SUBMISSION TO:

HPRAC Health Professions Regulatory Advisory Council

Health Professions Regulatory Advisory Council
56 Wellesley St. W., 12th Floor
Toronto, ON. M5S 2S3

Attention: Thomas Corcoran and Council Members,
RE: Second Consultation – Chiropody and Podiatry Review

BY:

Ontario Podiatric Medical Association

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

RE: Second Consultation - Chiropody and Podiatry Review

Dear Mr. Corcoran et al,

The Ontario Podiatric Medical Association (OPMA) represents a full spectrum of regulated footcare practitioners, namely members of the podiatrist class, graduates of Doctor of Podiatric Medicine (DPM) programs currently registered to practise in Ontario as chiropodists, chiropodists and Ontarians currently studying in any of the ten (10) DPM programs in United States and Canada, or engaged in postgraduate residencies in podiatry.

The OPMA appreciates this opportunity to comment on the College of Chiropodists' formal proposal to HPRAC to adapt a North-American-style podiatry scope of practice and model of practice in Ontario. In essence, the College aims to expand the diagnostic, therapeutic and surgical components of the current podiatry scope of practice and include the additional controlled acts that are necessary or incidental to the safe and effective practice of both the current and proposed scope. The objective is to enable podiatrists to provide a more extensive and seamless continuum of foot and ankle care and also to enhance access to non-institutional foot and ankle surgery in appropriate circumstances. One result will be to de-stress Ontario's health care system in terms of wait times for orthopedic surgery and the pressures on hospital inpatient and emergency facilities for foot and ankle care.

The OPMA enthusiastically and unequivocally supports the College's position.

Nevertheless, the OPMA wishes to provide to HPRAC the specific perspective and insights of our members on several of the components of the College's proposal.

1. Addressing Public, Patient and Practitioner Confusion: The College submission refers to public and practitioner confusion caused by use of the anachronistic chiropody title in Ontario. The difficulties created by the current structure of the *Chiropody Act* apply to members of the podiatrist class as well. The most common questions asked of the OPMA and of individual podiatrists are "What is a Podiatrist?" and "What is the difference between a Podiatrist and a Chiropodist?" Many patients believe that they have been treated by a podiatrist, when in fact they have actually been or are to be treated by a chiropodist.

The confusion isn't limited to the general public. Over the past decade, the OPMA has had to deal with a number of Community Care Access Centres (CCAC) that have refused to take a referral from a

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podiatrist or have refused to acknowledge a direct order pertaining to wound care or some other procedure from a podiatrist pursuant to subsection 5.5 (1) (b) of the *Nursing Act*. The difficulties caused for patients and for continuity of care are significant. By way of illustration, the most recent occurrence was with the Waterloo-Wellington CCAC that promulgated an internal intake policy that:

"Podiatrists cannot provide a direct order for the controlled act of wound care below the dermis..... nurses could consider orders from podiatrists as recommendations and initiate wound care." [1]

Such policies have been based on incorrect advice or misunderstandings about the regulatory status of podiatrists in Ontario. Other *Regulated Health Profession Act* (RHPA) Colleges have been known to advise their registrants that "podiatrists aren't regulated in Ontario", because the legislation refers only to the chiropody profession. Some colleges have advised that "podiatrists' scope of practice and authorized acts are more limited than those applying to chiropodists". Some practitioners, including nurses and physicians, thought that podiatry had ceased to exist as a profession in Ontario with the imposition of the podiatric cap on July 31, 1993. Until very recently, the scope of practice description for podiatrists on the Federation of Health Regulatory Colleges of Ontario (FHRCO) website was the only one that was blank. (See Annex A.) That website is a source for many practitioners, insurance companies, colleges and health delivery organizations to understand the regulatory status and scope of practice of healthcare professions in Ontario.

An incidental, but important, benefit of the restructuring the College has proposed to HPRAC will hopefully be to simplify and clarify the professional and regulatory status of podiatry and podiatrists in Ontario.

2. **Squaring the Circle on Alternate Footcare Models:** We have noted the Canadian Federation of Podiatric Medicine's (CFPM) unfortunate and misinformed attack on the US podiatry model. Among other things, it is the height of irony that chiropodists would refer to the podiatry model as exclusionary given that Ontario's chiropody model has statutorily blocked the registration of new podiatrists since 1993.

The CFPM suggests that HPRAC recommend a model that draws on best practices from around the world, without indicating what those best practices might be. The clear inference, however, is that Ontario should adopt some iteration of the UK chiropody/podiatry model. Whether practised in the UK, Australia, Manitoba, Saskachewan or elsewhere, the entry-level scope of practice and the competencies required are nothing more and usually less than those currently applicable in Ontario. It is bewildering to us why the chiropodists who comprise the membership of the CFPM would want to adopt a model with a more limited scope of practice than that which chiropodists currently have in Ontario under the *Chiropody Act*. It is also perplexing as to how doing so would address any of the concerns and problems identified by stakeholders during HPRAC's footcare model public consultation. As the College has noted in its submission to HPRAC, in addition to Ontario there are two other provinces in Canada that years ago adopted an iteration of the UK model. Of those, Manitoba is now actively considering conversion to a North American podiatry model and Saskatchewan has acknowledged serious issues with its model. Contrary to the CFPM's representations, the current iteration of the UK chiropody/podiatry model has not been adopted by

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any other regulated province in Canada.

Regardless, to accommodate the chiropody profession the OPMA would not oppose adoption of the structure to which the UK chiropody/podiatry model appears to be evolving. By this we mean that the scope of the chiropody profession would remain essentially as it is, but the ankle would be included in the scope of practice for members of the podiatrist class and the authorized acts for members of the podiatrist class (usually called "podiatric surgeons" in the UK model and its offshoots) would be expanded to include the full North American-style scope of practice and authorized acts recommended in the College's submission. The podiatrist class would be reserved for practitioners who have graduated with the DPM degree or its equivalent, or who have otherwise acquired equivalent competencies. In other words, Ontario would adopt a combination of the UK and the North America models to operate in parallel and allow practitioners to perform in either, depending on their aspirations, their education and their competencies. This structure is not dissimilar to Nurse Practitioners (Registered Nurses in the Extended Class) within the College of Nurses and has some similarities with orthopedic surgeons within the CPSO, or oral and maxillofacial surgeons within the RCDSO. The podiatric cap would, of course, have to be revoked.

Adopting this structure would obviate the need for the College to develop and operate what will almost certainly be a complicated testing of individual practitioner's competencies to perform the proposed new authorized acts, one by one. Arguably, this structure would also be more comprehensible to members of other professions, the public, patients and to those responsible for organizing foot and ankle care.

Based on the last 30 years' experience with Ontario's chiropody model, the OPMA believes that it is essential to avoid adoption of a model that consists of a hodgepodge of components from other models to create a unique, made-in-Ontario model. Ontario needs to adopt a model of foot and ankle care that not only serves Ontario's needs, but has been proven and is also recognized and recognizable to other jurisdictions in both Canada and elsewhere, in order to facilitate implementation, support professional mobility and research into and the sharing of clinical best practices and to make an indigenous education program viable.

3. **Interprofessional Collaboration:** The OPMA emphasizes that podiatrists want to be fully integrated into interprofessional primary care and will work hard to achieve that objective. Full integration has been frustrated in Ontario by funding models [2], the relatively small number of podiatrists brought about primarily by the podiatric cap, misinformation or a lack of information about podiatry in Ontario and professional turf protection.

Although not unexpected, the OPMA regrets the opposition to conversion to a North-American-style podiatry model expressed to HPRAC by the Ontario Association of Orthopedic Surgeons. On several occasions, the OPMA has reached out to the Ontario Association of Orthopedic Surgeons to initiate a dialogue, but has been rebuffed. At the practice level in jurisdictions where a podiatry model has been adopted, however, it is not at all unusual for individual orthopedic surgeons and individual podiatrists to work collaboratively. They refer to each other, they practise with each other and they learn from each other. That is not to say that podiatrists and orthopedic surgeons don't work

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together in Ontario today. In fact many podiatrists refer to orthopedic surgeons (albeit by way of the family doctor, as is required in the current Ontario healthcare delivery model) and vice versa and the OPMA would be happy to share with HPRAC instances of orthopedic surgeons spending time in Ontario podiatrists' clinics to learn podiatric surgical and other techniques. Orthopedic surgeons have been on the "faculty" of many of the OPMA's continuing education offerings. Podiatrists are also appearing with increasing frequency on the teaching staffs of medical schools in Ontario and elsewhere in Canada.

The lobby organizations representing orthopedic surgeons have, however, characteristically resisted adoption or expansion of podiatry scopes of practice. Although that resistance has often delayed adoption or expansion, it has ultimately failed. As indicated in the College's submission, 46 US states, plus the District of Colombia, all of the Mexican states, Alberta, British Columbia and to a lesser extent Québec have adopted a scope of practice analogous to that being proposed by the College for Ontario. According to data from Thomson Reuters, US podiatrists now perform over three times the number of common foot and ankle surgical procedures than orthopedic surgeons. It has been gratifying that despite their initial opposition, orthopedic surgeons have generally come to accept and work with podiatrists after the adoption or expansion of a podiatry scope. A preeminent member of the American Academy of Orthopedic Surgeons admonished his colleagues that

"[Podiatrists] have become experts in the field to the extent that it is ludicrous any longer to complain that their qualifications do not allow them to cover such a wide territory." [3]

In the United States, about 20% of licensed podiatrists work in group practices with orthopedic surgeons. [4] The OPMA is confident that the same will come to pass in Ontario. We will certainly try our best to have that happen!

Ontario podiatrists are not interested in supplanting -- and recognize that they cannot supplant --- orthopedic surgeons and we have no interest in competing with them. We are committed to working with them within a collaborative continuum of foot and ankle care delivery. Orthopedic surgeons will continue to play a critically important role in the surgical treatment of foot and ankle conditions. For at least the foreseeable future, there will be more than enough demand for complex or high risk foot and ankle surgery to keep Ontario's orthopedic surgeons fully occupied. The conversion to a podiatry model, however, will also provide patients with the ability to choose an alternate stream of treatment in instances where diagnostic, therapeutic, or surgical procedures of the foot and ankle can be performed safely, responsibly and effectively by podiatrists in non-institutional settings.

The Ontario Association of Orthopedic Surgeons expresses concern that the proposed scope expansion, particularly the anatomical expansion to include the ankle, will expose patients to undo risk of harm. The PICA Group provides professional liability insurance to about seventy percent (70%) of podiatrists practising in the United States. As such it has the largest databank of malpractice claims involving podiatrists in the world. According to PICA there is no significant difference in claims severity or claim frequency in US states that allow podiatrists to perform ankle procedures compared to the six (6) US States that do not allow ankle procedures at this time; and there has been no

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significant increase in claims severity or frequency when States expand the podiatric scope of practice to include the ankle. [5]

Despite the opposition of, or concerns expressed by, orthopedic surgeons, it is noteworthy that a letter to the College of Chiropodists, dated December 21, 2005 on behalf of the Committee on Drugs and Pharmacology of the Ontario Medical Association (that includes most orthopedic surgeons practising in Ontario within its membership) stated:

"*...the Committee is unclear as to why Ontario requires two separate categories of foot specialist and respectfully suggests that the College consider amalgamating these two professions, with a requirement for the higher level of training and more extensive scope of practice.*" [6]

4. Foot Orthotics: The OPMA notes HPRAC's question to the College pertaining to the need for consumer protection measures related to the prescription and fitting of foot orthotics. The OPMA wishes to make the following observations:

There is valid cause for concern about the excessive prescription and dispensing of foot and ankle orthotics and about the dispensing of ineffective, even harmful, foot and ankle orthotics. Additional protections are warranted, in fact are overdue, to serve and protect the public interest.

One solution that has been mooted is to make any or all of prescribing, dispensing, fabricating/fitting foot and ankle orthotics a controlled act under the RHPA, authorized only to those professions that have the relevant scopes of practice and appropriate competencies. This would approximate the approach currently taken in Québec. The case for doing so is at least as strong as constituting as controlled acts the prescription and dispensing of eyewear, or the fabrication of dental prostheses, or the prescription of hearing aids. The risk of harm to patients from unnecessary or improperly designed or fabricated and fitted foot and ankle orthotics is substantial. When we use the term "harm" we include financial losses incurred by patients as a consequence of having dispensed to them entirely inadequate devices held out to be "orthotics", but by our definition do not meet the standard

Bringing foot and ankle orthotics into the RHPA's controlled act regime, however, would exclude unregulated practitioners from manufacturing orthotics, except by delegation. Most prominently affected would be pedorthists and orthotists and prosthetists. Certified pedorthists, orthotists and prosthetists are fully competent in the fabrication of foot and ankle orthotics and play an important role in the footcare continuum, assuming that they have first been provided with appropriate diagnoses of the underlying foot or ankle conditions they are being asked to address. Excluding them would be unfair and contrary to the public interest.

The OPMA appreciates that pedorthists wish to be "recognized" in some way. The OPMA has consistently been in favour of an interprofessional dialogue with pedorthists to explore their regulation with the College of Chiropodists, or with the proposed College of Podiatrists, especially if there is a move to bring foot and ankle orthotics into the RHPA's controlled acts regime. As the Pedorthic Association of Canada has said, pedorthists work very well with podiatrists in podiatry

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model jurisdictions, such as Alberta, Québec and British Columbia in providing a continuum of foot and ankle care and the OPMA would like to see the same happen in Ontario.

If foot and ankle orthotics are not brought within the RHPA's controlled act regime, the OPMA would support consumer protection legislation to address excessive charges and excessive dispensing. The intersection or interaction between such legislation and the role of the RHPA Colleges in the instance of regulated practitioners would have to be carefully addressed, however, in order to avoid dual regulatory systems that lead to double jeopardy for regulated practitioners, place unregulated practitioners at a disadvantage with regulated practitioners, or vice versa, or lead to regulatory streams that are duplicative, in conflict or inconsistent with each other.

Another possibility may be to push the Medical Devices Bureau of the Therapeutic Products Directorate of Health Canada to set standards for and license the laboratories in which foot and ankle orthotics are fabricated in order to ensure that foot and ankle orthotics attain minimum standards of quality in their fabrication.

5. The "Dr." Title: The OPMA urges HPRAC to recommend that podiatrists who hold the degree Doctor of Podiatric Medicine/DPM or equivalent and who are registered in the podiatrists class be authorized to use the "Dr." title as a prefix when they are providing or offering to provide health care in Ontario. Podiatrists, meaning registered practitioners with DPM degrees, have the authority to call themselves "Dr." in every North American jurisdiction in which podiatry is regulated, including British Columbia, Alberta and Québec, but not in Ontario. Podiatrists are authorized to call themselves "Dr." in every US state in conjunction with the modifier "podiatrist", or "Doctor of Podiatric Medicine/DPM". In some states, podiatrists are authorized to use the titles "Physician" and in those states no modifier or qualifier is required. In Alberta, registered podiatrists are authorized to use the titles "podiatric surgeon", "Doctor/Dr. of Podiatric Medicine", "podiatric physician", "Dr." and" Doctor". [7] In British Columbia, podiatrists are authorized to use the titles "podiatric surgeon", "surgeon" and "Doctor/Dr. [8]. In Québec, podiatrists are authorized to use the "Dr." title as a prefix when modified by either "Podiatrist" or "Doctor of Podiatric Medicine". [9]

The inability to use the "Dr." title in Ontario is an anomaly relative to other non-physician professions that are authorized to use the Dr. title (chiropractic, optometry, dentistry, naturopathy, traditional Chinese medicine) and is particularly anomalous for any profession authorized to "communicate a diagnosis" (as defined by the RHPA) and to perform surgical procedures on soft and osseous tissues. [10]

Allowing full scope podiatrists to use the "Dr." title in Ontario under the new model would help to avoid public and practitioner confusion. Accordingly, the OPMA asks HPRAC to recommend that DPMs may use the "Dr." as a prefix in any or all of the following ways, but always with a podiatric modifier :

- "Dr. John Smith, Podiatrist,"
- "Dr. John Smith, Doctor of Podiatric Medicine,"
- "Dr. of Podiatric Medicine, John Smith,"

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6. The Podiatric Cap: The prohibition against the registration of new members of the podiatrist class after July 31, 1993 was an essential component of the imposition of the UK chiropody model by government fiat. It was explicitly recognized at the time that the chiropody model would not survive in Ontario if it had to compete with a podiatry model. Among others, the President of the Ontario Society of Chiropodists explained and defended the rationale for the podiatric cap when he appeared before the Standing Committee on August 12, 1991.

"Many in our profession, the Ministry of Health and our regulatory board see a continued existence of podiatry as a threat to our profession.... [A]s long as US-trained podiatrists are allowed to enter and practice (sic) in Ontario, chiropody will be stultified. It will never grow and develop..... Chiropody has benefited greatly in Ontario by being a creature of government. In crude terms, were it not for a government decision made a decade ago, the chiropody model would not *exist in Ontario. The burden of footcare would be delivered by podiatry--the profession chiropody has been designed to supplant--and by other healthcare professionals...". [11]*

Particularly with the benefit of hindsight and what the OPMA would characterize as the abject failure of the chiropody model to play its part in addressing the footcare needs of Ontarians, the podiatry cap illustrates the folly of any government swimming against the stream of healthcare professional and system evolution by artificially and unilaterally imposing one healthcare delivery model over another and creating an artificial environment to sustain it. Why anyone would wish to artificially prohibit, or even limit, the ability of any profession to respond to system demands is beyond us. The cap is also clearly inconsistent with the philosophy expressed in section 3 of the RHPA, namely allowing patients to have access to services provided by the health professionals of their choice and also runs contrary to the aspirations expressed by all parties during the debate on the Immigration Act (Bill 49) currently before the Ontario legislature. As the College has also noted in its Submission, the cap also offends the letter or spirit of Ontario's *Fair Access to Regulated Professions Act*, the AIT and NAFTA.

The OPMA notes in this regard the announcement made by federal Minister of Health, the Hon. Rona Ambrose on March 13, 2015 that included the observation that, with respect to the podiatric cap, speaks for itself

"Across Canada, access to health professionals continues to be a challenge. Approximate 4.6 million Canadians are without a regular family doctor. At the same time, there are around 10,000 newcomers to Canada that are health-related professionals. Many of these individuals face obstacles in finding jobs that match their skills and experience." [12]

The same announcement referred to $8.2 million being provided to HealthForce Ontario and the University of Toronto to support the integration of internationally trained professionals into the healthcare delivery. [13]

A major consideration in imposing the podiatric cap was that the medical profession and orthopedic

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surgeons in particular would be able to provide the services that would otherwise be provided by podiatrists. That has clearly not come to pass, leaving many Ontarians unable to access medically necessary foot and ankle surgery, or forcing them to wait significantly longer than clinical guidelines and best practices call for to access appropriately trained practitioners who can definitively diagnose their foot or ankle condition to best ascertain what treatment options, conservative or surgical will best meet their needs.

Persons speaking for the chiropody profession [14] have suggested that the cap should be removed for all but US-trained DPMs. Such a partial removal of the cap is, of course, nonsensical if Ontario does in fact move to a North American-style podiatry model. The OPMA also has abundant legal advice that such a "partial" or "targeted" cap would not survive a challenge under the AIT or NAFTA and would constitute a clear contravention of the *Fair Access to Regulated Professions Act*.

Although it is probably not a consideration for HPRAC, the podiatric cap has been and continues to be a huge affront to podiatrists in Ontario and around the world. If nothing else happens as a consequence of this review, podiatrists want to see the cap gone, thereby allowing the podiatry profession in Ontario to evolve naturally in response to patient and health care system demands and in response to advances in education and technology.

7. **Education & Competencies:** The OPMA noted that a number of chiropodists, organizations representing chiropodists [15] and other stakeholders (some of whom should know better) claim that the chiropody and podiatry educational programs and hence the respective competencies of chiropodists and podiatrists are the same or are essentially the same. The Professional Examination Services (PES) document appended to the College's submission to HPRAC conveys a materially different, but accurate, comparative analysis. In the OPMA's view, necessary regulatory change has been delayed by the insistence of chiropodists that they be treated the same as podiatrists in terms of competencies. For example, podiatrists' status with respect to prescribing drugs was in a state of some uncertainty from proclamation of the *Chiropody Act* in 1993 until 2008, at least in part because of chiropodists' insistence that they have access to the same drugs as podiatrists, notwithstanding the material differences in authorized acts and competencies. The OMA's Committee on Drugs and Pharmacotherapy encapsulated podiatrists' predicament very nicely in its commentary on the College's proposed drug list in 2005:

"Please note that the comments that follow deal only with chiropodists. Members of the OMA Committee on Drugs and Pharmacotherapy are comfortable that the training undertaken by podiatrists supports the drug list they manage.....

The Committee has concerns about a number of the drugs proposed on the drug list for chiropodists, most of which follow from the fact that chiropodists are not trained to undertake diagnosis and that this act/skill is critical to safe prescribing. In addition, chiropody training does not provide the skills necessary to either identify or manage adverse drug reactions or morbidities arising from drug treatment. The Committee is not persuaded that a course in pharmacology provides the necessary foundations for this element of practice and supports current practice, which requires M.D. collaboration for prescribing.....

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The Committee is concerned that the "chiropody" list is more appropriate to podiatry than it is (to) chiropody itself and (the OMA) does not support the list as proposed..." [16]

The limited scope of practice for podiatrists in Ontario – and the fact that such a podiatry scope of practice exists nowhere else – coupled with the podiatric cap have impeded the development of a podiatry education program in Ontario and arguably anywhere else in English-speaking Canada. The OPMA is absolutely of the view that the podiatry scope and authorized acts proposed by the College of Chiropodists need to be supported by a postgraduate podiatry degree program analogous to the DPM program offered by nine Colleges of Podiatric Medicine in the United States and by the Université de Québec à Trois Rivières (UQTR). Accordingly, the OPMA will continue to do everything it can to assist in the launch of such a program at an Ontario University, including a continuing education program for grandparented registrants. At the OPMA's instigation, the School of Podiatric Medicine at Kent State (Ohio) has already offered to help launch a podiatry program in an Ontario University and has also indicated an interest in providing bridging and refresher courses to current registrants of the College of Chiropodists who wish and need to upgrade their competencies to practise in the expanded scope. (The precedent, of course, is the alliance between the UQTR podiatry program and the New York College of Podiatric Medicine.) Once it becomes clearer what the model and scope will be and that the podiatric cap will be revoked, we can have more meaningful discussions with Ontario universities and with potential partners in other jurisdictions.

Submissions to HPRAC during the footcare model consultation clearly suggest that comprehensive, far-reaching and farsighted reforms are required in Ontario's foot and ankle delivery framework. Adoption of a podiatry model will not be the be-all and end-all, but it will be a good and substantial start. Podiatrists want to perform the role they have been trained to perform. To paraphrase a renowned former statesman: "Put your confidence in us... Give us the tools and we will do the job". [17]

The OPMA, its members in Ontario, Ontario residents in DPM programs and podiatric residencies and podiatrists in other jurisdictions have waited for a very long time for this HPRAC review in hopes that the review will prompt the correction of historic public policy blunders. We look forward anxiously to HPRAC's recommendations.

Yours sincerely,

Bruce Ramsden

Bruce Ramsden, B.Sc., DPM,
President

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ENDNOTES

1. "*WWCCAC policy relating to orders*". This particular situation came to the OPMA's attention when the Wellington-Waterloo CCAC refused to accept an order from a podiatrist under subsection 5.5. 1 (b) of the *Nursing Act,* 1991 for follow-up wound care for the podiatrist's patient in November, 2014. The WWCCAC was contacted and after a series of discussions, the policy was corrected in January, 2015. Similar refusals have occurred from time-to-time by this and other CCACs and CCACs have, from time to time, refused to accept referrals from podiatrists.

2. For example, funding for podiatrists in FHTs, NP-led clinics and the like has not been forthcoming because individuals may obtain podiatric care by OHIP.

3. Dr. Augusto Sarmiento, M.D., writing in the **Journal of Bone Surgery**, JBoneSurgAm, 2012; 94: E105, pages 1-3.

4. Data provided by PICA, February 6, 2015. PICA (the Podiatrists Insurance Company of America) is a member of Pro Assurance, the fourth-largest provider of medical professional liability insurance in the United States. PICA has an "Excellent" rating by AM Best.

5. Letter to Bruce Ramsden, OPMA President, from Barbara Bellione, Director, Risk Management, PICA, February 2, 2015. New York State recently adopted an expanded scope of practice for podiatrists that includes the ankle, but was included in the PICA analysis as a "non-ankle" State.

6. Ms. Barb LeBlanc, Director, Health Policy, Ontario Medical Association, Letter to Ms. Felecia Smith, Registrar, College of Chiropodists of Ontario, December 21, 2005.

7. *Podiatrist Professional Regulation*, 60/2012, subsection 14 (1).

8. *Podiatrists Regulation*, BC Reg. 2014/2010, section 3

9. Pursuant to regulations made under Article 183.1 of the *Code des professions du Québec.*

10. The College of Chiropodists has actually gone further than the prohibitions in section 33 of the RHPA. The previous Registrar advised the OPMA by letter dated June 26, 2000 that:

"*It is the view of the College, however, under section 33, that in both the content of the statement of law and the perception of the profession, it is the onus of the podiatrist (sic) as a self regulated practitioner to avoid use of the title "Dr." in any context relating to his or her practice, from marketing* ***to administration*** *to eliminate any chance of being caught by the restriction, or being perceived as unregulated will (sic) in this regard*" [Our emphasis added.]. So, for example, the College will not tolerate use of the "Dr." title by podiatrists in correspondence with the College relating to regulatory matters, clinical staff calling the podiatrist "Dr.", or the payment of College fees by cheque that uses the Dr. title,

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11. **Hansard of the Legislative Assembly of Ontario**, Standing Committee on Social Development, Consideration of Bill 43, August 12, 1991, *S-354-355*.

12. "Harper Government helping internationally educated health professionals work in Canada; Improving access to quality health services for Canadian families"; Government of Canada, News Release, March 13, 2015

13. Ibid.

14 **Hansard**, op. cit.

15. Ibid.

16. Barb LeBlanc, op. cit.

17. BBC Broadcast by Winston S. Churchill, February 9, 1941.

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ANNEX A

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