "podiatric cap" that prohibits the migration of podiatrists to Ontario from other jurisdictions regardless of demand and prohibits Ontario residents who have graduated from US or Québec podiatry schools from practising podiatry in Ontario.

Furthermore, orthopedic surgeons have not been able to fulfill the role envisaged for them by the government in the early 1980s. That was a critical part of the rationale for converting to a chiropody model. To begin with there are no more than 25 orthopedic surgeons in Ontario specializing in the foot and ankle. A submission by orthopedic surgeons to the Ministry of Health and Long-Term Care in March 2009 acknowledges that "the numbers of orthopedic surgeons in Ontario with a specific interest in foot and ankle surgery are few and the demand far exceeds the ability of the few to fulfill the needs of Ontario citizens". The same submission notes that "Some foot and ankle specialists are reducing the number of less specialized foot and ankle surgeries they will perform, in some cases because operating room (OR) time is limited for these types of procedures." The submission also notes that...
"... most orthopedic residents graduate from programs with insufficient exposure to foot and ankle pathologies and thus do not manage these problems unless they have received additional training in the form of a foot and ankle fellowship". 63

The pie chart at Figure 3, page 16 illustrates the current distribution of chiropodists and podiatrists across Ontario. Substantial portions of the Province are unserviced or substantially underserviced by podiatrists and chiropodists. The near absence of chiropodists and podiatrists in North-Western Ontario, for example, is arguably at least a major factor in the high amputation rate for feet and lower limbs due to the lack of timely and effective diagnosis and treatment of diabetes and other diseases and disorders of the foot.

Nurses and others are already performing many of the routine, non-surgical aspects of the legislated scope of practice of chiropody and podiatry. The transformation the College proposes recognizes that trend and its inevitable and appropriate continuation. The proposed transformation also recognizes the acknowledged and important role for orthopedic surgeons to continue to perform the more complex surgical procedures on the foot and ankle that require, in the main, access to hospital operating rooms. "In the middle" so to speak, will be podiatrists providing a wider range of diagnoses and treatment, to the full extent of their competencies and in response to public demand, primarily in more accessible, non-institutional, community-based settings within a seamless continuum of care.

Q 14: “How would the proposed change in scope of practice affect current members of the profession? Other health professions? The public? Describe the effect of the proposed change in scope of practice might have on:"

Response:

a. Practitioner Availability: The Labour Market Information Division of Employment and Social Development Canada maintains a National Occupational Standard for chiropodists and podiatrists, but does not track either profession in terms of employment growth or demand. This is perhaps because of the relatively small size of the professions in Canada and their varied status with respect to scope and titles across the provinces and territories. Figure 3 compares the ratios of podiatrists and chiropodists to population in the other Canadian provinces where the profession is recognized and in comparable
foreign jurisdictions. The ratio of chiropodists to population in Ontario has reached --- in fact exceeded -- the target set by the government circa 1980. Nevertheless, that target was based on a different delivery model than the one that characterizes the chiropody profession today. Although the practitioner/population ratio set circa 1980 has been achieved, there are huge variations in the supply of chiropodists and/or podiatrists across the Province. (See Figure3; Page17.) Furthermore, although the numbers of chiropodists and podiatrists are small relative to other primary care professions, they are sufficient to have a meaningful and positive impact on healthcare delivery, particularly for patients who do not have access to a family physician. Despite having achieved the practitioner/population target, as stated and explained elsewhere in this Application, the College believes that the growth of the podiatry and chiropody professions in Ontario has been seriously stunted by the podiatric cap and by the limited scope of practice that does not allow many practitioners to perform to the full extent of their competencies, nor to fulfill their patients' expectations or the demands of Ontario's healthcare delivery system. The College is convinced that revocation of the podiatric cap (coupled with an indigenous podiatry education program) will remove huge obstacles to practitioner number growth. As evidence, the College cites the fact that it has received an unprecedented number of inquiries over the past several months from DPM graduates about the prospects of registration as podiatrists in Ontario in light of the HPRAC review. The College is also convinced that an enhanced scope of practice will be attractive and act as an incentive for individuals to follow a career in podiatry in Ontario.

The current numbers of podiatrists and chiropodists have led to their very uneven distribution across Ontario. Chiropodists and particularly podiatrists tend to be concentrated in Ontario's large urban centres. The College anticipates that an increase in the number of practitioners will be particularly felt in enhanced practitioner availability by those areas of the province that are currently unserviced or underserviced.

About one quarter of podiatrists' and chiropodists' patients report not having a family physician. As primary care and primary access practitioners, therefore, chiropodists provide many patients with access to the healthcare system that they would not otherwise have except through emergency departments and walk-in clinics.

*Podiatry care not only reduces amputation risk, but also dramatically impacts the rate of hospitalization and reulceration.*


Increased availability of podiatrists can logically be projected to decrease the demand for footcare services delivered by orthopedic surgeons. Nevertheless, evidence also clearly suggests that there is more than enough demand for footcare especially for routine, non-invasive cases to keep everyone busy. That situation will persist for the foreseeable future because of population growth and
demographic trends. Accordingly, increased availability of podiatrists is unlikely to displace any existing practitioners. The College does hope, however, that increased availability of podiatrists will reduce the utilization of unregulated practitioners who are performing sometimes risky procedures without appropriate training, safeguards or supervision; and are doing so primarily with vulnerable populations, such as seniors.

b. **Education and training programs, including continuing education:** The College has committed to existing registrants to expend best efforts to ensure that refresher and bridging programs pertaining to the proposed scope of practice are reasonably available in Ontario. The College is also operating on the premise that the Government of Ontario would insist, or at least prefer, that a podiatry program that generates the competencies required to perform all of the proposed authorized acts would be established in Ontario as soon as possible. To that end, the College has initiated discussions with a number of academic institutions in Ontario with a view to their launching either or both the refresher and bridging programs and the full-time podiatry program. In the absence of a clear and reliable signal that the podiatric cap will be revoked and the proposed scope of practice implemented, these communications have not progressed beyond the discussion stage.

It should be emphasized that the decision to perform any or all of the new or expanded authorized acts will be left entirely to individual grand-parented practitioners. Based on the College’s survey of registrants, the intention to perform and the perceived competency to perform vary widely among the proposed authorized acts.

c. **Enhancement of quality of services:** Enhancement of services will result largely from podiatrists being able to provide a more extensive and seamless continuum of care, thus significantly reducing the need for time wasting and expensive referrals and circular referrals for diagnostic tests. The more extensive continuum of care leads to greater continuity of care that has been demonstrated to improve quality of service and patient outcomes. The result will be substantially enhanced convenience for patients; more timely diagnosis and treatment; and healthcare system efficiencies. Enhancement of services will also occur by the provision of care in more accessible and patient-friendly community-based clinics, rather than in acute or chronic care institutions and emergency departments.

> Podiatric medical care in people with a history of diabetic foot ulcers can reduce high level amputation from between 65% and 80%.


d. **Costs to Patients or clients:** As discussed elsewhere in this Application, the advent of a podiatry scope of practice in Ontario can be expected to generate net healthcare system savings. Currently, services rendered by chiropodists are paid for by most extended health benefits insurers, the WSIB, auto insurers
(under the Statutory Accidents Benefits Schedule) and patients themselves. OHIP partially covers podiatrists' services up to a maximum of $135/year (plus up to $15 for x-rays). Most extended health benefits insurers, the WSIB, auto insurers and patients themselves also pay for podiatrists' services. According to a recent study conducted in Arizona, net system costs increased and outcomes decreased as a consequence of the delisting of podiatry from the State's Medicare Plan.

Discussions with the Provider Services Branch of the Ministry of Health and Long-Term Care, the Canadian Life and Health Insurance Association and the WSIB give no reason to believe that implementation of the proposed podiatry model will change the status quo and, thereby, have a material impact on the costs to patients or clients.

e. **Access to services:** As explained in a. and elsewhere in this Application, the College believes that access to services will be significantly enhanced by converting to a podiatry model as proposed. Patients' reliance on hospitals, where wait times for foot surgery are characteristically longer than clinical guidelines, will be reduced and access in areas of the province that are currently unserviced or underserved will be improved. Conversion to the proposed podiatry model is also expected to have a ripple effect on other professions, for example helping to reduce wait times for orthopedic surgeons for complex foot and ankle surgeries and for other types of orthopedic surgery.

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Each $1 invested in care by a podiatrist for people with diabetes results in $27 to $51 of healthcare savings.

- JAPMA, 101(2), 2011
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f. **Service efficiency:** The principal service efficiency that will be realized is to reduce the need for referrals for diagnosis and treatment within the proposed podiatry scope of practice and circular referrals for diagnostic tests, which are time-consuming for patients and delay timely diagnosis and treatment.

g. **Interprofessional healthcare delivery:** Please see the response to Question Five in the Submission on HPRAC's 18 Additional Questions.

h. **Economic issues:** The Applicant foresees no material economic impacts. Studies referenced elsewhere in this Application give reason to project net health system efficiencies and cost reductions. The clinical evidence identified in other parts of this Application clearly suggests that the adoption of a podiatry model will lead to better health outcomes. The economic literature clearly indicates that better health outcomes have a positive impact on employment, productivity and economic growth. Clinical evidence also indicates that the proposed podiatry model will improve health outcomes particularly from the management of chronic diseases such as diabetes, arthritis and cancer. These in turn lead to cost savings through a reduction in hospital stays, emergency room visits and also improved productivity. Better
continuity of care lowers resource utilization and reduces systemic healthcare costs. Accordingly, the proposed podiatry model can be expected to generate positive micro and macroeconomic outcomes, but the College acknowledges that those outcomes are unlikely to be material in the Ontario context, at least in the short-term, in light of the small size of the profession and its economic impact.64

Q 15: "Are members of your profession in favour of this change in scope of practice? Please describe any consultation process and the response achieved."

Response: The following chiropody and podiatry professional associations are on record as supporting the conversion to a podiatry scope of practice, model of footcare delivery and regulation as put forward in this Application: The Ontario Society of Chiropodists (OSC); the Ontario Podiatric Medical Association (OPMA); and the Canadian Podiatric Medical Association (CPMA) that is the national association for podiatrists. The Canadian Federation of Podiatric Medicine (CFPM) is a national association primarily representing those who currently practise in the UK model. In its submission to HPRAC during the Ontario footcare model review, the CFPM came out strongly against the North American podiatry model and in favour of the UK model. For the reasons indicated in the response to Question 30, the College believes that adoption of the UK model would represent a serious backward step for Ontario and not be in the public interest.

In December, 2012, the College convened a number of working groups for the HPRAC review, including a Working Group on Member Consultations & Communications. The Working Group on Member Consultations & Communications consists of chiropodists and podiatrists registered with the College. Its role is to design and implement a communications strategy with the College membership on every aspect of the HPRAC review. The Working Group will continue in operation at least until the end of the HPRAC review.

In March of 2013, the College launched a website, (called the "HPRAC Portal"), that is accessible to all registrants through the members-only section of the College of Chiropodists’ official website. The HPRAC Portal provides an abundance of information on all aspects of the HPRAC review, including the details of, background to, rationale for and implications for members of the recommendations being made to HPRAC to convert to a full scope podiatry model of footcare and regulation. The content of the Portal is continuously updated. One of the features of the HPRAC Portal is an interactive capability whereby registrants may make comments, ask questions and offer suggestions to which the College responds. One third of College registrants have accessed the Portal at least once and most of them have accessed the Portal multiple times.

The College also launched an HPRAC-specific electronic newsletter called "SCOPE". SCOPE editions are sent to all registrants by electronic E-Blast. As of the date of this Application, 15 SCOPES have been published. Each addresses, or calls registrants' attention to, a specific HPRAC review-related topic --- and also reminds registrants to access the HPRAC portal.

Updates on the project to convert to a full scope podiatry model of regulation and footcare are also provided at each College Council meeting during the public sessions.

The College also offered town hall meetings and webinars to registrants in order to keep them informed on all aspects of the HPRAC review. The College also expended best efforts to identify any areas of concern or opposition within the membership.

Historically, there have been many frictions and divisions within and between the chiropody and podiatry professions in Ontario. In that context, the consensus in support of the conversion to a full scope podiatry model is a truly remarkable achievement for all concerned and bodes well for the future of the profession.

Q 16: "Describe any consultative process with other professions that might be impacted by these proposed changes."

Response: In early 2013, the College began to assemble an "HPRAC Review Stakeholder List". That list included professional associations representing, and RHPA Colleges responsible for regulating, professions that would be impacted, or might perceive themselves as being impacted, by the changes being proposed. The professions encompassed within the List included medicine, chiropractic, pedorthics, pharmacy, physiotherapy, nursing and optometry, including specializations and classes of members thereof.

Beginning in February, 2013, the College sent individualized letters to each College and Association on the List. The letter conveyed a high-level description of what the College intended to propose to HPRAC, including the proposed wording of the expanded scope of practice and new and expanded authorized acts, plus the proposed new or expanded authorities under the Healing Arts Radiation Protection Act and the Laboratory and Specimen Collection Centre Licensing Act. Each letter offered a follow-up briefing session by the College.

Follow-up briefing sessions were subsequently convened with the College of Physicians and Surgeons of Ontario, the Ontario Medical Association, the Ontario Chiropractic Association, the College of Physiotherapists of Ontario, the Ontario Physiotherapy Association, the Canadian Federation of Podiatric Medicine, the Canadian Podiatric Medical Association, the American Podiatric Medical Association, the Council on Podiatric Medical Education, the Ontario Association of Non-Profit Homes & Services for Seniors, the Canadian Life and Health Insurance Association, the Ontario Society of Chiropodists, the
Ontario Podiatric Medical Association, the Ontario Orthopedic Association, the Ontario Association of Medical Laboratories and the The Michener Institute for Applied Health Sciences.

Thematic subjects raised by the associations and Colleges in these sessions included:

Will all current registrants of the College of Chiropodists be automatically grand-parented to perform all of the new or expanded authorized acts, or alternatively will all registrants have to acquire the requisite competencies to perform all of the new or expanded authorized acts?

**Answer:** The College proposes that the performance of any the new and expanded authorized acts will not be mandatory by current College registrants and by students who are in-stream at the Michener chiropody program, but will be mandatory for all other first-time registrants. Using the PES Analysis as a foundation, grand-parented registrants and Michener graduates will have to demonstrate to the College's satisfaction that they have acquired the requisite knowledge, skill and judgment to perform whatever new or expanded authorized acts they elect to perform.

Grand-parented registrants and Michener graduates who choose not to perform any or all of the new or expanded authorized acts, or who do not demonstrate the competencies to do so, will have terms, conditions and limitations applied to their registrations by the College.

How will other healthcare practitioners and members of the public distinguish between those who have been authorized by the College to perform any or all of the new or expanded authorized acts and those who have not?

**Answer:** Following the precedent of other Colleges that have gone through analogous scope of practice changes, such as the College of Dental Hygienists of Ontario and the College of Physiotherapists, the intention is that the College of Podiatrists will make a roster publicly available on the College's official website listing each registrant and the authorized acts he/she has been deemed competent by the College to perform.

Will podiatrists seek hospital privileges?

**Answer:** The College's proposal does not include hospital privileges for podiatrists.

Where and how will new podiatrists be educated?

**Answer:** The College has determined that a university-based, post baccalaureate podiatry program is required to provide the competencies necessary to practise the proposed scope of practice and authorized acts safely and effectively. The College's preference is to have the podiatry program affiliated with an Ontario medical school. To that end, the College has initiated exploratory discussions with seven Ontario universities that have medical schools and two that do not have medical schools, but have health sciences faculties that could be expanded to include a podiatry program.
Will the College impose a post-graduation residency or internship requirement and, if so, what are the College's plans to have teaching hospitals open up sufficient places?

**Answer:** New registrants and grand-parented registrants wishing to perform the more complex surgical procedures authorized within the proposed scope of practice will be expected to complete or have completed surgical residencies in accredited hospitals. The residency stream in Ontario is expected to be separate and apart from that for orthopedic surgeons and therefore, would not impact on the availability of residency spaces available for them.

<table>
<thead>
<tr>
<th>Clinical Scenario FRACTURE</th>
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<td>19 year old healthy female injured playing soccer on a weekend. Telephones the Podiatrist at the office and directed to the on call practitioner who instructs the patient to meet at the office (No referral or ER visit required).</td>
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Exam reveals swelling and discomfort to the lateral left foot and ankle with some tenderness to the proximal left fibula. Exam is otherwise normal. A letter is written by the podiatrist/chiropodists to the patient’s primary care physician recommending an x-ray. The patient returns to the primary care physician for further treatment.

**PROPOSED/EXPANDED SCOPE:**

A weight-bearing x-ray is taken immediately in the office and interpreted by the Podiatrist revealing a non-displaced spiral oblique fracture of the distal left fibula and a displaced fracture of the proximal metaphysis of the fifth metatarsal left foot.

A compression dressing is applied along with a removable fracture boot. The patient is instructed to be non-WB with crutches. A prescription for a non-steroidal anti-inflammatory (NSAID) and pain medication was dispensed along with a prescription for crutches which can be picked up at the pharmacy. An x-ray at an outpatient imaging facility was ordered by the Podiatrist of the left knee to rule out fracture of the proximal left fibula (Treatment for a proximal fibula fracture actually occurs distally at the ankle joint.).

Surgical consultation was provided for open reduction with internal screw fixation (ORIF) of the left fifth metatarsal fracture to be performed within a week by the Podiatrist in the office surgical suite (or outpatient surgery center?) utilizing IV sedation or nitrous oxide, mid-calf tourniquet and local anesthetic. An order for pre-operative CBC, platelet count, PT/PTT, HCG and urinalysis was given for the local outpatient laboratory. Pre-operative IV antibiotic, prophylaxis was administered 30 minutes prior to surgery. A post-op intramuscular injection of Toradol (NSAID) was administered prior to discharge.

Routine post-operative care was performed with the involvement of CCAC wound care Registered Nurses. Serial dressing changes and x-rays to assess healing. Local redness and swelling occurs along the incision at 10 days after surgery. A small amount of local purulent drainage is noted. A culture and sensitivity is obtained from a swab of the wound. CBC with differential, erythrocyte sedimentation rate and C-reactive protein levels are obtained from blood work ordered by the Podiatrist at the outpatient laboratory. A prescription is given for an empiric antibiotic and then changed to a more specific antibiotic after the culture and sensitivity results are returned and the local infection has not completely resolved when the patient is subsequently examined. The infection completely resolves with specific antibiotic therapy and the surgical wound heals without further complication. The patient fell one week after surgery. An x-ray was taken in the Podiatrist’s office which displayed loosening of the internal hardware. The patient was taken back to the outpatient surgical suite by the Podiatrist and the internal fixation was replaced and reduction of the fracture was maintained. Cast immobilization of the foot and ankle fractures continue via strict non-WB and crutches for 4-6 weeks. Outpatient physical therapy begins at 4 weeks. The patient returns to full activity within 2 months after the initial injury. The Podiatrist fits the patient for an ankle brace and an orthotic.
Q 17: "How will the risk of harm to the patient or client be affected by the proposed change in scope of practice?"

Response: As discussed elsewhere in this Application, the College will ensure that only those grand-parented members who demonstrate the competencies to do so will be allowed to perform whatever new or expanded authorized acts they elect to perform. Terms, conditions and limitations will be applied to all grand-parented registrants to prohibit them from performing any of the new or expanded authorized acts for which they do not have the required competencies. From the proclamation date forward, new applicants for registration to the College, except for those graduating from the chiropody program at The Michener, will have to demonstrate that they have obtained the competencies to perform all of the controlled acts authorized to the profession. Michener graduates will be treated the same as grand-parented registrants.

There is no reason to fear that patients' safety will be in any way compromised by the implementation of the proposed model. The College's Code of Ethics stipulates that:

"The public is entitled to safe, effective and ethical care performed by knowledgeable, skilled, accountable practitioners in accordance with the professional standards of the College."

"Each member will provide individualized comprehensive and safe care, recognizing the patient's particular needs, and respecting their cultural background."

Any College registrant doing something for which he or she is not competent would be liable to prosecution for professional misconduct.

The College believes that the risk of harm to patients will actually be reduced as a consequence of the system-wide impacts of the proposed reforms. The current limited scope prompts circular referrals to order diagnostic tests and to perform treatment modalities that are actually within the competencies of many registrants, but beyond their legislated scope of practice. Those circular referrals tend to increase patient risk by delaying diagnosis and treatment. The College is convinced that the proposed model will enhance patient safety by providing a more extensive continuum of care and by facilitating more timely diagnosis and treatment. It is also at least an arguable proposition that the community-based delivery model will not only be more convenient and accessible to patients and families in clinically-appropriate instances, but will also reduce the risk of patient infections and other complications, compared to hospital inpatient care.

For example, adverse events are a serious cause of concern to the healthcare system. Adverse effects are defined as anything that causes injury to a patient as the result of a medical intervention rather than the underlying medical condition. A study published in 2004 randomly selected 20 hospitals across five provinces, examined 2.5 million annual hospital admissions and found that the overall incidence rate of
adverse events was 7.5%. Conversely a study on the rate of adverse events in outpatient care in Canada from 2013 found outpatient rates to be only 4.2%.

Likewise, in Canada there are an estimated 220,000 healthcare associated infections acquired in healthcare facilities, with 8,000 deaths attributable to these infections annually. In acute care in-hospital settings, the average infection rates range from 6.3/1000 patient days in the Gyn. & Orthopedic setting, to 20.3/1000 patient days in the ICU. This number is drastically reduced in the outpatient setting with infection rates of 5-6/1000 resident days in long-term care settings and surgical site infection rates of 1.4-3.1% in ambulatory settings.

Podiatrists and chiropodists have the knowledge, skill and judgment to determine when care by another practitioner, or in a hospital, or other delivery venue, is in the best interest on the patient. They will refer whenever it is in the patient's best interests and are required by the College to do so.

The College believes that the community-based delivery model of which the podiatric model is a part, will ensure enhanced public safety by reducing the number of patients required to be admitted to a hospital for treatment, thereby reducing infection rates and other complications. The College notes, in this regard, the Ontario government's "key commitment" to move low risk, OHIP-covered surgical procedures to community-based specialty clinics to help more patients receive the most appropriate care in the most appropriate place.

**Q 18:** "What other regulated and unregulated professions are currently providing care with the competencies proposed as an expansion to your scope of practice? By what means are they providing this care (e.g. under delegation, supervision or on their own initiative)?"

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Response: Please see the Response to Question # 1 in the Submission in response to HPRAC’s 18 Additional Questions.

Q 19: "Specify the circumstances (if any) under which a member of the profession should be required to refer a patient/client to another health professional, both currently and in the context of the proposed change in scope of practice."

Response: Subsection 1.15 of the College's Professional Misconduct Regulation (Ontario Regulation 750/93) stipulates that professional misconduct by a member includes:

"Failing to advise the patient to consult with a physician or other regulated health professional where the member recognizes, or ought to recognize, a condition that is beyond the competence or experience of the chiropodist or that requires such a consultation to ensure the proper care of the patient."

A Standard of Practice of the profession is that each member must practise within his or her scope of practice, education and competency.

In sum, the College requires each member to refer patients to, or consult with, another health professional whenever the patient's condition or the treatment required is, or may be, beyond the member's individual knowledge, skill and judgment, or is beyond the legislated scope of practice of the profession, or the controlled acts authorized to the profession. It is the College's clear expectation that these requirements would persist under the proposed changes in scope of practice and authorized acts.
Clinical Scenario: WOUND CARE & DIABETES

A 45 y/o insulin dependent diabetic gentleman comes into the office with a red and swollen left foot. He does not recall any trauma and has no pain. He says that he has been diabetic since he was a teenager and he is taking injectable insulin on a daily basis. He says that he only checks his blood sugar every few days and he has not checked his blood glucose today. He says that he saw a doctor at the clinic last week because he was sick to his stomach and felt feverish but the doctor did not check his feet. He was told to take OTC Tylenol for his fever by the clinic. He states that he still does not feel well with fever, chills and some nausea.

Past medical history is positive for insulin dependent diabetes mellitus, hypercholesterolemia and high blood pressure. Past surgical history includes tonsillectomy and appendectomy. He denies smoking or alcohol use. He is employed on the line in the local factory and stands all day in steel-toed shoes. Family history is positive for cardiac disease and diabetes. Review of systems reveals some left knee pain from limping on his left foot, kidney trouble and diabetic retinopathy, but otherwise ROS is non-contributory.

Physical exam reveals his blood pressure, heart rate and respirations are all wnl. Blood glucose accu-check taken in the office reveals his blood sugar is elevated 4x normal. His body temperature is wnl.

This is a slightly overweight appearing gentleman sitting comfortably in the exam room chair in no apparent acute discomfort or distress.

Lower extremity vascular examination reveals that popliteal pulses (behind the knee) are palpable on both sides. Posterior tibial (behind the ankle) and dorsalis pedis (top of the foot) pulses are normal on the right side and bounding on the left foot. Capillary refill time is two seconds on both feet. Diffuse non-pitting left foot and ankle edema noted on the left foot. No edema noted to the right lower extremity. There is edema and pain at the back of the left knee with palpable lymph nodes.

Neurological exam reveals deep tendon reflexes, Achilles and patellar are normal. Reduced vibratory sensation and reduced proprioception (position sense) on both lower extremities. Protective sensation is absent to the distal aspect of both feet as measured by the 5.07 Semmes-Weinstein monofilament.

Skin exam reveals diffuse redness with cellulitis and lymphangitis with proximal streaking to the dorsal lateral left foot and plantar left arch. Otherwise skin is warm and dry with hair growth present on both feet. Mild maceration with hyperkeratosis noted to the fourth interdigital space left foot. Hyperkeratosis and underlying ulceration noted to the tip of the fourth toe left foot. Upon debridement of the fourth interdigital space left foot approximately 5ml of thick purulent drainage and foul odor is noted with deep tracking and penetration to the fourth and fifth MPJ level with deep tissue necrosis. The lesion at the distal tip of fourth toe left foot probes to bone with purulent drainage. There are no other open lesions or signs of infection on either foot.

Musculoskeletal exam reveals no pain on palpation or range of motion to either lower extremity. The fourth digit on the left foot is contracted plantarly at the proximal interphalangeal joint but it is reducible. (FLEXIBLE HAMMERTOE) There is collapse of the medial plantar arch on the left foot with abduction of the left forefoot noted and medial bony prominence noted to the left instep and dorsal left midfoot. Crepitus is noted upon palpation and range of motion of the joints throughout the left midfoot. Muscle strength is within normal limits. He limps when he walks and he is unable to perform single limb heel raise on the left side.
More specifically, by way of illustration, and without limiting the generality of the foregoing, under the proposed scope of practice podiatrists would:

- Refer to an orthopedic surgeon, infectious disease specialist or general practice physician any patient with a condition for which safe and effective treatment would require, or best be conducted in, a hospital operating facility;

- Refer to an orthopedic surgeon or general practice physician any patient with a condition whose treatment requires general anesthesia or inpatient hospital care;
• Refer to a vascular surgeon or general practice physician any patient with a condition for which safe and effective treatment would require, or best be conducted in, a hospital operating facility;

• Refer to or consult with an oncologist any patient requiring the evaluation and/or treatment of any cancer as it pertains to the foot and ankle;

• Refer to or consult with a rheumatologist or a general practitioner any patient for evaluation and treatment of rheumatologic conditions (such as sero negative, sero positive, etc.);

• Consult with a neurologist or a general practitioner any patient requiring evaluation and treatment of neurological conditions (such as Charcot-Marie Tooth, mono and poly neuropathy, drop foot and weakness) and testing (such as NCVs and EMGs);

• Refer to a physiotherapist or other regulated rehabilitation professional patients requiring post-surgical rehabilitation;

• Refer to an occupational therapist any patient requiring professional advice and assistance with respect to the patient’s activities of daily living (ADL);

• Refer to an Infectious Disease Centre or a general practitioner any patient with a condition for which safe and effective treatment would require, or best be conducted in, a hospital operating facility;

• Refer to or consult with a pain management specialist any patient needing evaluation and treatment of a complex regional pain syndrome, fibromyalgia and/or radiculopathy;

• Consult with a radiologist any patient requiring an MRI, CT scans, diagnostic ultrasound and/or bone scans;
• Refer to or consult with a dermatologist any patient needing evaluation and treatment of skin cancer;

• Refer to or consult with an endocrinologist any patient for the evaluation and treatment of diabetes management and/or osteoporosis;

• Refer to or consult with a wound care specialist any patient for the evaluation and treatment of chronic wounds;
• Refer to or consult with a plastic surgeon any patient requiring a skin graft, tissue defect and/or skin flap procedure;

• Refer to or consult with a hyperbaric oxygen treatment centre any patient for the evaluation and treatment of chronic wounds, PVD and/or diabetic wound management;

• Refer to or consult with a designated ADP assessor in all circumstances where a patient requires an assistive device under the Ministry of Health and Long-Term Care's ADP Program;

• Refer to or consult with a medical doctor (i.e. ER Dr.) or appropriate medical specialist any patient with a condition that would benefit from such a referral and/or consultation or for which safe and effective treatment would require, or best be conducted, in a hospital facility; and

• Refer to or consult with an emergency facility whenever the patient's condition requires.

[In the above list, "refer" is understood to mean sending a patient to another practitioner to assume ongoing management of the patient's condition. "Consult" is understood to mean sending a patient to another practitioner for advice and assistance for the referring podiatrist about the diagnosis and proposed treatment of a particular case, but case management is expected to remain with the practitioner. "Consult" may or may not require the referred practitioner to conduct a physical examination of the patient.]

It is important to add, however, that access to diagnostic testing and a broader scope of practice more reflective of podiatrists' competencies will reduce the need for circular referrals to other healthcare practitioners and thereby improve patient convenience, expedite diagnosis and treatment and reduce wait times and system-wide costs.

Q 20: "If this proposal is in relation to the current supervisory relationship with another regulated health profession, please explain why this relationship is no longer in the public interest. Please describe the profession's need for independent/autonomy in practice."

Response: Podiatrists have always practised independently primarily in sole practitioner clinics, but also in multiple healthcare delivery venues such as long-term-care homes, hospitals and in privately-funded multidisciplinary clinics. Chiropodists and podiatrists are recognized as primary healthcare practitioners who have the knowledge, skill and judgment to deliver footcare autonomously within their legislated scope of practice and authorized acts. As explained elsewhere in this Application, the original (circa 1980) concept for the chiropody model in Ontario was for chiropodists to work, by and large, as salaried personnel in hospitals and analogous institutions under a supervisory relationship with physicians. That model is now passé. Because of hospital cost-cutting and other changes in Ontario's healthcare delivery
framework, less than 20% of chiropodists work full or part-time in hospitals or in analogous institutions today. Although chiropodists have made some penetration into multidisciplinary primary care delivery organizations such as Family Health Teams and the like, most chiropodists’ practice venues are identical or very similar to those of podiatrists.

The podiatry model of care being proposed is essentially a community clinic-based model, with podiatrists working independently or as parts of multidisciplinary health teams in a range of clinical settings. This model is actually an alternative to the hospital-centric model of healthcare delivery and derives its benefits from being so. Furthermore, addressing the growing supply/demand gap for safe and effective footcare, particularly in areas of the province that are currently chronically underserviced or not serviced at all, requires podiatrists to be able to practise independently within a scope of practice that reflects their competencies.

The proposed model is founded on the continuation of podiatrists being primary healthcare practitioners and being able to practise independently (but not necessarily independently) in multiple, non-institutional venues. In this context, a delegation system would constitute a step backwards and be incompatible with the objectives being sought. A delegation system would not be in the best interests of patients, for the healthcare system generally.

Q 21: “Does the proposed change in scope of practice require the creation of a new controlled act or an extension of or change to an existing controlled act? Does it require delegation or authority to perform an existing controlled acts or a subset of existing controlled act?”

Response: This Application does not contemplate the creation of a new controlled act, or an extension of or change to an existing controlled act. The Application does propose:

a) Expanding the anatomical boundaries of the scope of practice and existing and proposed authorized acts to include the ankle and structures affecting the foot or ankle;

Extending the controlled acts and non-RHPA authorities currently authorized to members of the podiatrist class to include appropriately-qualified chiropodists (who would be grand-parented as podiatrists in the new College) and podiatrists who opt to perform any or all of those authorized acts; and

b) Adding the controlled acts of i) "setting or casting a fracture of a bone or dislocation of the joint in the foot or ankle; ii) "applying or ordering the application of a prescribed form of energy"; and the authority to iii) order certain laboratory tests within the proposed scope of practice and authorized acts.

The Applicant proposes that these controlled acts be legislatively authorized to the profession, rather than requiring delegations from members of another profession. Very few chiropodists or podiatrists
currently perform any controlled acts pursuant to delegations. The practice venues and practice situations of the majority of registrants make a delegation system problematic.

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

Response: The College of Chiropodists currently has in place a policy that authorizes registrants to assign public domain acts, but prohibits the delegation of authorized acts. There is no intention to change this approach.

While the College proposes controlled acts being authorized for the profession, the College wishes to emphasize that grand-parented registrants would have to demonstrate to the College their competencies to perform any of those controlled acts before being authorized to do so. Those authorized practitioners would then be identified by a public roster on the College's website. Terms, conditions and limitations would apply to all other grand-parented registrants.

Under the Nursing Act, 1991 (subsection 5. (1) (b)), registered nurses may perform controlled acts authorized to chiropodists and podiatrists pursuant to an "order" from a chiropodist or podiatrist to do so. By letter dated February 21, 2013 the Applicant approached the College of Nurses of Ontario to discuss the subject-matter of this Application and these provisions of the Nursing Act in particular. The College of Nurses indicated it does not intend to engage in HPRAC's review and has no basis on which to judge the competencies of College of Chiropodists' registrants to perform the proposed expanded scope of practice and the proposed new or expanded authorized acts.

The Applicant reached out to each College whose members are currently authorized to perform any of the proposed new or expanded authorized acts. The College met with the College of Physicians and Surgeons of Ontario on June 20, 2013 and the College of Physiotherapists of Ontario on November 21, 2013. No other College indicated interest in what the Applicant is proposing, or any intention to engage in the HPRAC review. As of the date of this Application, neither the CPSO nor the College of Physiotherapists has registered any opposition with the Applicant.

Q 23: "Are the entry-to-practise (didactic and clinical) education training requirements of the profession sufficient to support the proposed change in scope of practice? What methods are used to determine the sufficiency? What additional qualifications might be necessary?"

Response: The current entry-to-practice requirements are geared to the chiropody scope of practice and authorized acts listed in subsection 5 (1) of the Chiropody Act, 1991. These requirements are not sufficient to support the proposed change in scope of practice. The College aspires to an Ontario-based university podiatry program that, once fully operational, would graduate in the range of 25 podiatrists
per year who would be fully competent to perform the proposed scope of practice and enable performance of all of the proposed authorized acts. In this regard, the Kent State University College of Podiatric Medicine has written to the College offering to assist an Ontario University to set up and launch a podiatry program and to provide upgrading, bridging and refresher courses for grand-parented registrants who wish to acquire the competencies to provide some or all of the new or expanded authorized acts.

In order to determine the sufficiency of the training and education programs from which current registrants graduated vis-à-vis the proposed scope of practice expansion, the College retained Professional Examination Services (PES) to conduct a comprehensive review. PES determined that the following cohorts of registrants are competent to perform any and all of the new or expanded authorized acts:

- Graduates of US DPM programs who are practising in Ontario as chiropodists.
- Graduates of the podiatry program offered by the Université de Québec.
- All current or future graduates from podiatry programs in the United States or the Université de Québec.
- Registrants in the podiatrist class of members, albeit in many cases requiring "refresher" courses.

Q 24: "Do members of the profession currently have the competencies to perform the proposed scope of practice? Does this extend to some or all of the members of the profession?"

Response: About 15% of current registrants are judged to currently possess the competencies to perform all of the proposed new or expanded authorized acts. This compares very favourably to the percentage of dental hygienists currently performing "scaling, root planing and curettage" without a dentist's order and the percentage of physiotherapists who have registered to perform "expanded practice physiotherapy" roles under the scope of practice expansion that came into effect in 2010. As averred elsewhere in this Application, the education and training of current registrants now spans a wide range. Following the precedent of other professions that have gone through scope of practice expansions, the College proposes that the performance of any of the new or expanded authorized acts not be mandatory for existing registrants who would be grand-parented into the proposed new College. The same would apply to graduates of the Michener chiropody program who registered in the program prior to the proposed scope of practice changes coming into effect. Grand-parented practitioners who wish to perform any or all of the proposed new or expanded authorized acts would have to demonstrate to the College that they have the competencies to do so safely and effectively. Again, following the precedent of other professions that have gone through scope of practice expansions, the College will
create a publicly-available roster of those practitioners who have been deemed by the College as competent to perform the authorized acts. The roster would list those practitioners on an authorized act-by-authorized act basis.

For purposes of the “Gap Analysis” conducted by PES, current registrants were divided by PES into six cohorts and PES determined the competencies of members of each cohort to perform the proposed additional and expanded authorized acts. The full PES report is reproduced at Appendix A. In summary PES made the following determinations:

- The 85 College registrants who graduated from US DPM programs are assumed to have received the training necessary to perform the expanded scope of practice. Nevertheless, although they may have acquired these competencies as part of their DPM education, some have not exercised those competencies for a considerable period of time because of the limited scope of practice in Ontario. Those individuals, including those who have graduated since 1995, will require refresher or upgrading programs should they choose to perform any or all of the proposed authorized acts.

- The 20 practitioners who graduated from DPM programs since 1993 but practise as chiropodists have the competencies to perform all of the proposed new and expanded authorized acts.

- The single practitioner who graduated from the DPM program at the Université de Québec has the competencies to perform all of the proposed new and expanded authorized acts.

- The George Brown/Michener programs have gone through many changes in terms of curriculum length and content over the past 30 years. Any of the graduates of those programs who are current registrants of the College and who wish to perform any or all of the proposed expanded or new authorized acts will require some bridging programs.

- There are currently 43 registrants who are graduates of education programs outside of North America (i.e. the UK, Australia and South Africa). The multiplicity of programs from which these registrants graduated made it impossible for PES to reach any uniform or general conclusions. In order to practise any or all of the proposed authorized acts the College will evaluate each practitioner individually and practitioners may require at least refresher programs and perhaps a bridging program as well.

As indicated elsewhere, there is a substantial number of Ontario residents, or former Ontario residents, who have obtained DPM degrees and are practising podiatry elsewhere than Ontario. There are also roughly seven Ontario residents currently enrolled in DPM programs in Québec or the US. The currently-limited scope of practice discourages many from contemplating a return to Ontario to practise. Should
the scope of practice be expanded as proposed in this Application, however, the College anticipates that a significant number of these practitioners and graduates will return to Ontario. Those returnees will be fully competent to perform all of the proposed new and expanded authorized acts. Perhaps as validation, the College notes that 18 DPM graduates have applied for registration in Ontario over the last six months, likely in anticipation of removal of the podiatric cap and the launch of a scope of practice more reflective of their competencies and practice aspirations.

The PES report provides the foundation for the design of refresher and competency programs. It is the College's clear preference that any refresher or bridging programs be reasonably available to grandparented registrants in Ontario. To that end, the College has initiated discussions with a number of universities. Those discussions have been somewhat hampered by, and no conclusions have been reached because of, the podiatric cap. Unless and until there is a reasonably clear signal that the podiatric cap is to be revoked, educational institutions are very reticent to engage in such discussions, let alone provide any commitments.

**Q 25:** "What effect will the proposed change in scope of practice have on members of your profession who are already in practice? How will they be made current with the changes, and how will their competency be assessed? What quality improvement/quality measurement programs should or will be put into place? What educational bridging programs will be necessary for current members to practise with the proposed scope?"

**Response:** The College proposes that current registrants not be obligated to acquire the competencies to perform any or all of the proposed authorized acts. Those grand-parented registrants who elect to perform any or all of the authorized acts would have to demonstrate to the College that they have, or have acquired, the competencies to do so safely and effectively. Nonetheless, the College anticipates that patient expectations, clinical best practices and competitive considerations will prompt practitioners to acquire those competencies in order to provide a more extensive and seamless continuum of care. Each individual registrant will continue to be governed by the College's professional misconduct regulation obliging them to have the knowledge, skill and judgment to perform any controlled act safely and effectively. As it has already done with its drug regulation, the College will be vigilant in its communications and in its quality assurance mechanisms to ensure that only fully competent practitioners are performing the podiatry authorized acts.

As indicated elsewhere, many of those practitioners currently practising as chiropodists (except for those who have DPM degrees) would require bridging courses before practising any of the new authorized acts. Many members of the podiatrist class would require some form of refresher courses. Also, as indicated elsewhere in this Application, the College has initiated discussions with academic institutions in Ontario to provide the requisite bridging/refresher courses and to make those programs reasonably available to those grand-parented registrants who wish to take them.
Q 26: "How should the College ensure that members maintain competence in this area? How should the College evaluate the membership's competence in this area? What additional demands might be put on the profession?"

Response: The College intends to benefit from the experience of other Colleges that have recently gone through analogous scope of practice changes and has already initiated discussions with Colleges to that end. As explained elsewhere in this Application, the approach being recommended by the College is for current members of the College of Chiropodists to be automatically grand-parented into the College of Podiatrists, but their performance of any of the new or expanded authorized acts will not be mandatory. The same would apply to students of the Michener Institute who are in train at the time the new legislation is proclaimed. The College would attach terms, conditions and limitations to grand-parented registrants' registrations prohibiting them from performing any of the new or expanded authorized acts for which they had not demonstrated requisite competencies to the College's satisfaction. Otherwise, applicants for new registration would have to satisfy the competency criteria to perform all of the authorized acts.

The College believes that its long history of effective regulation, which the Ministry has endorsed, demonstrates the College's ability and commitment to ensuring that its members are fully competent to practise safely and effectively. Much can be learned and adapted from the many podiatry professional regulators in Canada and the United States that have regulated similar podiatry scopes of practice for considerable periods of time. The Professional Examination Services' Report provides a good start in terms of defining the competency gap and the bridging or refresher requirements for current registrants. Other Ontario Colleges have gone through similar scope of practice enhancements (e.g. College of Physiotherapists) and the College has reached out to them to learn from their experience. Furthermore, the College will expend best efforts to have upgrading and refresher courses launched in Ontario, along with a full-time, university-level podiatry program that is accredited by the CPME.

Q 27: "Describe any obligations or agreements on trade and mobility that may be affected by the proposed change in scope of practice for the profession. What are your plans to address any trade/mobility issues?"

Response: The chiropody model as it currently exists in Ontario and the "podiatric cap" in the Chiropody Act, create insurmountable impediments to inter-jurisdictional mobility for both podiatrists and chiropodists. Primarily because of the podiatric cap, but also because of the chiropody curriculum at the Michener Institute, chiropody and podiatry are the only regulated healthcare professions in Canada that have been unable to sign a Mutual Recognition Agreement (MRA) under the Agreement on Internal Trade (AIT) with other provinces and territories. Ontario residents who have graduated from DPM programs since 1993 have also been prohibited from returning to practise in Ontario as podiatrists.

71 Letter from the Minister of Health and Long-Term Care (Ms. Mathews) to HPRAC, June 24, 2011.
The podiatric cap has also been the principal impediment to listing podiatrists (or chiropodists) in the Medical/Allied Professions category of Appendix 1603.D. 1 pursuant to Section D of Annex 1603 of the North American Free Trade Agreement.

The podiatric cap is also in conflict with the Government of Canada’s policies and commitments with respect to foreign credential recognition.

The College's legal advice, furthermore, is that the podiatric cap contravenes at least the spirit of the Fair Access to Regulated Professions Act.

Accordingly, conversion to a podiatry model as proposed by the Applicant will remove these impediments, bring the profession into compliance with the Fair Access to Regulated Professions Act, open the way to the execution of an MRA under the AIT and facilitate the inter-jurisdictional mobility of practitioners.

**Foreign Credential Recognition**

“Internationally-trained workers help fill skills shortages in key occupations and make important contributions to Canada’s economy. That’s why attracting and recruiting the best international talent is critical to Canada’s long-term success...

The Government of Canada is committed to streamlining foreign credential recognition so that skilled workers are able to find meaningful work that contributes to Canada’s economy and overall prosperity”.

- Employment and Social Development Canada

**Q 28:** "How do you propose to educate or advise the public of this change in scope of practice?"

**Response:** The College would have a multifaceted communications plan ready to launch when the necessary legislation is close to Proclamation. Part of the communications plan would consist of a five-pronged external communications strategy:

1. **Prong #1:** Intra-Professional Communication to advise foot health professionals, chiropodists and podiatrists plus peer groups such as orthopaedic surgeons, vascular surgeons, rheumatologists, family physicians, nurses, etc. of the changes and their implications.

2. **Prong #2:** Healthcare sector Advocacy Groups that have been part of driving the demand for the scope changes to improve access, efficacy and outcomes of foot health for seniors, diabetics, arthritis sufferers, sport and occupational injuries, etc. will be advised promptly of the implications of the scope changes and what they will mean to the groups of healthcare consumers they represent.
3. **Prong #III**: The general public needs to learn about the changes and benefits as quickly as possible and over a sustained period to ensure the messages are received. This will allow members of the public to take full advantage of the improved quality of care, improved choice and access and improved continuum of outcomes experienced as tools to managing chronic conditions such as diabetes, arthritis, circulatory challenges from heart and other conditions while gaining mobility.

4. **Prong #IV**: Message champions and communication channels such as media, family practice and physician offices, hospital and healthcare waiting rooms, health centres, walk-in clinics and a variety of social media portals linked to stakeholder groups will be provided with the news of the changes and the impacts.

5. **Prong # V**: Leading up to proclamation of the new legislation, the College will communicate the new entry to practice requirements to podiatry and chiropody educational programs in other countries and advise chiropody and podiatry regulators and professional associations of the scope of practice and entry to practice requirements. The resources and networks of organizations such as the International Federation of Podiatrists/Fédération Internationale des Podologues (FIP) would be used to whatever extent can be negotiated.

The communication tactics to be applied throughout the implementation of the five-phased plan will include:

- Use of the College website and public information section;

- Partnering with interested groups, such as CARP/Zoomer, the Canadian Diabetes Association, the Ontario Association of Non-Profit Homes and Services for Seniors and the Arthritis Association to get the message out;

- Use of the College’s portal for chiropodists and podiatrists on the HPRAC Review and scope of practice topics to provide tools to registrants to communicate the changes and their implications to their patients;

- Information flyer for posting on community billboards in libraries and community centres;

- Digital posting through Rogers and Shaw electronic community information boards via regional community cable TV;

- Information packages to healthcare reporters, editors, publishers;

- Public awareness campaign using print and broadcast ads to major outlets across Ontario;
• PSAs (Public Service Announcements) to community newspapers and other outreach;

• Brochures for distribution to College registrants for use in their practice settings;

• Information to other healthcare professional groups;

• Information to long-term care facilities, retirement homes, CCACs, providers of supports and services for seniors, school boards and institutional channels; and,

• Dialogue and follow-up with specific risk population groups such as provincial not-for-profit organizations dedicated to diabetes and other key conditions in which good foot health promotes better overall health outcomes.

Q 29: "What is the experience in other Canadian jurisdictions? Please provide copies of relevant statutes and regulations."

Response: Podiatry and/or chiropody are statutorily regulated in all Canadian provinces except Nova Scotia, Prince Edward Island and Newfoundland and Labrador. In New Brunswick (no more than 15 practitioners) the legislation delegates regulation of the profession to the professional association. In the remaining provinces "colleges" analogous to RHPA Colleges exist, although the structure and terminology pertaining to scopes of practice and authorized acts and the legislative frameworks vary materially.

Over the last 20 years or so, the "podiatrist/podiatry" title and professional designations have been adopted by all provinces except Ontario. Alberta and British Columbia manifest the North American podiatry model. Québec is somewhere between the UK chiropody model and the North American podiatry model. Saskatchewan and Manitoba manifest the UK chiropody model, although the College has been given to understand that Manitoba would like to adopt the North American podiatry model.

DPM graduates are eligible to practice the profession in all regulated provinces. Only graduates of DPM programs are eligible to register to practise the profession in British Columbia, Alberta and Québec. Graduates of DPM programs and baccalaureate and diploma-level programs in chiropody and podiatry accredited by the respective regulatory bodies are eligible to practise the profession in Saskatchewan, Manitoba and New Brunswick.
Alberta

**Titles:** “Podiatrist”, "podiatric surgeon", "doctor of podiatric medicine", "podiatric physician", "DPM", "Dr." "doctor" (Section 14 of the Podiatrist Profession Regulation, Alberta Regulation 60/2012)

**Regulation/Registration for Podiatrists:** College of Podiatric Physicians of Alberta

**Scope of Practice:**

- Diagnose and treat ailments, diseases, deformities and injuries of the human foot and ankle, including the articulation of the tibia and fibula and those muscles and tendons directly affecting foot function, including the employment of preventive measures and the use of medical, physical or surgical methods but not including treatment of systemic disease, except the local manifestations in the foot,
- Engage in research, education and administration with respect to health, and
- Provide restricted activities authorized by the regulations.

"Restricted" Acts (Section 15):

**Bone and soft tissue surgery;**

- Set or reset a bone fracture;
- Reduce a dislocation of a joint;
- Administer vaccine;
- Prescribe or administer nitrous oxide for anesthesia or sedation;
- Order or apply any form of ionizing radiation in medical radiography nuclear medicine;
- Order or apply forms of nonionizing radiation (e.g. MRI, ultrasound).

Health Professions Act
PODIATRIST PROFESSION REGULATION
Alberta Regulation 60/2012

**Authorization to use titles**

14(1) A regulated member registered on the general register or courtesy register may use the following titles, abbreviations and initials:

(a) podiatrist;
(b) podiatric surgeon;
(c) doctor of podiatric medicine;
(d) podiatric physician;
(e) D.P.M.;
(f) doctor;
(g) Dr.

(2) A regulated member registered on the provisional register may use the following titles, abbreviations and initials:

(a) podiatrist;
(b) doctor of podiatric medicine;
(c) podiatric physician;
(d) D.P.M.;
(e) doctor;
(f) Dr.

(3) A regulated member registered on the general register or courtesy register may use the title “specialist” if the regulated member

(a) meets the requirements established by the Council for the use of the title specialist, and
(b) is authorized by the Registrar to use that title.

**Restricted activities**

15(1) A regulated member registered on the general register, courtesy register or provisional register may, in the practice of podiatry and in accordance with the standards of practice, perform the following restricted activities for the purpose of diagnosing and treating ailments, diseases, deformities and injuries of the human foot and ankle:

(a) to cut a body tissue, to administer anything by an invasive procedure on body tissue or to perform surgical or other invasive procedures on body tissue;
(b) to set or reset a fracture of a bone;
(c) to reduce a dislocation of a joint;
(d) to prescribe a Schedule 1 drug within the meaning of the Pharmacy and Drug Act;
(e) to dispense, compound, provide for selling or sell, incidentally to the practice of podiatry, a Schedule 1 drug or Schedule 2 drug within the meaning of the Pharmacy and Drug Act;
Authorized Drugs:

- Subject to the *Controlled Drugs and Substances Act*, a podiatrist may purchase and supply to the podiatrist’s patients only those drugs, chemicals and compounds that are authorized by the Lieutenant Governor in Council and may prescribe those authorized drugs, chemicals or compounds for compounding under the direction of a pharmacist or restricted practitioner under the *Pharmaceutical Profession Act*.

For a complete list of Schedule I and II Drugs see http://cocoohprac.wildapricot.org/resources/For%20Links%20ONLY%20-%20No%20Portal%20Access/Provincial%20Drug%20Lists.pdf.

**British Columbia**

**Titles:** “Podiatrist, Podiatric Surgeon”, "surgeon", "doctor". (Subsection 3 (1) Podiatrists Regulation, BC Regulation 2014 2010)

**Regulation/Registration Podiatrists:** College of Podiatric Surgeons of British Columbia.

**Scope of Practice:** A registrant may practise podiatric medicine.

**Authorized Acts/Restricted Activities:**

A registrant in the course of practising podiatric medicine may do any of the following:

- make a diagnosis identifying, as the cause of signs or symptoms of the individual, a disease, disorder or condition of the foot or lower leg;

- perform a procedure on tissue below the dermis of the foot or lower leg;

- to administer a vaccine;

- to prescribe or administer nitrous oxide gas for the purposes of anaesthesia or sedation;

- to order any form of ionizing radiation in medical radiography and nuclear medicine;

- to apply any form of ionizing radiation in medical radiography;

- to order any form of non-ionizing radiation in magnetic resonance imaging or ultrasound imaging;

- subject to subsection (2), to apply any form of non-ionizing radiation in ultrasound imaging.

(2) No regulated member shall perform the restricted activity described in subsection (1)(k) in respect of a fetus.

*For the complete Act please visit:* http://www.qp.alberta.ca/documents/Regs/2012_060.pdf
• set or cast a fracture of a bone of the foot or lower leg;
• reduce a dislocation of a joint of the foot or lower leg;
• administer intravenous fluids by injection;
• for the purpose of arthroscopic surgery of the ankle, put an instrument or a device, hand or finger into an artificial opening into the body;
• apply (i) laser, for the purpose of cutting or destroying tissue, or
(ii) X-rays, for diagnostic or imaging purposes, excluding X-rays for the purpose of computerized axial tomography;
• issue an instruction or authorization for another person to apply, to a named individual,
  (i) ultrasound for diagnostic or imaging purposes, excluding any application of ultrasound to a fetus,
  (ii) electromagnetism for the purpose of magnetic resonance imaging, or
  (iii) X-rays for diagnostic or imaging purposes, including X-rays for the purpose of computerized axial tomography;
• in respect of a drug specified in Schedule I or II of the Drug Schedules Regulation, B.C. Reg. 9/98,
  (i) prescribe the drug,
  (ii) compound the drug,
(iii) dispense the drug, or  
(iv) administer the drug by any method;  
• conduct challenge testing for allergies  
  (i) that involves injection, scratch tests or inhalation, if the individual being tested has not had a previous anaphylactic reaction, or  
  (ii) by any method, if the individual being tested has had a previous anaphylactic reaction.

**Authorized Drugs:**

In respect of a drug specified in Schedule I or II of the Drug Schedules Regulation, B.C. Reg. 9/98, a Podiatrist may;  
  (i) prescribe the drug,  
  (ii) compound the drug,  
  (iii) dispense the drug, or  
  (iv) administer the drug by any method.

For a complete list of Schedule I and II Drugs see http://cocoohprac.wildapricot.org/resources/For%20Links%20ONLY%20-%20No%20Portal%20Access/Provincial%20Drug%20Lists.pdf.

**Saskatchewan**

**Titles:** “Podiatrist” and “Podiatric Surgeon”

**Regulation/Registration for Chiropodists/Podiatrists:**

Saskatchewan College of Podiatrists (SCOP)

**Scope of Practice:** Podiatry is defined as the primary healthcare discipline concerned with the diagnosis

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**B.C. Reg. 214/2010**  
**M195/2010 (British Columbia) – CONT’D**

(i) in respect of a drug specified in Schedule I or II of the Drug Schedules Regulation, B.C. Reg. 9/98,  
(i) prescribe the drug,  
(ii) compound the drug,  
(iii) dispense the drug, or  
(iv) administer the drug by any method;  
(j) conduct challenge testing for allergies  
  (i) that involves injection, scratch tests or inhalation, if the individual being tested has not had a previous anaphylactic reaction, or  
  (ii) by any method, if the individual being tested has had a previous anaphylactic reaction.

(2) Only a registrant may provide a service of podiatric medicine as set out in this regulation if, on the day before this section comes into force, the provision of the same service by anyone other than a person authorized under the Podiatrists Act was prohibited.

**For the complete Act please visit:**

http://www.bclaws.ca/civix/document/id/complete/statreg/538573

**The Podiatry Act (Saskatchewan)**

**COLLEGE**

**Association continued as college**

3 The Saskatchewan Association of Chiropodists is continued as a corporation to be known as the Saskatchewan College of Podiatrists.

**PROHIBITION**

**Protection of title**

21(1) Subject to subsection (2), no person other than a member shall use the title “Podiatrist” or “Chiropodist” or any word, title or designation, abbreviated or otherwise, to imply that the person is a member.

(2) A podiatric surgeon who is registered pursuant to section 42.1 of The Medical Profession Act, 1981 may use the title “Podiatrist”.

**Use of title “Doctor”**

22(1) A member may use the title “Doctor” but only in conjunction with the word “podiatrist”, “podiatry”, “chiropodist” or “chiroprody” to indicate clearly that the member is not a physician or podiatric surgeon within the meaning of The Medical Profession Act, 1981.

(2) Clause 80(1)(c) of The Medical Profession Act, 1981 does not apply to a member who uses the title “Doctor” in accordance with subsection (1).
and treatment of disorders and injuries and anatomic defects of
the human foot.

**Authorized Acts:** Podiatry primarily concerns itself with the
diagnosis and treatment of diseases and disorders of the skin and
nails of the human foot, local manifestations of systemic diseases
in the human foot and underlying foot pathomechanics and gait
anomalies. "Podiatric Surgeons" may be authorized by the
Saskatchewan College of Physicians and Surgeons to be registered
as Podiatric Surgeons by the College of Podiatrists and authorized
to perform within a scope of practice defined by the College of
Physicians and Surgeons. [Subsection 42. 1, Medical Profession
Act, 1981, as amended.] It is the College's understanding that no
member of the College of Podiatrists has, in fact, registered as a
"Podiatric Surgeon".

**Authorized Drugs:** Currently no prescribing or diagnostic rights
exist for Podiatrists within this province as those authorities in the
Podiatry Act have not yet been proclaimed.

**Note:** The Saskatchewan Government decided not to embed scopes or
"controlled acts" in individual professions' acts. It was determined that the
overlaps in professional scopes obviated the need for statutory definition. All of
the definitions provided in this section are from the Saskatchewan College of
Podiatrists' Regulatory By-Laws.

**Manitoba**

**Titles:** “Podiatrist”, “Chiropodist”

**Regulation/Registration for Chiropodists/Podiatrists:** College of
Podiatrists of Manitoba

**Scope of Practice:**

- The practice of podiatry is the use of medical, physical or
  surgical methods to prevent, diagnose and treat ailments,
  diseases, deformities and injuries of the human foot, but
does not include treatment of systemic disease, except for
the local manifestations in the foot.

For purposes of the Podiatrists Act, the foot is described as
including the articulation of the tibia and fibula with the bones of
the foot and the muscles and tendons directly affecting foot function.

**Authorized Acts:**

- Subject to the regulations, in the course of practising podiatry, a podiatrist may:
  a) Cut into the subcutaneous, ligamentous, and bony tissues of the foot and the tendons directly affecting the function of the foot;
  b) Inject substances into the foot; and
  c) Prescribe drugs.

Podiatrists authorized to perform surgical procedures must be listed in a separate College register.

**Authorized Drugs:**

- Under the *Podiatrists Act* of Manitoba, podiatrists have prescribing rights, subject to regulations. At this time no such regulations exist and, accordingly, podiatrists in Manitoba may not prescribe.

**Québec**

**Titles:** “Podiatrist”

**Regulation/Registration for Podiatrists:** Ordre des Podiatres du Québec

**Scope of Practice:**

- Every act which has as its object the treatment of local disorders of the foot which are not systemic diseases constitutes the practice of podiatry.

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**C.C.S.M. c. P93 The Podiatrists Act (Manitoba) – Cont’d**

**Use of title**

3(2) No person except a podiatrist shall use the title "podiatrist" or "chiropodist", a variation or abbreviation of that title, or an equivalent in another language.

**Use of title "Doctor"**

3(3) A podiatrist registered under this Act may display or make use of the title "Doctor" or the abbreviation "Dr.", provided it is used in connection with the word "podiatrist", clearly indicating that he or she is not a physician within the meaning of The Medical Act.

**PART 3**

**COLLEGE OF PODIATRISTS OF MANITOBA**

**College established**

4(1) The Association of Chiropodists is continued as a body corporate under the name College of Podiatrists of Manitoba.

**For the complete Act please visit:**
http://web2.gov.mb.ca/laws/statutes/ccsm/p093e.php

**PODIATRY ACT (QUEBEC)**

**DIVISION II**

**THE ORDRE DES PODIATRES DU QUÉBEC**

2. All the persons qualified to practise podiatry in Québec constitute a professional order called the “Ordre professionnel des podiatres du Québec” or the “Ordre des podiatres du Québec”.
1973, c. 55, s. 2; 1977, c. 5, s. 229; 1994, c. 40, s. 438.

3. Subject to this Act, the Order and its members shall be governed by the Professional Code.

**DIVISION IV**

**PRACTICE OF PODIATRY**

7. Every act which has as its object the treatment of local disorders of the foot which are not systemic diseases constitutes the practice of podiatry.
1973, c. 55, s. 7.

8. A podiatrist may determine the podiatric treatment indicated, by clinical and radiological examination of the feet.

However, a podiatrist shall not make radiological examinations unless he holds a radiology permit issued in accordance with section 187 of the Professional Code.
1973, c. 55, s. 8.

11. Every podiatrist is authorized to use the medications which he may need in the practice of his profession, and to administer and prescribe medications to his patients, provided that they are medications contemplated by the regulations made under section 12.

He may also issue attestations relating to the supplying of such medications.
1973, c. 55, s. 11.
Authorized Acts:

- A podiatrist may determine the podiatric treatment indicated, by clinical and radiological examination of the feet. However, a podiatrist shall not make radiological examinations unless he holds a radiology permit issued in accordance with section 187 of the Professional Code. Podiatrists are authorized to prescribe and use the medications which they may need in the practice of their profession and to administer and prescribe medications to their patients, provided that they are medications contemplated by the regulations.

Authorized Drugs:

- Podiatrists may use in the practice of their profession or administer or prescribe to their patients the medications listed in Schedule I and II of the Regulation on Medicines a Podiatrist may use in the Exercise of his Profession or Administer or Prescribe to his Patients.

For a complete list of Schedule I and II Drugs see http://cocoohprac.wildapricot.org/resources/For%20Links%20ONLY%20-No%20Portal%20Access/Provincial%20Drug%20Lists.pdf.

New Brunswick

[The College admits to experiencing some difficulty in obtaining information pertaining to the practise of podiatry in New Brunswick and despite expending best efforts to do so, cannot guarantee the accuracy of the information provided below.]

Titles: "Podiatrist", "Chiropodist", "Dr.", "Doctor"

Regulation/Registration for Chiropodists/Podiatrists:
New Brunswick Podiatry Association.

PODIATRY ACT (QUEBEC) – CONT’D

12. The Office des professions du Québec shall prepare periodically, by regulation, after consultation with the Institut national d’excellence en santé et en services sociaux, the Ordre des podiatres du Québec, the Ordre des médecins du Québec and the Ordre des pharmaciens du Québec, a list of the medications which a podiatrist may use in the practice of his profession or which he may administer or prescribe to his patients, and determine, where required, the conditions subject to which a podiatrist may administer and prescribe such medications.

1973, c. 55, s. 12; 1974, c. 65, s. 109; 1977, c. 5, s. 14, s. 229; 1989, c. 30, s. 2; 2002, c. 27, s. 41; 2010, c. 15, s. 74.

13. No podiatrist may sell orthopaedic shoes or prostheses.

Nor may a podiatrist have a direct or indirect interest in an undertaking for the manufacture or sale of orthopaedic shoes or prostheses. If an interest in such an undertaking devolves to him by succession or otherwise, he shall dispose of it immediately.

However, a podiatrist is authorized to manufacture, transform, alter or sell podiatric ortheses even if the podiatrist does not hold a permit issued under the Act respecting medical laboratories, organ and tissue conservation and the disposal of human bodies (chapter L-0.2).

For the complete Act please visit: http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/P_12/P12_A.html

ACTS OF NEW BRUNSWICK 2005

CHAPTER 35

An Act to Amend An Act Respecting Podiatry

“podiatrist” means a person who holds a current certificate of membership in the association and is certified to practice podiatry, chiropody, acupuncture of the foot and massage in connection therewith.

(b) by repealing subsection (2) and substituting the following:

2(2) The practice of podiatry does not include amputation of, or treatment of, or injuries to, or infection of the hands or fingers.

For the complete Act please visit: http://www.gnb.ca/0062/acts/BBA-2005/Chap-35.pdf
Scope of Practice:

"Podiatrists" is defined as a person who holds a current certificate of membership in the Association and is certified to practice podiatry, chiropody, acupuncture the foot and massage in connection there with. The practice of podiatry does not include amputation of or treatment of or injuries to or infections of the hands or fingers.

Indications from the New Brunswick Department Health indicate that New Brunswick podiatrists are very limited in the surgical procedures they may perform, are not authorized to prescribe, dispense or administer drugs nor to order diagnostic tests.

Q 30: "What is the experience in other International jurisdictions?"

Response: In most developed nations there exists a health profession specifically concerned with or specializing in pedal health. At the risk of oversimplification, the UK's chiropody model was the original model and many jurisdictions' pedal health model (including Ontario's) reflect a direct lineage from that model. The US' pedal health was originally based on the UK chiropody model, but in the latter half of the 20th century the US model changed significantly into what became known as a podiatry model. That podiatry model now predominates in North American jurisdictions and for that reason it is referred to as the "North American podiatry model". Nevertheless, many countries in Europe and elsewhere have adopted the North American podiatry model, or have moved or are moving towards it.

Nomenclature, however, can be very confusing. For several decades, the pronounced trend worldwide has been to adopt the "podiatry" and "podiatrist" descriptors and titles, but a "podiatry" designation doesn't necessarily equate with a North American-style podiatry scope of practice and competencies. For example, the professions in Manitoba and Saskatchewan are called "podiatry" and the practitioners are called "podiatrists", but the scope of practice is more reflective of the UK chiropody model. Since circa 1994, "chiropody" and "podiatry" and "chiropodist" and "podiatrist" have been used interchangeably in the UK for what is really the traditional chiropody scope of practice.

Comparing and Contrasting the UK Chiropody/Podiatry and North American Podiatry Models

As related in the FORWARD to this Application, the essential differences between the two models can be characterized as follows:

- The North American podiatry model emphasizes the advanced medical diagnostic, non-surgical and surgical components of the footcare scope of practice. The UK chiropody model includes limited surgical procedures below the dermis and focuses on the nonsurgical treatment of conditions.
- The UK chiropody model focuses largely on the foot. The North American podiatry model includes the ankle, as well as the foot, and in some jurisdictions podiatrists are authorized to diagnose and treat conditions of the lower leg and other parts of the anatomy as well.

- The UK chiropody model does not include bone surgery; the North American podiatry model does.

- The practice venue for the UK chiropody model tends to be multidisciplinary and institution-based, although many chiropodists practise in other delivery streams. The practice venue for the North American podiatry model tends to be non-institutional podiatry or multidisciplinary clinics, surgical centres and wound care clinics and many podiatrists also have hospital privileges.

- The UK chiropody model does not include the ability to prescribe drugs or order diagnostic tests independently. The North American podiatry model includes the independent prescription of drugs, including narcotics and other controlled substances and the ordering of a full range of diagnostic tests commensurate with the scope of practice.

- The education programs under the UK chiropody model tend to be three-year diploma or baccalaureate programs, reflecting the chiropody scope of practice. The educational programs for the North American podiatry model tend to be four-year, post baccalaureate programs, followed by one year of hospital-based general residency, perhaps followed by another year or more of surgical residency.

Over the last several decades the titles and professional descriptors, "podiatrist" and "podiatry" have replaced, or are replacing, "chiropodist" and "chiropody". (Since 1994, the chiropody and podiatry titles have been interchangeable in the UK, but the podiatry title has become predominant. In the UK, the "chiropodist" title tends to be used by the older cohort of practitioners.) As indicated earlier, jurisdictions' adoption of the "podiatry" professional title and descriptor has not necessarily been accompanied by scope of practice changes. Sometimes the "podiatry" title has simply been superimposed on a chiropody scope of practice. More frequently, the adoption of the "podiatry" title has coincided with or has been prompted by some expansion in scope of practice beyond the traditional UK chiropody model and towards the North American podiatry model. While the North American podiatry model has spread largely in its "pure" form in terms of the scope of practice and related competencies (Québec being a notable exception), the spread of the UK chiropody model has tended to include components of the North American podiatry scope of practice.  

model manifests the most extensive scope of practice in pedal health extant anywhere. 48 US States and the District of Columbia, the 31 Mexican states, Alberta and British Columbia have in place scopes of practice analogous to that being proposed for Ontario in this Application.

**The Current State of Podiatry in the US**

With roughly 15,000 practising Podiatrists, graduating primarily from nine US academic institutions, the US podiatrist to general population ratio is roughly 1:20,928. The total student population in podiatry programs in the US is roughly 1,700 with an average annual intake between 550 and 600 students. These students are full-time for four years, followed by a year's general residency, often followed by one or more years of surgical residency taken in both hospitals and private practices. Upon completion of the academic program, graduates are awarded the degree of Doctor of Podiatric Medicine/DPM. Podiatrists in the US may generally diagnose, assess and treat conditions of the foot and ankle through, among other things, both soft and bony tissue surgery. Nonetheless, the podiatry scope of practice often excludes amputations. This description is largely applicable for all American states, as podiatrists are licensed to practise in all 50 states, the District of Columbia and Puerto Rico. However, since rights are ascribed to them under the regulatory or credentialing body of their respective states, the scopes of practice vary somewhat among these jurisdictions. In all states, diagnosis and treatment of the foot are authorized, as is the prescription of drugs, including narcotics. Treating the ankle in addition to the foot is permitted in 44 states plus the District of Columbia, with two additional states, New York and Massachusetts, currently putting forward legislation to include the ankle.

The work of American podiatrists is primarily carried out in private practices, surgical centres and wound care clinics; however they also serve on staff in hospitals and long-term care facilities, in municipal health departments and as commissioned officers in the Armed Forces. Podiatrists in the US are often

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members of group practices in which they work alongside members of other professions. American podiatrists have independent prescribing rights and as such may prescribe on their own initiative. Furthermore, podiatrists are also able to set fractures, take and interpret x-rays and order laboratory and other diagnostic tests consistent with the scope of practice.

**The UK Model**

Because Ontario adopted the UK chiropody model in the late 1970s and that model persists under the *Chiropody Act, 1991*, the College spent considerable time analyzing the UK model as it currently exists and whether its continuance in Ontario would serve and protect the public interest.

**FEETfirst Report 1994**

The foundation for today's UK chiropody/podiatry model in part springs from a 1994 Report of the joint Department of Health and the National Health Service Chiropody Task Force, entitled "FEETfirst" (sic). Remarkably, that report deals with many of the issues with which HPRAC is currently grappling in the chiropody and podiatry review. For that reason, the College has provided a copy of the complete Report in Appendix C.

Among the particularly noteworthy components of the Report in the context of HPRAC's review are the following:

- The Task Force recognized that the terms "podiatrist" and "podiatry" are increasingly being used within the profession and parts of the National Health Service in preference to the older and more familiar terms of "chiropodist" and "chiropody" (Page 5)

- In assessing the need for footcare, the Task Force found, inter alia, that "The aging of the population is the main factor increasing need for all healthcare, but this is particularly relevant for footcare services because such a high proportion of the service is provided for older people. There is no evidence that the diseases which cause major foot problems—namely osteoarthritis, diabetes and peripheral vascular disease—will change significantly in the forthcoming decades, or that there will be any marked change in the age-specific incidence and prevalence of these conditions. However, need will increase not only because of population aging, but also because of technological developments, that are poised to increase the range of effective interventions for people with foot problems. If need is defined as a problem for which there is an effective intervention, the need for footcare will increase to a greater degree than would be predicted by population aging alone."
It can be expected that alongside an increase in need, demand for footcare services will increase as expectations rise. Those who will be elderly in the future will have higher expectations than those who are elderly today.

Furthermore, certain populations have a higher level of need—such as the homeless whose conditions may also be complicated by alcoholism—and the need for chiropody may be high in inner-city areas." (Page 8).

- There should be an increased emphasis on "closed loop" treatment, by ensuring that patients' footcare conditions are effectively treated within an "episode of care", which requires the engagement of all providers having the requisite expertise. This is instead of continuous, long-term (and expensive) footcare, where patients' symptoms are more or less effectively treated, but the causes, systemic or otherwise, are not resolved.

- The Task Force urged a reorientation and reorganization of the chiropody profession. The growth of "Surgical Podiatry" should be encouraged to address the growing demand for what the Task Force called "operative footcare". The Task Force recommended that surgical podiatrists "should work in close association with orthopedic surgeons, but have their own distinct professional contribution" (Page 11). Footcare assistants should be trained by chiropodists/podiatrists and should assist chiropodists/podiatrists in basic footcare in order to enhance chiropodists'/podiatrists' productivity.

- Chiropody/podiatry should be more integrated with other professions and in multidisciplinary treatment centres.

(i) Difficulties in Comparing the UK and Ontario Models

Before getting to its analysis of the UK model in its current state of development and the conclusions the College drew therefrom, it is important to emphasize that an "apples to apples" comparison proved to be very difficult for a number of reasons:

- The UK professional regulatory model administered by the Health and Care Professions Council (HCPC) is quite different from the RHPA model. There is equivalent title protection and the titles "chiroprapist" and "podiatrist" are protected titles reserved for members of the profession who are in good standing with the HCPC. What we understand in Ontario as legislated "scopes of practice", however, are not prescribed, although there are "restricted acts" that are analogous to RHPA controlled acts. Instead, the HCPC approves educational programs and requires its registrants to practise within the limits of the knowledge, skills, training and experience they have acquired through those programs and through their clinical experience. Practitioners'
scopes of practice will, therefore, change over their careers due to additional clinical and didactic training, specializing and clinical experience.\(^77\)

- The UK chiropody/podiatry model is also in the process of evolution and has been for some time. The current status of the profession is somewhat short of the status recommended by "FEETfirst", for reasons that the College has been unable to discover. It is not possible to project where the UK model may end up in terms of what we understand to be the profession's scope of practice and authorized acts.

- Finally, accurate, consistent and up-to-date information about the practise and regulation of chiropody/ podiatry in the UK proved very difficult to come by. This was a cause of considerable frustration for the College. Even Professional Examination Service encountered difficulties in this regard.\(^78\)

### Why the College Chose not to Pursue the UK Model

From the information and documentation the College was able to retrieve, cross-reference and verify from multiple sources in the UK, the College concluded that adoption of the UK chiropody/podiatry model, as currently practised in the UK, would constitute a very substantial backward step and would do nothing to address the service gaps and access issues in footcare the College and others have identified. More specifically:

- UK chiropodists/podiatrists as a profession may not yet independently order or take laboratory tests or diagnostic imaging, unless authorized by the policy of the service provider for which they are working. According to the HCPC "... it would be unusual for chiropodists/podiatrists to be independently involved in making decisions about these kinds of diagnostic tests. They are decisions made by other members of the healthcare team (i.e. doctors, nurse practitioners)".\(^79\)

- The situation with respect to chiropodists'/podiatrists' prescriber status is complicated. In 2003 chiropodists/podiatrists were granted "supplementary prescriber" status. As such, they may (if employed within the National Health Service) independently prescribe any medicine from the British national formulary (BNF), except controlled drugs, for any condition within their competence under an agreed clinical management plan. Clinical management plans are usually

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\(^{77}\) E-mail to Don Gracey, The CG Group, from Nicole Casey, Policy Manager, HCPC, November 5, 2014.


\(^{79}\) E-mail to Don Gracey, The CG Group, from Michael Guthrie, Director of Policy and Standards, HCPC, October 29, 2014.
devised by General Practice physicians and dentists who have independent prescriber status.\textsuperscript{80} In 2012, the applicable law was amended to authorize chiropodists/podiatrists who have successfully completed a post-graduate pharmacology course approved by the HCPC to be "independent prescribers."\textsuperscript{81, 82}

- The "scope of practice" of UK chiropodists/podiatrists does not include bone surgery.

- UK chiropodists/podiatrists "may perform procedures on the foot under local anesthetic, some of which may be considered surgical in nature. This includes removal of toe nails and removal of neurovascular corns/verrucae via electrosurgery/radiolase. They are not allowed to undertake deep tissue/bone surgery such as correcting various toe deformities."\textsuperscript{83} (These procedures are within the scope of practice and authorized acts of podiatrists in Ontario and some are within the scope of practice of chiropodists.)

- Graduates of the UK chiropody/podiatry diploma, baccalaureate and even Masters programs experience a great deal of difficulty passing the College of Chiropodists of Ontario’s registration exams that include pharmacology. In fact, many are unsuccessful even after many attempts at taking the examination. This would suggest that the competencies deemed necessary to practise within the UK scope are not geared to those required to practise chiropody in Ontario.

- Acupuncture is not deemed to be within the scope of practice of UK chiropodists/podiatrists, as a profession.

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\textsuperscript{80} NHS Choices: "Who can write a prescription?", January 24, 2013.

\textsuperscript{81} The additional education is at the Level 6 (baccalaureate) or Level VII (Masters) and includes didactic and supervised clinical work. E-mail to Suzanne Sterling, The CG Group, from Dr. Paul Chadwick, FFM, RCPS, October 30, 2014.) Chiropodists/podiatrists who complete this additional training have their names "annotated" in the HCPC Register. As of September 1, 2014, 26 chiropodists/podiatrists had qualified as independent prescribers.

\textsuperscript{82} "(Chiropodist/podiatrists with independent prescriber status may only) prescribe medicines for those conditions where they have the knowledge, understanding, training and skills to do so safely and effectively. Independent prescribing means that qualified podiatrists would be able to make their own independent decisions about whether an individual patient needs to have a particular medicine. They would be able to write a prescription script. They could administer having prescribed, or delegate the administration to someone else (for example, this is the same way in which a doctor might decide a patient needs a medicine and a delegated administration to another member of the healthcare team). So, someone who is an independent prescriber may also "sell" or "administer" those medicines they are authorized to prescribe." E-mail to Don Gracey, The CG Group, from Michael Guthrie, Director of Policy and Standards, HCPC, October 28, 2014.

\textsuperscript{83} E-mail from Kim Bryan, UK Society of Chiropodists and Podiatrists, to Don Gracey, The CG Group, September 15, 2014.
Clearly, the UK chiropody/podiatry scope of practice is more limited and limiting than the chiropody scope of practice and authorized acts that currently exist under the *Chiropody Act*, 1991. That is why the College concluded that adoption of the UK model would actually represent a step backwards for footcare in Ontario. As the submissions to HPRAC in the "current footcare model review" clearly demonstrated, there are many professions in Ontario that currently provide footcare that would be deemed to be within the UK chiropody/podiatry scope of practice. The gaps in Ontario’s footcare delivery exist in the specialized medical diagnostic and surgical continuum of foot and ankle care. Those gaps are beyond the scope of UK chiropodists/podiatrists, but are within the Alberta and British Columbia scopes that the College wishes to emulate.

In addition, adoption of the UK chiropody/podiatry model, or a facsimile thereof, would do nothing to address the inter-jurisdictional mobility issues that chiropodists and podiatrists face in Ontario. Ontario’s chiropodists would continue to be very restricted as to where they could practise in Canada. Québec, British Columbia and Alberta would continue to be closed to them. The same would be the case with Manitoba if it is successful in its quest to adopt a podiatry model emulating the British Columbia and Alberta models. Likewise, there would be no incentive for DPM podiatrists from other provinces or graduates of DPM schools to register to practise in Ontario in order to help address the footcare HR deficits in this Province.

It is also our understanding that Saskatchewan is experiencing challenges with its "podiatry" model which is very much cast in the UK form. There has been a substantial net decline in the number of registrants, due to some practitioners leaving to practise elsewhere and other practitioners leaving the profession entirely. (In one year alone, the net number of registrants is reported to have declined by 25%.) The Saskatchewan College of Podiatrists is concerned that patients are not able to access the right practitioners at the right time for their foot conditions as a consequence. Attempts to expand the scope of practice to include diagnostic tests and prescribing rights are in limbo.84

All this is not to say that the College rejects the UK model in its entirety. As in British Columbia, an “add-on” to the UK chiropody/podiatry model is developing called "Podiatric Surgeons". These practitioners have completed approximately seven years of didactic and clinical education set or approved by the UK College of Podiatric Surgeons,85 after having been registered with the HCPC.86 Their scope of practice and competencies are very similar to the scope of practice and competencies that the College recommends be adopted in Ontario. The HCPC has mounted a public consultation around a proposal to annotate the HCPC register of chiropodists/podiatrists to identify certified Podiatric Surgeons. The public consultation is scheduled to end in January, 2015. One of the principal issues with which the HCPC

84 Telephone interview with Axel Rohrmann, Registrar of the College of Podiatry of Saskatchewan, October 8, 2014. [The relevant authorities in the Saskatchewan Podiatry Act have not been proclaimed.]
85 The College is a division or an affiliate of the UK Society of Chiropodists and Podiatrists.
is grappling is the recognition or accreditation of the clinical and didactic courses necessary for practitioners to be "annotated" in the HCPC register as podiatric surgeons.

The podiatric surgeon "class" is still in the developmental process for regulatory purposes.\footnote{The College made numerous attempts by e-mail and telephone to connect with the UK Society of Chiropodists and Podiatrists and the UK College of Podiatrists for information about the chiropody and podiatry profession as it is practised and regulated in the UK and the number, training and certification of podiatric surgeons in the UK. In a few instances, we were referred to the regulatory body, the Health and Care Professions Council. Otherwise, the UK Society and College were not as responsive as the College expected or required.} Furthermore, the UK Health and Care Professions Council indicates that the situation is "not straightforward". Accordingly, the College has reproduced verbatim the explanation provided by the HCPC via e-mail dated November 26, 2014 at Figure 9.

" ........ What is commonly referred to as podiatric surgery however, is significantly different from the scope of practice of a chiropodist/podiatrist at entry to the profession. Podiatric surgery incorporates interventions beneath the skin and can include work with the bone.

Podiatrists who have at least one year’s post-registration practice can undertake further study of about 3 years, culminating in the FCPodS (Fellowship of the Faculty of Podiatric Surgery). Graduates are considered qualified to undertake podiatric surgery, though typically FCPodS holders continue to receive supervision whilst carrying out surgery. There are about 180 holders of the FCPodS. After a further three years of training and supervised surgical practice, they can achieve the Certificate for the Completion of Podiatric Surgery Training (CCPST). Such surgery may include mid- and rear-foot work. There are about 100 holders of the CCPST. They perform surgery without supervision.

I should also note that there is work underway in Scotland to develop another route to qualification in podiatric surgery. Neither of these routes lead to annotation of podiatric surgery qualification on the HCPC Register, as discussed. At the moment we do not have information about the number of podiatrists / chiropodists practising podiatric surgery. However it is our intention in future to begin to annotate for podiatric surgery, and part of that will be to conduct approval processes for all of the relevant training programmes with reference to a new set of standards......"

Nicole Casey
Policy Manager
The Health and Care Professions Council
Park House, 184 Kennington Park Road, London, SE11 4BU www.hcpc-uk.org

Figure 9: Email dated November 26, 2014 from the Health and Care Professions Council (HCPC)
AUSTRALASIA

The "podiatry" model in Australasia appears to be very similar to the UK chiropody/podiatry model with some notable variations. The regulatory framework for healthcare professions also appears to be very similar to that in the UK.

Australia

Like Canada, Australia is a federation and the regulation of healthcare professionals is within state jurisdiction. "Podiatrists" are registered in each state and the Australian Capital Territory and regulated by a statutory professional regulatory body in each of Queensland, New South Wales, Tasmania, Victoria, South Australia, Western Australia and the Australian Capital Territory (ACT). In some States there is a specific Podiatry Act. In other states (e.g. South Australia and the ACT) podiatrist regulation is included within a single, omnibus statute applying to a number of health professions. The scopes of practice are materially the same among all the states and the ACT.

In 1977 the official nomenclature changed from "chiropodist/chiropody" to "podiatrist/podiatry", ostensibly to reflect an expanded scope of practice and upgraded education.

Unlike the UK, however, the anatomical scope of practice includes the "lower limb" as well as the foot and the role of podiatric surgeons as a specialization within the profession appears to be more established and advanced.

Currently in Australia there are 4,034 podiatrists in active practice, including 27 podiatric surgeons; a practitioner: population ratio of 1:5100. A three-year baccalaureate degree in one of the eight podiatry programs approved by the Podiatry Board of Australia is required to be eligible for registration.

According to the Podiatrists' Association of Australia, the podiatry scope of practice is

"....... the prevention, diagnosis, treatment and rehabilitation of medical and surgical conditions of the feet and lower limbs. The conditions podiatrists treat include those resulting from bone and joint disorders such as arthritis and soft-tissue and muscular pathologies, as well as neurological and circulatory disease. Podiatrists are also able to diagnose and treat any complications of the above which

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88 The Podiatry Board exercises authorities delegated by the Australian Health Practitioners Regulation Agency (AHPRA) and all Board members are appointed by the AHPRA. Qualification to register as a podiatric surgeon requires additional clinical training and didactic training at the postgraduate level.
affect the lower limb, including skin and nail disorders, corns, calluses and ingrown toenails. Foot injuries and infections gained through sport or other activities are also diagnosed and treated by podiatrists." 89

Except for podiatric surgeons, bone surgery is beyond the scope of practice and soft tissue surgery appears to be limited to procedures such as the surgical correction of chronically ingrown toenails and treating corns and calluses. Podiatrists are authorized to dispense or administer OTC pharmaceutical agents, apply specialist wound dressings, provide physical therapies and prescribe and dispense foot orthoses. The Podiatry Board determined that acupuncture should not be included within the podiatry scope of practice, although a number of podiatrists are cross-registered with the Chinese Medicine Board of Australia to do so.

Podiatrists who have successfully completed additional education may prescribe and dispense what are referred to as "Section 2, 3, 4 and 8 Medicines".

Multidisciplinary practice appears to be the preferred venue for podiatrists' employment.

New Zealand

New Zealand presents a reasonable facsimile of the UK chiropody model.

"Podiatrists" in New Zealand are regulated by the Podiatrists Board of New Zealand under the Healthcare Practitioners Competence Assurance Act, 2003. The Act came into legal force and effect on September 18, 2004. (Those who practised as chiropodists prior to 2003 weregrandparented into the Board as "podiatrists" on that date.) The Act was subject to a statutory sunset review in 2012, but the College has been unable to ascertain whether the review actually took place and if it did, the outcome.

Under the Act, entry-level podiatrists are described as

"A registered primary health care practitioner who utilizes medical, physical, palliative and surgical means other than those prescribed in the Podiatric Surgeon Scope of Practice, to provide diagnostic, preventive and rehabilitative treatment of conditions affecting the feet and lower limbs."

To be eligible for registration with the Board an individual must have successfully completed a baccalaureate-level degree in podiatry from an accredited New Zealand University, or complete an overseas qualification deemed to be equivalent by the Podiatrists Board. All accredited Australian podiatry programs are recognized by the Board.

Podiatrists are authorized to administer local anesthesia in order to conduct surgical procedures within their scope of practice.

Podiatrists who have obtained additional education are eligible to be granted prescribing rights by the New Prescribers Advisory Committee and, as such, are authorized to prescribe medications designated by the Podiatry Board. Such practitioners are referred to as "Podiatric Prescribers".

Podiatric Surgeons' scope of practice is defined as

"(The performance of) foot surgery by way of sharp toe nail wedge resection; surgical correction of lesser digital deformities affecting the phalanges, metatarsals and associated structures; surgical corrections of deformities affecting the first toe, first metatarsal and associated structures; surgical correction of osseous deformities of the metatarsus, mid-tarsus, rearfoot and associated structures; surgical correction and removal of pathological subcutaneous structures such as tendinous and nervous tissues and other connective soft tissue masses of the foot."90

Podiatric Surgeons must have successfully completed a postgraduate program in podiatric surgery approved by the Podiatrist Board.

There is a further class of podiatrists prescribed by the Board, "Podiatric Radiographic Imager", defined as a podiatrist who has obtained post-graduate qualifications and

"......who is qualified to use radiological equipment, and is licensed by the National Radiation Laboratory, to obtain plain radiographic images of the foot, ankle and lower leg."91

**Chiropody and Podiatry in Continental Europe**

In Europe the "podiatry" nomenclature has been almost universally adopted, but scopes of practice differ and often fall substantially short of the North American podiatry model. It is probably more accurate to describe these models as blends of the US and UK models and, therefore, for purposes of this description we use the "chiropody/podiatry" nomenclature.

Outside of the UK, countries such as Spain, Sweden, France, Germany, Italy and Finland have all adopted a chiropody/podiatry model, though the scopes of practice vary from country to country. Spain most closely approximates the US model with one of the most extensive scopes of practice. It also has one of the highest numbers of podiatry educational institutions and one of the highest numbers of podiatrists (known locally as “Podologists,”) in Europe. There are roughly 5000 podiatrists in active practice in Spain and an estimated annual intake of 500 new students.92 Spanish podiatrists are authorized to perform

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91 "New Zealand Podiatrist Board Notice ...." Ibid.

most surgical procedures on soft or bony tissue – rearfoot and forefoot – but they are not authorized to perform amputations.

The authority of practitioners to perform surgery is one of the major variables in scopes of practice across jurisdictions on the European Continent. "Podiatrists" in countries such as Finland, France, Germany and Sweden are not authorized to perform any type of subcutaneous surgery as part of their scopes. Conversely, podiatrists in Italy are allowed to perform both soft tissue and bone surgery on the foot and ankle.

Similarly the prescribing rights of podiatrists in European nations vary significantly. In Sweden, Italy, Germany and Finland podiatrists have no prescribing rights as of 2007.93 94 95 For the most part this coincides with the lack of authority to perform subcutaneous surgical operations. In other European countries such as France, podiatrists have prescribing rights for topical medicines. Spanish podiatrists have more extensive prescribing rights, although they are not clear-cut. In Spain Podiatrists are neither explicitly allowed to, nor are they forbidden from, prescribing drugs. As such, access is governed by Pharmacists’ willingness to supply.

Other Jurisdictions

Outside the US and Europe, there are a number of countries that have adopted the UK chiropody/podiatry model. In Hong Kong, Singapore, Cyprus and Israel the traditional British model of chiropody exists, although in Israel (like Ontario), a North American-style podiatry model exists in parallel. These countries have no schools of their own. Students attend United Kingdom, United States, Australasian or South African schools. These countries generally follow the prescribing rights of the UK model and allow for the performance of soft tissue surgery as part of their scopes of practice, as well as bone surgery on the foot and ankle for podiatrists in Israel.

The legal authority to perform surgery is an indicator of the extent to which a podiatry model has been adopted. Podiatrists in many jurisdictions are authorized to perform soft tissue surgery (e.g. South Africa, Hong Kong, Singapore). The prescription of drugs, at the very least analgesics, is often included within the scope of practice for Podiatrists internationally. Prescribing rights are understandably usually linked to the extent to which the performance of surgical procedures are authorized.

Q 31: "What are the potential costs and benefits to the public and the profession in allowing this change in scope of practice? Please consider and describe the impact of any of the following economic factors."

Response:

Economic Assessment of Podiatric and Orthopedic Surgery Costs in Australia

“A recent report by Access Economics describes the results of an economic impact analysis estimating the potential impact of improving access to podiatric surgeons in the Australian health sector. The report assesses the cost effectiveness and cost benefit of using podiatric surgeons to perform foot and ankle surgery compared with using orthopaedic surgeons.

Key findings of the report are that:

- podiatric surgery is less costly than orthopaedic surgery across all categories of procedures on average by $3,635 per procedure; and
- in addition to the $3,635 per procedure saved in financial costs, there is a relative gain in well-being calculated at $5,016 per procedure for podiatric surgery relative to orthopaedic surgery.

The report’s conclusions support the greater utilisation of podiatric surgeons in the Australian health system. Specifically the report cites benefits including:

- substantial financial savings associated with reduced lengths of stay;
- decreased waiting times for elective foot and ankle surgery;
- increased productivity;
- improved prevention of co-morbidities associated with decreased waiting times; and
- a quicker return to an improved quality of life” (AHWI, 2008. 12).

Case Study 6. Caption from Australian Department of Human Services, “Foot and Ankle Surgery Project Literature Review”.

System-wide benefits will be generated as a consequence of the following factors:

- The more extensive scope of practice and authorized acts will allow podiatrists to provide a more complete continuum of care, reducing the number of circular referrals and the costs and delays in timely diagnosis and treatment that circular referrals prompt;

- Attracting more podiatrists to practise in Ontario by a scope of practice that better reflects the competencies they have acquired and reduces the frustrations inherent in the current limited scope of practice, thus reducing wait-times for podiatrists, physicians/orthopedic surgeons through the displacement effect;

- Reducing the demand on hospital beds and hospital operating rooms, by siphoning off to podiatric clinics those surgical foot and ankle surgical procedures that can be safely and effectively conducted by podiatrists in other settings.
• Reducing the utilization of hospital ERs for foot and ankle conditions that can be safely and effectively treated by podiatrists in their clinics (e.g. setting or casting a fracture or dislocation). 96

• Reducing the demand on orthopedic surgeons for less complex foot and ankle surgeries. In this regard, a March, 2009 submission to the Ministry of Health and Long-Term Care by orthopedic surgeons stated that:

"Performing a high proportion of less complex foot and ankle surgeries is not an efficient use of highly specialized foot and ankle surgeons. Because so many cases are being referred to these specialist, many referrals, where it is clear there is no need for specialized care, are simply returned to the referring physicians and patients are not seen within the health care system" 97;

• Providing enhanced access to foot and ankle care, especially in rural, remote, northern and other underserviced areas of Ontario and for those who do not have access to a family physician;

• Reducing the number of foot and ankle cases handled in hospital emergency departments;

• Reducing the incidence (and cost) of foot and ankle ailments and systemic and chronic diseases that manifest themselves in the feet and ankles. For example, reducing the number of foot amputations caused by diabetic conditions; and

• Enhancing access to podiatric care in home care, long-term-care homes, retirement homes and in other seniors' congregate living centres and community-based programs. Seniors, by far, are the largest consumers of footcare services even though proper footcare for seniors is chronically neglected, notwithstanding the fact that proper footcare helps to keep seniors ambulatory, active and independent.

1. Direct patient benefits/costs

(Appendix B catalogs the costs/benefits of podiatric procedures on a procedure-by-procedure basis). The patient benefits and costs have been enumerated elsewhere in this Application.

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96 According to an internal study by the Institute for Clinical Evaluative Studies, the number of visits to Ontario hospital ERs has increased by 14% over eight years. When population growth is factored in, the rise in ER utilization has been 5.5%. "The prevailing theory is that the increase is a reflection of the difficulty patients have in accessing primary care. When patients have easy access to family doctors and other primary care providers they are less likely to visit ERs". "Health care, the forgotten issue Ontario's election", the Toronto Star, November 12, 2014.

To summarize, the major patient benefits will be:

- Expanding "one stop" diagnosis and treatment of foot and ankle conditions through the provision of a more extensive continuum of care within the competencies of individual practitioners;

- Reducing the requirement for circular referrals and thereby enhancing patient convenience and the timeliness of patient diagnosis and treatment;
• Reducing or addressing the incidence of chronicity in foot and ankle ailments;

• Reducing the incidence and the morbidity of foot and ankle-related diseases, disorders and dysfunctions;

• Returning patients to the maximum pre-injury or pre-disease status possible;

• Enhancing patient access to quality foot and ankle care, particularly in areas of the Province that are currently underserviced;

• Reducing wait times for elective and non-elective foot and ankle care; and

• The provision of clinically-proven safe, effective and innovative care in patient-convenient ambulatory, community-based clinics.

The services rendered by members of the podiatrist class are currently partially covered by OHIP. Chiropodists' services and the non-OHIP portion of podiatrists' services are covered by most extended health benefits insurers. The WSIB pays for chiropodists' and podiatrists' services pursuant to a fee-for-service schedule and under the WSIB's lower extremities Program of Care.

Preliminary discussions with the Ministry indicate no inclination to reduce or withdraw public funding for those podiatrists currently registered under OHIP. The College has had discussions with the Canadian Life and Health Insurance Association and kept it fully informed of the College's proposals with respect to scope of practice changes. CLHIA has expressed no concerns about what is being proposed and has given no indication that its members would reduce or withdraw coverage as a consequence. The WSIB has indicated that the reimbursement status quo would continue under an expanded scope of practice.

The Applicant believes, accordingly, there is no reasonable basis to project that patients' costs would be increased as a consequence of the proposed changes.

2. Benefits and costs to the broader healthcare service delivery system.

Ontario's Action Plan for Health Care acknowledges the need to make trade-offs and shift spending patterns to generate the best value for money. The Commission on the Reform of Ontario’s Public Services’ report (the Drummond Report) also called on the Ontario government to devise policies that shift people away from in-patient, acute care settings to community care, where appropriate; and to use competition to fund procedures based on price and quality. Both the Action Plan and the Drummond Report acknowledge that procedures performed in specialty clinics in community settings can be provided at a lower cost than in hospital acute care settings. Ontario's Action Plan for Health Care and
the Drummond Report aim to moderate the increase in healthcare expenditures while maintaining or enhancing quality care by:

- Reforming the manner in which procedures are delivered;
- Maintaining hospital capacity to provide inpatient and higher acuity procedures while allowing community-based healthcare providers to perform procedures currently provided in hospitals when appropriate to reduce the number of patients admitted to hospital when they may not need that level of care;
- Shifting procedures to more efficient healthcare providers while maintaining quality;
- Encouraging hospitals to specialize in some procedures to avoid duplication in the system and create efficiencies.

"Performing a high proportion of less complex foot and ankle surgeries is not an efficient use of highly-specialized foot and ankle (orthopedic) surgeons"

- Daniels et al, 2009. 20.

The podiatry model being proposed by the College in this Application is entirely consistent with the Action Plan and with the recommendations of the Drummond Report and will help the Ontario government achieve the objectives set by both. Implementation of the podiatry model proposed in this Application will increase system-wide efficiencies and will apply healthcare dollars for foot and ankle care more efficiently and effectively.

"...a strategy to achieve early detection and treatment of the foot and ankle conditions for patients within Ontario is required"

- Daniels et al, 2009.10.

- Thomson Reuters Healthcare carried out the study utilizing its MarketScan Data Base examining claims from 316,527 patients with commercial insurance (64 year of age and younger) and 157,529 patients with Medicare and an employer sponsored secondary insurance.
- The study focused on one specific aspect of diabetic foot care: those patients who developed a foot ulcer. For those who developed a foot ulcer, the year preceding the development of a foot ulcer was examined to see if they had seen a podiatrist. Those who saw a podiatrist were compared to those who did not over a three year time period.
- A comparison was then made between those who had at least one visit to a podiatrist prior to developing the foot ulcer to those who had no podiatry care in the year prior to developing the foot ulceration.

The results were significant:
- **Average savings over a three-year time period (year before ulceration and two years after ulceration occurred):**
  - Commercial Insurance: Savings of **$19,686** per patient if they had at least one visit to a podiatrist in the year preceding their ulceration
  - Medicare Insured: Savings of **$4,271** per patient

- **Decrease in amputations: Limbs saved.**

- **If we extrapolate these results so that all insured in the commercial and Medicare populations with diabetes and at risk for a foot ulceration had a visit to a podiatrist:**
  - **$1.97 billion** could be saved in the commercial insurance group in one year
  - **$1.53 billion** could be saved in the Medicare insurance group in one year
The new model is projected to apply healthcare expenditures for foot and ankle care more efficiently and effectively in the following ways:

- By reducing the number of circular referrals and referrals to other healthcare practitioners and healthcare delivery venues for care that is within the podiatric scope of practice;
- According to the Ministry of Health and Long-Term Care, in 2010/11 there were 27,000 ER visits that could have been treated in alternate primary care settings. A substantial portion of the ER visits relating to diseases, disorders or dysfunctions of the foot and ankle could be drained off to podiatrists practising to their full competencies in the proposed scope of practice.
- The podiatry model revolves around the provision of care in ambulatory, community-based clinics, thereby reducing pressures on hospital inpatient resources, so those resources can be more accessible to those patients who genuinely need them;
- By helping to keep seniors ambulatory and independent as long as possible, thereby reducing the demand for long-term-care and home care;
- By reducing complications and the morbidity of foot and ankle diseases through timely and effective care, particularly in the instances of the major drivers of healthcare expenditures such as diabetes and arthritis;
- By enhancing access to expert foot and ankle care in areas of the Province that are currently underserviced or not serviced at all by footcare specialists;
- By helping to “de-stress” demand for orthopedic surgeons and hospital operating rooms and, thereby reduce wait-times for complex procedures; and
- By fully utilizing the investment made in the training of chiropodists and podiatrists, by allowing them to utilize fully the competencies they have acquired.

There have been several studies comparing the cost of podiatrists performing procedures and the cost of those identical procedures being performed by orthopedic surgeons and others in hospitals. The cost of podiatric procedures usually ranges from 25 to 50% less (See Appendix B). Podiatric outcomes are as good or better. Even at that, the savings are probably significantly understated due to the hidden costs of hospital care that are not included, or at least are undervalued. (Appendix C contains a comparison of podiatrist and orthopedic surgeon Medicare fees in in British Columbia and Alberta.)

The podiatry model is not projected to increase net, per capita healthcare expenditures. There may be an apprehension that providing podiatrists and chiropodists with authority to order new or additional diagnostic tests will increase the utilization of those tests and thereby add to total healthcare expenditures. In fact, GPs currently order tests requested by podiatrists---and probably more than those
requested by podiatrists. In any event, this concern is belied by experience in other jurisdictions. When the authority to order diagnostic tests has been extended to other professions in other jurisdictions, characteristically the total number of tests has actually declined. For example, allowing physiotherapists to order radiographs in Australia and in the United Kingdom led to a reduction in the number of radiographs ordered. 98

“In 2010/11, over 271,000 emergency room visits were made to Ontario hospitals that could have been treated in alternate primary care settings.”

3. Benefits and costs associated with wait times:

According to a 2013 report by The Fraser Institute, Ontario (with New Brunswick and Labrador) leads Canada in reducing wait times for surgical procedures. Nevertheless, the same report found that the wait times for orthopedic procedures in Ontario still exceed clinical guidelines. The actual median wait time between the first specialist consultation and orthopedic surgery is 18.9 weeks versus the median clinically reasonable wait of 11.2 weeks; a difference of 69%. 99 The estimated number of procedures for which patients are waiting after an appointment with a specialist is 269,617 in Ontario, of which 43,676 fall under the Orthopaedic Surgery specialty, an increase of 10% from 2012. 100 Of the procedures pertaining to the foot or ankle, many could be safely and effectively performed by podiatrists under the proposed scope of practice, such as 3,120 for Menisectomy/Arthroscopy, 1,887 for Removal of Pins, 29,114 for Arthroplasty (Hip, Knee, Ankle, Shoulder), 1,004 for Arthroplasty (Interphalangeal, Metatarsophalangeal), 599 for Hallux Valgus/Hammer Toe, 2,220 for Digit Neuroma, 1,174 for Rotator Cuff Repair, 3,000 for Ostectomy (All Types), and 1,559 for Routine Spinal Instability.

4. Workload, training and development costs:

As explained elsewhere in this Application, the performance of any of the proposed new or expanded authorized acts by current College registrants who are grand-parented into the new College will not be mandatory. Those grand-parented registrants who choose to perform any or all of the new or expanded authorized acts and who require refresher or upgrading courses in order to do so, will be required to


complete those courses at their own cost. The College has undertaken to expend best efforts to make such courses reasonably available in Ontario. At this time, however, the College cannot project what the cost of those courses might be and the cost per practitioner would vary materially on a practitioner-by-practitioner basis.

The College does not anticipate a net increase in workload for present members of the profession. At this time, most members of the profession are working at or very close to capacity. For the profession as a whole, we anticipate a progressive movement into the surgical components of the existing and proposed scope of practice and progressively less focus on the nonsurgical/public domain components. The College anticipates that increased demand for the public domain components of the scope of practice will be increasingly provided by members of other regulated and unregulated professions, either on their own or in collaboration with podiatrists.

5. Costs associated with educational and regulatory sector involvement:

The College has used two sources to endeavour to calculate the start-up and operating costs of a University-level podiatry program in Ontario: The Université de Québec that has had a four-year DPM program operational for about four years and a Business Plan prepared by the University of Alberta to set up a four-year DPM program. Both are based on an intake of 25 students per year, for a total of 100 students in-stream in full, four-year, operation. The actual total operating cost of the UQTR program is $1.7 million annually. The projected cost of the Alberta program was $2.5 million (which included amortized start-up costs). The extent and nature of start-up costs in Ontario would vary materially depending on the type of institution launching the program, in particular whether the program is incorporated with an existing medical school. If a podiatry program is grafted onto an existing medical school, the startup costs would be minimal and the operating costs would be calculated on a marginal cost basis. If a podiatry program is launched de novo, the startup costs (likely amortized in the annual operating costs) can be expected to be substantial.

Offset against these costs would be the current operating expenditures required to provide the three-year Advanced Diploma Program in Chiropody at the Michener Institute. The College asked The Michener Institute for revenue and expenditure data pertaining to the Institute's administration of the chiropody program. The Institute responded that the information "is not publicly available". Accordingly, it is not possible for the College to project the net costs of launching a podiatry program at an Ontario University.

There will be net additional costs for the proposed College of Podiatrists and for any interim or transitional work conducted by the College of Chiropodists to devise and implement the transitional and foundational regulations, By-Laws, standards of practice, policies, guidelines and competency evaluation for grand-parented registrants and to communicate the changes and their implications to members, the public, other professions and stakeholders. Those costs are expected to be substantial. Nonetheless, the College believes that the transitional costs can be covered by the College's existing financial reserves
and resources and thereafter by existing registration fees. Some cost pressures currently faced by the College will be reduced and regulatory efficiencies enhanced by regulating a single profession and by removal of the podiatric cap. The College also anticipates that the enhanced scope of practice proposed in this Application and removal of the podiatric cap will lead to an increase in membership that exceeds historical trends. See response to Question # 7 in the Submission in response to HPRAC's 18 Additional Questions.

**Q 32:** "Is there any other relevant information that HPRAC should consider when reviewing your proposed request for a change in scope of practice?"

**Response:** The College wishes to emphasize several points that are fundamental components of the rationale to convert to a podiatry scope of practice:

1. The proposal for change in scope of practice entails a change in practice model. The traditional chiropody model on which the current *Chiropody Act, 1991* is founded is based on chiropodists functioning as salaried personnel within hospitals and analogous healthcare institutions. The podiatry practice model is primarily, but not exclusively, a de-centralized non-institutional model where diagnosis and treatment are performed, including surgical procedures that can be safely and effectively conducted outside of institutions. The traditional chiropody model may well have been consistent with the healthcare delivery paradigm of the late 1970s and early 80s when the model was instituted. The proposed podiatry model of practice is clearly consistent with the healthcare delivery paradigm articulated by the current government and will lead to enhanced access to care, system-wide efficiencies, more patient convenience and more effective use of scarce healthcare resources.

2. The history of chiropody and podiatry in Ontario demonstrates that, for the better part of last 100 years, successive Ontario governments have grappled with the design of the appropriate footcare delivery model for Ontario. The current chiropody model is very much a construct of past governments' policies, rather than a response to external and internal pressures and forces that usually define the evolution of healthcare professions. One result is that Ontario has been left behind in its footcare delivery model. The College believes and the clinical evidence indicates that a North American podiatry model of care represents best practices. An objective of the proposed scope of practice change is to acknowledge and adapt the evolution of footcare delivery, regulation and practice models that has occurred in comparable jurisdictions and has generated positive outcomes for patients and for the healthcare system generally.

3. A gap in the demand for the footcare services contemplated in the proposed scope of practice and authorized acts and the supply of practitioners competent to provide those services has been documented in this Application. That gap exists today and is projected to widen as the population ages. Addressing that gap requires a number of substantive changes: a) Revocation of the podiatric cap; b) Implementing a broader scope of practice that allows existing practitioners to use their competencies to the fullest, create a more extensive, seamless continuum of care and to create an incentive for future
practitioners to enter the profession; c) Implementing a broader scope of practice that will activate a practice model that will enhance patient access to care.

4. Despite whatever else may happen as a consequence of this Review, the College urges HPRAC to correct mismatches in the current scope of practice and authorized acts of chiropody and podiatry. It is anomalous, if not nonsensical, for chiropodists and podiatrists to be authorized to perform surgical procedures below the dermis, but not be authorized to order the laboratory tests necessary to plan, perform and follow-up on those procedures safely and effectively. It is anomalous, if not nonsensical, for podiatrists to be authorized to surgically break bones and joints, but not have the authority to set them. The same applies to the authority of chiropodists to assess, diagnose and treat diseases and dysfunctions of the foot, but not being able to order or utilize "forms of energy" such as MRIs. These "mismatches", that are arguably a result of the institution-based chiropody practice model that was adopted in the late 1970s and early 1980s, have become evident as chiropodists abandoned that practice model, are particularly anomalous for members of the podiatrist class and would be even more anomalous under the proposed podiatry delivery model.

Ontario's Action Plan for Healthcare aims to achieve "Access to the right care at the right time in the right place."

The Minister has articulated two subsidiary components to judge proposed changes or innovations in healthcare delivery:

"Is it better for patients?"

"Is it a more cost-effective use of healthcare dollars?"

The College is absolutely convinced that the proposals set out in this Application satisfy or exceed these criteria and are therefore entirely consistent with and supportive of the government's policy objectives for healthcare in Ontario.