Contents

Introduction and Terms

Adopted 12/11, Revised and Effective 01/2014

Standards of Practice Introduction

As set out in the *Health Professions Act* in Alberta, all self-regulating health professions are required to have Standards of Practice (Standards). Each profession's regulatory body must establish, maintain and enforce a set of Standards for their profession. The College of Chiropractors of Alberta (CCOA) is responsible for the establishment of such Standards for chiropractors who practice in Alberta.

The CCOA Standards of Practice are standards of professional behaviour and conduct required of all chiropractors in Alberta to ensure chiropractors interact safely and appropriately with their patients and the public. The **Standards of Practice** of the College of Chiropractors of Alberta (CCOA) are the **minimum** standards of professional behaviour and conduct expected of all regulated members registered in Alberta.

Standards are a part of the structure within which the CCOA governs members in a manner that protects and serves the public by providing direction to chiropractors and regulating the practice of chiropractic. Each chiropractor, in their professional capacity, is required to understand and comply with these Standards, which are enforceable under the *Health Professions Act* and which will be referenced in the management of complaints and discipline hearings and appeals.

The CCOA Standards of Practice continue to evolve with the profession of chiropractic in Alberta and may change from time-to-time. New Standards and/or significant revisions will come into force after a period of consultation with chiropractors and others as set out in the Section 133 of the *Health Professions Act*.

Enforceability

The *Health Professions Act* includes a detailed definition of professional misconduct including contravention of the Act, the code of ethics and standards of practice. Any chiropractor identified as non-compliant or in contravention is subject to the investigations and complaints process as set out in Part 4 of the *Health Professions Act*.

Definitions

1. Throughout the standards of practice:

   a) **authorization** means the right to perform an activity;
   b) **CCOA** means College of Chiropractors of Alberta;
   c) **chiropractor** means a regulated member registered with the CCOA who holds an active practice permit;
   d) **competence** means the combined knowledge, skills, attitudes and judgment required to provide professional services;
   e) **competence committee** means a competence committee established under the Act;
   f) **continuing competence program** means a program of continuing competence provided for in the Standards of Practice and Continuing Competence Program Manual;
   g) **courtesy register** means the courtesy register category of the regulated members register;

h) **direct supervision** means that the authorized regulated member be present at and during the performance of the restricted activity;
i) **general register** means the general register category of the regulated members register;
j) **indirect supervision** means the authorized regulated member be readily available for guidance and consultation, including being in the same facility but not necessarily present at and during the performance of the restricted activity;
k) **information manager** means a person or body (as defined by the Health Information Act) that:
    i. processes, stores, retrieves or disposes of health information,
    ii. in accordance with the regulations, strips, encodes, or otherwise transforms individually identifying health information to create non-identifying health information, or
    iii. provides information management or information technology services;
l) **may** means the regulated member may exercise professional discretion;
m) **must** means the regulated member is required to comply as directed;
n) **patient** means the patient, or where applicable, the patient's substitute decision maker;
o) **preceptor** mean a regulated member authorized to provide supervision during clinical practice and facilitates the application of theory to practice for students;
p) **regulated health professional** means:
    i. in the case of humans, a health professional who practices under the terms of the Health Professions Act or similar legislation that governs a health profession in Alberta, and
    ii. in the case of animals, a veterinarian or veterinary technologist who practices under the terms of the Veterinary Profession Act;
q) **regulated member** means an individual registered on a register referred to in Section 2 of the Chiropractor Professions Regulation;
r) **restricted activities** mean diagnostic and therapeutic procedures considered to be high risk activities identified under the Health Professions Act that require specific professional authorization and competence to be performed safely;
s) **substitute decision-maker** means a person other than the patient who is legally authorized to decide on behalf of the patient;
t) **student** means an individual registered as a student in a Council or Chiropractic Education accredited Doctor of Chiropractic Program.

2. Unless these standards provide a more specific definition, terms used in these standards have the same meaning as in Schedule 2 to the Health Professions Act and the Chiropractors Profession Regulation.
3. Where a courtesy chiropractor engages in the practice of chiropractic, that courtesy chiropractor must comply with the standards of practice.

SP 1.0 Advertising, Promotions and Presentations

Adopted 12/11, Revised and Effective 01/2014

Purpose and Objective

To ensure chiropractors, regardless of venue or circumstance, demonstrate professional credibility by ensuring all advertising, promotional, and presentation materials and commentary are:

- Appropriate to the setting, truthful and within the scope of practice for chiropractic
- Of a nature that ensures credibility and engenders public trust
- Considerate of the overall integrity and reputation of the profession
- Compliant with copyright law and all other applicable legislation

This Standard supports public education and practice-building opportunities within defined parameters of professional communication while upholding public trust.

Information or direction not specifically identified in this Standard must be approved by the Office of the Registrar prior to use or release.

1.1 Advertising, Marketing and Practice Promotion

Adopted 09/2005, Revised and Effective 07/2017

Materials, information and presentations designed to reflect or promote a chiropractor's practice to both current and potential patients must be:

a) truthful and factual in all respects;
b) professional in description, content and presentation;
c) respectful in every manner of other health professions and chiropractic colleagues;
d) clearly identifiable as being provided by a Doctor of Chiropractic;
e) inclusive of only matters within the training and scope of practice of chiropractic;
f) of a nature that does not inappropriately evoke concern or fear;
g) exclusive of any claims of guaranteed results, or clinically predictive or specific outcomes;
h) compliant with patient confidentiality requirements;
i) compliant with all CCOA Standards, policies and position statements;
j) reflective of broadly accepted evidence-based research and information;
k) respectful of widely accepted public health doctrine;
l) exclusive of any claims or allusion to professional superiority.

Examples of Advertising, Promotions and Presentations

Example 1) business cards, exterior office signs, letterhead:

May include:	May not include:
• Practitioner and clinic name • Address, including directional wording • Phone and fax numbers • Website and email addresses • Hours of operation • Professional Corporation information • Photos/images • Methods of payment accepted • Languages spoken • Services/techniques available • CCA, CCOA member and clinic logos • CCOA recognized chiropractic specialties as specified in SP 1.3 • WCB authorization • Accessible (facility) availability for people with disabilities • Other current province/state licenses • Academic credentials from post-secondary degree-granting institutions and/or accredited chiropractic colleges	• Information that violates the requirements of any other Alberta legislation (e.g., *Veterinary Medicine Act*) • Information restricted by copyright law • Information or statements in conflict with any CCOA Standards, Code of Ethics, policies or position statements

Example 2) flyers, handbills, advertisements, billboards, bus benches, postcards, Yellow Pages and directory listings

May include:	May not include:
• All information permitted in example one • General chiropractic health information • Testimonials (with written patient permission) • Practitioner or clinic photographs/graphics	• Same restrictions as example one

Example 3) chiropractor's personal or clinic website and social media accounts

May include:	May not include:
• All information permitted in examples one and two • Link to the CCOA website • Link to other chiropractic information sites that do not provide information contradictory to CCOA standards or policies • Clinic fees and current promotions with eligibility clearly defined	• Same restrictions as example one

Example 4) internal practice promotion materials

May Include:	May not include:
• All information permitted in examples one and two • Patient photos (with written patient permission) • Practitioner/staff (with written permission) photos and information about activities • Specific fee and promotional information with eligibility clearly specified • Personal patient acknowledgement (with written permission)	• Same restrictions as example one • Sign-in sheets (in accordance with privacy legislation)

Example 5) internal materials related to promotional fees

May include:	May not include:
• Promotional discounts with specific fees and eligibility clearly specified Please note: An internal fee schedule for current patients must clearly identify the parameters of promotional services.	• Same restrictions as example one

Example 6) external materials related to promotional fees

May include:	May not include:
• Reference to promotional activities with specific fees and eligibility clearly specified	• Same restrictions as example one

Example 7) television and radio

May include:	May not include:
• All information permitted in categories listed above	• Same restrictions as example one

Penalties for findings of guilt related to advertising, promotions and presentations will be determined on a case-by-case basis but may include fines from $1,000 for first offences and may increase with repeat offences. Additional sanctions may include referral to a hearing with the potential for substantial fines as well as other additional sanctions as determined by the Hearing Tribunal.

1.2 Professional Communication

Adopted 03/2011, Revised and Effective 01/2014

Communication with patients, members of the public, other health professions, chiropractic colleagues and any other party that a chiropractor interacts with in the context of their professional capacity must be:

a) truthful and factual in all respects;
b) professional in its content and presentation;
c) clearly identifiable as being provided by a Doctor of Chiropractic;
d) inclusive of only those matters within the training and scope of practice of chiropractic;
e) respectful in every manner of other health professions and chiropractic colleagues;
f) of a nature that does not inappropriately evoke concern or fear;
g) exclusive of any claims of guaranteed results, or clinically predictive or specific outcomes;
h) compliant with patient confidentiality requirements;
i) compliant with all CCOA Standards, policies and position statements;
j) reflective of broadly accepted evidence-based research and information;
k) respectful of widely accepted public health doctrines;
l) exclusive of any claims or allusion to professional superiority.

1.3 Use of Protected Title

Adopted 10/2022, Effective 04/2023

A protected title is part of the agreement between the province and the regulated health profession. Use of protected titles indicates that anyone using the title is appropriately trained and registered with

the regulatory body. Regulated members of the CCOA are restricted to using titles authorized by the Regulations, and as indicated in this Standard of Practice. A person not trained and/or registered cannot use the protected titles.

1. A regulated member on the general register or the courtesy register may use the following protected titles, abbreviations, and initials in connection with providing a health service and within the practice of chiropractic (including for the purpose of advertising service to prospective patients):
    a. Doctor of Chiropractic;
    b. Chiropractor;
    c. Registered Chiropractor;
    d. D.C.;
    e. Doctor or Dr., in connection with providing a health service within the practice of chiropractic.
2. No regulated member shall use the protected title of Specialist or any abbreviations and initials for a specialty area of practice, unless the regulated member:
    a. is registered on the general register or courtesy register;
    b. has successfully completed a Council approved specialty area;
    c. is authorized by a prescribed specialty college for the specialty area to use the title, abbreviations and initials for the specialty area;
    d. is authorized by the Registrar to register on a specialty registry for the specialty area.
3. For Standard 1.3 (2)(c), the following are prescribed specialty colleges:
    a. Chiropractic College of Radiologists (CCR);
    b. College of Chiropractic Sciences (CCS);
    c. College of Chiropractic Orthopaedic Specialists (Canada) (CCOS(C));
    d. Canadian Chiropractic Specialty College of Physical and Occupational Rehabilitation (CCPOR(C));
    e. Royal College of Chiropractic Sports Sciences (RCCSS(C)).

SP 2.0 Financial Accountability

Adopted 04/2012, Revised and Effective 01/2014

Purpose and Objective
To ensure chiropractors demonstrate financial accountability by:

- Using fee schedules that are consistent with ethical, professional billing practices
- Offering patients choices with appropriate payment options
- Ensuring payment options reflect appropriate clinical recommendations for each unique patient circumstance

Chiropractors have a professional responsibility to ensure their financial processes and billing practices are appropriate, ethical and confined to the boundaries prescribed by law as well as the CCOA Standards of Practice.

2.1 Fee Schedule

Adopted 04/2005, Revised and Effective 01/2014

A fee schedule is required in every clinic and is defined as the usual and customary fees established by the chiropractor that is published and available to patients and payers.

With respect to fees charged by a chiropractor:

a) a posted fee schedule must be up-to-date, clear and readily available to current and potential patients;
b) fees for a proposed course of treatment must be congruent with the clinic fee schedule and must be reviewed in detail with the patient prior to the commencement of treatment;
c) chiropractors must have and apply a consistent fee schedule regardless of insurance coverage;
d) fee schedules may contain fee stratification regarding specific patient groups such as children, students, and/or seniors provided that such stratification is equally applied to all patient billing circumstances;
e) individual financial consideration for reduced fees based on a patient's personal circumstances (other than insurance coverage) may be applied at the discretion of the chiropractor;
f) where legislation or contractual agreement governs fees specific to the delivery of chiropractic services, e.g., WCB, Minor Injury MVA Protocols, the specified fee schedule is appropriate.

2.2 Provider Contractual Agreements

Adopted 04/2005, Revised and Effective 01/2014

A provider contractual agreement is a written agreement between a chiropractor and a specific organization representing a defined patient group, and specified fees and services.

Chiropractors may enter into contractual agreements to provide specified services to specified patient groups that are employees or members of an organization, corporation, society, or union. Such arrangements must:

a) be appropriately documented;
b) clearly define the specific services to be provided;

c) identify the patient group and fee schedule that will be charged to all patients in the group (or third-party payers on behalf of the patient group);
d) have a defined timeline (sunset clause) for review and renewal;
e) be agreed to in writing by both parties (authorized and signed by chiropractor and the Corporate Officer representing the patient group who is authorized to enter into such an agreement);
f) be available for review by the CCOA upon request or as part of the CCOA Practice Visit process.

2.3 Prepayment of Fees

Adopted 02/2011, Revised and Effective 01/2014

Prepayment of fees is a financial option that may be available to a patient to allow them, at their discretion, to prepay for chiropractic care not yet received.

The financial option of prepayment, if available, must:

a) be at the sole discretion and choice of each patient;
b) be clearly presented as one option for payment with all other options for payment also presented to the patient prior to payment of any sort being charged or made;
c) be a maximum dollar value of $1,000; but may be less if desired by the patient;
d) be considered as a deposit process for pre-booking of services;
e) allow an administrative discount of up to 10% of the total prepayment provided it is made clear this is an administrative discount and not a discount for professional services;
f) ensure a full refund of any unused portion of the prepaid amount at the request of the patient
    i. within seven business days; and
    ii. with no processing or administrative fee related to providing the refund.

2.4 Patient Financial Agreement for Care

Adopted 09/2006, Revised and Effective 01/2014

A financial agreement for care may be offered to an individual patient for specified chiropractic care. Financial agreements for care, if available, must:

a) be consistent with fees charged on an individual *per session* fee;
b) be offered only as an option to the individual *per session* fee;
c) be presented as a financial agreement for care and not a binding contract for a specified treatment regime, period or suggested outcome;
d) be offered as a payment option only after the patient has been given the recommendations for care as presented in the Report of Findings;
e) only pertain to fees incurred after the initial consultation and examination;
f) be based on a unique patient treatment plan and shall not create or reflect a *case fee* or *unlimited care at fixed fee* agreement;
g) contain a clause indicating the plan may be terminated by the patient at their sole discretion;
h) contain a clause indicating “Upon termination of the agreement, treatments-to-date used under the terms of the financial agreement will be assessed at the lowest fee-per-treatment rate specified in the agreement and not adjusted to a higher rate due to withdrawal from the proposed treatment plan”;
i) be free from financial penalty to the patient for terminating the agreement;

j) contain a clause indicating "The balance of funds remaining in the patient account will be refunded within seven days of the termination of the agreement";
k) be consistent with section 2.1 Fee Schedules;
l) adhere to the maximum financial incentive/discount of 10% as described in section 2.2 Prepayment of Fees and not contain any addition financial incentives or discounts;
m) adhere to the maximum prepayment limit as outlined in section 2.3 Prepayment of Fees regardless of the number of treatments as agreed to in the agreement;
n) be consistent with the CCOA Standards related to Patient Files and Records;
o) be free from requirements or suggestions that the patient refer others to care.

2.5 Billing Practices

Adopted 05/2005, Revised and Effective 01/2014

Chiropractors bill for professional goods and/or services. This may include activities related to direct billing to patients, third-party billing and contracts. A chiropractor's billing practices must:

a) be made only for services rendered or goods sold unless a financial agreement for services has been agreed to by the patient;
b) be made only for the dates on which services are provided or goods were received unless a financial agreement for services has been agreed to by the patient;
c) be made only for the person to whom the services or goods were provided;
d) adhere to the clinic's general fee schedule or the contract within which services or goods are provided and are not inflated beyond these specific fees;
e) be billed only to one patient or that patient's third-party payer(s).

Any action involving billing anomalies that result in a chiropractor's receipt of funds under false pretences is considered fraudulent and constitutes professional misconduct.

SP 3.0 Provision of Information

Adopted 04/2012, Revised and Effective 01/2014

Purpose and Objective
To make clear the responsibilities of a chiropractor regarding information that is required to be given to or received from a patient to ensure patients are informed of all aspects of their care.

3.1 Informed Consent

Adopted 06/2004, Revised and Effective 01/2014

Informed consent provides the vehicle for chiropractors to discuss with their patients information about the benefits, risks and side effects of chiropractic treatment. The process of informed consent provides a structured opportunity for patients to discuss questions, concerns or uncertainties with the chiropractor.

Reference to *patient* throughout is understood to be inclusive of the patient or where appropriate the substitute decision maker.

As part of the informed consent process, chiropractors are responsible for disclosing to each patient:

1. The diagnosis and purpose for the treatment proposed
2. The nature of the proposed examination, treatment or procedure
3. The potential risks including those that may be of a special or unusual nature

Chiropractors must provide patients the opportunity to ask questions concerning the treatment proposed and the risks involved and should answer these questions to the patient's satisfaction.

Following the disclosure of information and addressing any questions, and before commencing any examination, diagnostic procedure or treatment, chiropractors must obtain consent from every patient.

Informed consent must:

1. Be signed by the patient
2. Be signed by a witness (preferably the chiropractor at the conclusion of the consent discussion)
3. Be dated by both patient and witness
4. Indicate the patient's consent to treatment
5. Indicate it is the doctor's obligation to keep patients informed by advising them of any changes to the treatment or the risk of treatment
6. Be present on all existing patient files (if verbal informed consent is noted from previous treatment, this must be replaced by written consent on the next patient visit)

3.2 Treatment Recommendations and Referrals

Adopted 04/2005, Revised and Effective 03/2018

Treatment recommendations for services and products are what the chiropractor has deemed appropriate for the specific patient based on case history, examination and any other diagnostic measures.

Chiropractors must communicate the findings of examination, specific diagnosis and treatment recommendations to the patient based on their presenting complaint, case history, physical examinations and corresponding investigations to ensure each patient is specifically and fully informed of the plan for their care.

Treatment recommendations presented to the patient must be consistent with the recorded individual treatment plan and cannot be contingent upon any other factors than those listed above.

Chiropractors must explain to the patient the purpose, expected health benefit and any fees associated with the recommended treatment (products and services).

Treatment recommendations presented to the patient must also fully disclose, by name and occupation, who in the clinic will provide the treatment, including identifying if the individual is an independent regulated health care provider, or an unregulated healthcare provider, or is a member of the chiropractor's clinical support staff.

A chiropractor who refers a patient (within the clinic or outside the clinic) for treatment provided by another healthcare provider must communicate the purpose, expected health benefit, fees associated with the recommended treatment, and qualification of the provider, specifically informing the patient of the provider is a member of an unregulated health care profession.

3.3 Disclosure of Harm

Adopted 03/2007, Revised and Effective 01/2014

Disclosure of harm is the acknowledgement and discussion of a negative outcome as the result of a harm (any outcome that negatively affects the patient's health and/or quality of life) that occurs during chiropractic treatment.

If a chiropractor becomes aware the patient has suffered harm while receiving care and that harm does, or can be reasonably expected to, negatively affect the patient's health and/or quality of life, the chiropractor is obligated to inform the patient. Once a situation is identified or recognized, the chiropractor must respond effectively and in a timely manner to mitigate client harm, ensure disclosure and prevent reoccurrence.

The disclosure of harm:

1. May be made to the patient directly or through the substitute decision maker
2. Should take place as soon as possible, considering the clinical and emotional condition of the patient

3. Where the patient requires treatment for the harm that was sustained, should include identification of remedial care proposed by the chiropractor or referrals to other health care providers or health care facilities, if appropriate

SP 4.0 Provision of Professional Services

Adopted 05/2012, Revised and Effective 03/2018

Purpose and Objective

To provide direction and clarity on the provision of professional services, and to ensure an appropriate clinical perspective within a public health and safety context. This Standard:

- Explains the services that are within the scope of practice of chiropractic in Alberta
- Addresses authorized activities that have additional competency requirements (other authorized activities as set out in section 14 of the Chiropractors Profession Regulation)
- Addresses the responsibilities of chiropractors when engaging clinical support staff and unregulated healthcare providers

In the delivery of professional services, a chiropractor must always be current in their knowledge and skills to provide safe and effective care and treatment to the patient and only ever perform any chiropractic service to the level they are competent and that is appropriate to the area of practice and procedure being performed.

4.1 Scope of Practice for Chiropractors

Adopted 10/2022, Effective 04/2023

The scope of practice for chiropractors includes:

1. As outlined in the *Health Professions Act*, Schedule 2.3 chiropractors do one or more of the following in their practice:
   (a) examine, diagnose and treat, through chiropractic adjustment and other means taught in the core curriculum of accredited chiropractic programs, to maintain and promote health and wellness
   (a.1) teach, manage and conduct research in the science, techniques and practice of chiropractic; and
   (b) provide restricted activities authorized by the regulations.
2. Therapeutic and diagnostic procedures taught in the core curriculum, postgraduate or continuing education divisions of most programs accredited by the Council on Chiropractic Education.
3. Other therapeutic and diagnostic procedures as approved by the Council of the CCOA.

4.2 Clinical Services Provided by Unregulated Healthcare Providers

Adopted 03/2011, Revised and Effective 03/2018

Chiropractors are responsible for the care and treatment of their patients. Appropriately trained clinical support staff may be assigned various activities in support of this care and treatment, but the authority and responsibility rests with the chiropractor.

When the chiropractor's treatment recommendations include a recommendation for treatment provided by a member of the clinical support staff, or by an unregulated healthcare provider in the chiropractor's clinic, the clinical responsibility for the patient's care remains with the chiropractor, as the regulated healthcare provider.

Responsibilities of the chiropractor
In the assignment of any activities to clinical support staff, a chiropractor (under whose authority and supervision these assignments occur) must:

- Be present and available to provide direction and supervision to clinical support staff.
- Ensure clinic staff are appropriately trained in and maintain the necessary competencies to perform the assigned activities.
- Ensure a record of clinical support staff training is documented and updated as required.
- Ensure clinical support staff training meets manufacturer's and/or professional requirements to competently deliver the assigned activity via a therapeutic device.
- Ensure that for any services provided by clinical support staff, appropriate chart entries have been made by these staff.
- Ensure clinical support staff's use and disclosure of any health information is within the context of the *Health Information Act* and that these staff are fully aware of and compliant with all other requirements of the *Health Information Act.*
- Ensure an appropriate policy and procedure for recording treatment notes by clinical support staff delivering the assigned treatment is in place and that these staff are well trained in recording treatment notes.
- Ensure an appropriate policy and procedure for the reporting and recording of adverse events is in place and that clinical support staff are trained in this procedure.
- Ensure clinical support staff are trained in and implement routine public health procedures such as hand hygiene and cleaning of equipment and environment.

Activities that may be assigned

1. Facilitating the completion of general intake forms and documents.
2. Assisting the chiropractor during diagnostic or treatment activities, for example, handling passive limb movement, gait training, exercise instruction, facilitating the practice of functional activities (such as passive and assisted range of motion activities) and positioning of the patient at imaging.
3. Carrying out basic diagnostic data gathering activities, such as vital signs, ranges of motion with instrumentation, SEMG scans and thermographic scans.
4. Carrying out planned chiropractic treatment activities (e.g., preparing and applying chiropractic adjunctive modalities) for each patient following the supervising chiropractor's assessment, prescription and specific written instructions/treatment plan (include all details for treatment activities, application instruction, dosage settings and application area).
5. Performing activities related to patient care but not part of the chiropractic treatment, for example, accompanying patients, preparing patients for treatment and preparing patient files.
6. Providing follow-up explanation or clarification regarding home/self-care programs or exercise programs that were initially provided to the patient by the chiropractor.

Activities that may not be assigned
Activities that may not be assigned to clinical support staff specifically include all activities listed as restricted activities in the chiropractic regulation of the *Health Professions Act* and any restricted activity specified in other Alberta legislation.

Other activities that chiropractors may not assign to clinical support staff:

- Individual and specific case history elicitation
- Subjectively assessed physical examination procedures
- Imaging production/application of ionizing radiation (except to *qualified individuals)
- Assessment and interpretation of findings
- Diagnosis
- Initiating or changing a treatment plan
- Determining or changing any therapeutic modality application parameters
- Discharge planning
- Discussing a patient's condition with anyone other than the patient or their guardian

*A qualified individual is defined as a person regulated under the *Health Professions Act* who is authorized to apply ionizing radiation in medial radiography in accordance with the regulations under the *Health Professions Act.*

4.3 Infection Prevention and Control

Adopted 10/2010, Revised and Effective 01/2014

To incorporate current, appropriate and generally accepted infection control measures as established by and updated from time-to-time by Health Canada[1] and Alberta Health and Wellness in their clinical practice, chiropractors must:

1. Remain current in generally accepted routine practices[2] and infection control protocols relevant to their practice context.
2. Develop, incorporate and keep up–to-date, infection control polices to promote the use of infection control measures, which may be unique to their personal professional practice style.
3. Ensure their clinic facility is equipped, operated and maintained to meet generally accepted infection control guidelines including requirements for:
    a. hand hygiene, which must include the use of a hand cleaner or hand washing before and after each patient contact;
    b. use of protective barriers[3] as standard practice whenever contact with blood and body fluids is likely to occur during patient contact (barriers must also be used when a patient's personal care equipment is likely to have been contaminated with potentially infected fluids (e.g., wheelchairs, walkers)).

[1] Health Canada 1999 Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Health Care. Infection Control Guidelines, Canada Communicable Disease Report, Volume 25S4, Health Canada Standards.

[2] Routine Practices: defined by Health Canada, form the foundation for limiting the transmission of microorganisms in all health care settings and is the generally accepted level of care for all clients. Elements of routine practice are hand hygiene; risk assessment related to client symptoms; care and service delivery including screening for infectious diseases; risk reduction strategies using PPE; cleaning of environment, laundry, disinfection and sterilization of equipment; waste management, safe sharps handling; client placement and healthy workplace practices; and education of health care providers, clients, families and visitors.

[3] Personal Protective Equipment (PPE): specialized equipment or clothing used by health care workers to protect themselves from direct exposure to clients' blood, tissue or body fluids. Personal protective equipment may include gloves, gowns, fluid-resistant aprons, head and foot coverings, face shields or masks, eye protection, and ventilation devices (i.e., mouthpieces, respirator bags, pocket masks).

4. Ensure internal environment cleaning, disinfecting, and sterilizing of equipment and facilities; and managing of wastes and materials contaminated by blood or body fluids (see Appendix A) as may be relevant to their practice context.
5. Adopt appropriate infection control measures including contact management protocols (and continually monitor their use and effectiveness to identify problems, outcomes and trends).
6. Provide infection prevention and control training for clinic staff and monitor implementation of IPC procedures and activities.
7. Conduct ongoing assessments of current risks of infection and transmission to patients, staff, colleagues and other health professionals, and take appropriate remedial action in a timely manner consistent with professional requirements and the applicable law based on consideration of the following:
    a. the assessments of treatment interventions planned or conducted;
    b. the health conditions of patients being assessed or treated;
    c. the degree of infection risk currently present in the internal practice environment;
    d. the degree of infection risk currently present in the external practice environment;
    e. current best practice in infection control protocols relevant to his or her professional practice style;
    f. the health and immunization status of the chiropractor, the staff and all other individuals in the practice environment.
8. Consider the necessity of self-immunization for common and/or preventable illness as appropriate and based on the outcome of this consideration ensure appropriate action is taken in a timely manner to ensure patients are properly protected from diseases while being treated.
9. Screen for symptoms of infectious diseases and segregate those patients from others.
10. Use appropriate personal protective equipment in circumstances indicating such measures.
11. Report reportable communicable diseases to their public health unit.

Appendix A
Common Definitions

- **Infection Control:** measures practiced by health care practitioners intended to prevent spread, transmission and acquisition of agents or pathogens between patients, from health care practitioners to patients and from patients to health care practitioners in the health care setting. These measures are determined after an assessment of the facility and of the patient population. Infection control measures instituted are based on how an infectious agent is transmitted and include standard, contact, droplet and airborne precautions.
- **Cleaning:** involves the physical removal of foreign material such as dust, soil and organic material including blood, secretions, excretions and micro-organisms. Cleaning physically removes rather than kills micro-organisms. Removal of material is necessary to permit the effective disinfection or sterilization of equipment. It is accomplished with water, detergents and mechanical, scrubbing action. The terms "decontamination" and "sanitation" may be used for this process in certain settings. Cleaning reduces or eliminates the reservoirs of potential pathogenic organisms. Cleaning agents are the most common chemicals used in housekeeping activities.
- **Disinfection:** the inactivation of disease-producing micro-organisms. Disinfection does not destroy bacterial spores. Disinfection usually involves chemicals, heat or ultraviolet light. Varying levels of disinfection have been recommended based upon the nature of the procedure, infection risk and type of equipment. Disinfectants are used on inanimate objects while antiseptics are used on living tissue.

- **Sterilization:** involves a multi-step process that results in the destruction of all forms of microbial life including bacteria, viruses, spores and fungi. Items must be cleaned thoroughly before effective sterilization can take place. The decision to sterilize equipment is based upon the procedure, risk of infection and the type of equipment. Various methods of sterilization exist, the most common include steam and heat (autoclave), dry heat (dry heat sterilizer) or chemicals. Monitoring the effectiveness of sterilization procedures is essential. Monitoring can be achieved using biologic, chemical and mechanical methods.
- **External practice environment:** any locale beyond the internal practice environment, and may extend to municipal, provincial, national or international borders depending on the nature of the infection risk being considered.
- **Internal practice environment:** the physical location(s) where chiropractic services may be provided to patients. These physical locations can include not only the chiropractor's private practice facilities/clinics, but also could include hospitals, athletic venues, and patients' homes.

4.4 Acupuncture

Adopted 03/2007, Revised and Effective 01/2014

To provide needle acupuncture, chiropractors must:

1. Be certified in needle acupuncture and make demonstration of training to the satisfaction of the Registrar.
2. Provide evidence of professional liability protection for needle acupuncture.
3. Use only single-use, disposable needles.
4. Observe the principles and health care industry standards for aseptic technique and the Alberta Infection Prevention and Control (IPC) Standards.
5. Not list or promote acupuncture as a specialty anywhere, as it is not a fellowship recognized by the Canadian Federation of Chiropractic Regulatory and Education Accreditation Boards (CFCREAB).
6. Restrict themselves to performing those activities they are competent to perform and to those that are appropriate to the member's area of practice and the procedure being performed, despite any authorization to perform the restricted activities for acupuncture.

4.5 Chiropractic Treatment of Animals

Adopted 06/2004, Revised and Effective 01/2014

Veterinary medicine has exclusive jurisdiction over the care and treatment of animals. Chiropractors who have an interest in chiropractic treatment and spinal adjusting of animals must do so in consultation with a member of the Alberta Veterinary Medical Association.

In all circumstances, chiropractors may only treat animals in consultation with or with a written directive from a member of the Alberta Veterinary Medical Association.

4.6 Setting a Fracture

Adopted 11/2006, Revised and Effective 01/2014

Chiropractors may set or reset simple fractures as part of their therapeutics and as an advanced restricted activity, subject to the following requirements:

1. Attaining chiropractic orthopedist Fellowship status through a Chiropractic Orthopedists board exam acceptable to the College of Chiropractic Orthopedists (Canada) and providing evidence on an annual basis that this status remains current.
2. Acquiring the postgraduate knowledge as set out in orthopedic specialty program curriculum in casting/splinting:
    a) technique of application;
    b) time frame for x-ray/imaging (e.g., MRI and/or bone scan);
    c) complications of casting;
    d) delayed union;
    e) non-union/pseudo-union;
    f) aseptic necrosis;
    g) reparative process for fractures.

In the setting of a fracture, the chiropractor is restricted to setting simple fractures. A chiropractor must only ever perform a restricted activity to the level they are competent and that is appropriate to the area of practice and procedure being performed.

4.7 Sacro-coccygeal Adjustments

Adopted 03/2007, Revised and Effective 01/2014

To perform manipulative procedures of the sacro-coccygeal joint, a chiropractor must be competent to perform the procedure and to evaluate and consider contraindications.

Chiropractors must be familiar with the following areas essential for the adjustment of the sacro-coccygeal joint:

- The anatomic structures of the sacro-coccygeal joint and the surrounding area
- The presentation of coccydynia and the ability to differentiate this pain from that of a referred pattern
- The examination and diagnostic procedures of the sacro-coccygeal joint
- The treatment and adjustive techniques for coccygeal correction

Consideration of Patient Understanding and Consent
As per SP 3.1 Informed Consent, a chiropractor shall fully explain the diagnosis, options, proposed treatment procedure and prognosis to the patient before proceeding with the manipulation of the tailbone. Due to the sensitive and personal nature of this type of adjustment, specific consent must be fully informed, voluntarily given and evidenced in written form.

4.8 Gynecological and Urological Examinations

Adopted 03/2007, Revised and Effective 01/2014

Regardless of commonly understood routine gynecological and urological examinations were taught in the curriculum of an accredited chiropractic program, a chiropractor may not conduct these procedures, as they are restricted activities that do not fall within the chiropractic scope of practice in Alberta.

Chiropractors must refer patients who need a gynecological or urological examination to a medical facility.

4.9 Performance, Authorization, Competency and Supervision of Restricted Activities

Adopted 10/2022, Effective 04/2023

General rules for Restricted Activities

1. No regulated member shall engage in performance of a restricted activity in the practice of a chiropractor, unless the regulated member:
    a. is performing a restricted activity that the member is competent, and authorized to perform; and
    b. is complying with all applicable provincial legislation and regulatory requirements.
2. In the practice of a chiropractor, a regulated member must:
    a. assess the risks and benefits associated with the activity and communicate these to patients; and
    b. establish and apply critical event management plans to potential adverse events associated with restricted activities they are competent and authorized to perform.
3. In the practice of a chiropractor, a regulated member may perform a restricted activity under supervision
    a. where the supervising practitioner is authorized to perform the restricted activity according to applicable provincial legislation or regulatory requirements; and
    b. the regulated member has obtained authorization and permission from the Registrar in writing of the restricted activity the regulated member intends to perform under supervision;
    c. written authorization and permission from the Registrar for a restricted activity they are not authorized to perform according to applicable provincial legislation or regulatory requirements and are performing under the authority and supervision of a regulated member of another profession who is authorized and competent to perform the restricted activity.
4. No regulated member shall supervise the performance of a restricted activity unless the regulated member is
    a. competent to perform the restricted activity and authorized to perform the restricted activity in compliance with all applicable provincial legislation and regulatory requirements.
5. A regulated member must have written permission from the Registrar to be under the supervision of a competent regulated health professional of another regulated health profession. This authorization only applies for restricted activities that can be performed under supervision and under the practice permit of the competent regulated health professional.

Restricted Activities Authorization

6. A regulated member:
    a. on the general or courtesy register, in the practice of chiropractic and in accordance with the regulatory requirements, who is competent, and is authorized to perform the following restricted activities:
        i. to use a deliberate, brief, fast thrust to move the joints of the spine beyond the normal range but within the anatomical range of motion, which generally results in an audible click or pop;
        ii. to insert or remove instruments, devices or fingers
            A. Beyond the cartilaginous portion of the ear canal;
            B. Beyond the point in the nasal passages where they normally narrow;

C. Beyond the anal verge;
iii. to reduce a dislocation of a joint;
iv. to order any form of ionizing radiation in
A. medical radiography; and
B. nuclear medicine;
v. to apply any form of ionizing radiation in medical radiography; and
vi. to order non-ionizing radiation in
A. magnetic resonance imaging; and
B. ultrasound imaging;

Needle Acupuncture

7. A regulated member who is:
a. on the general or courtesy register, and
i. demonstrates competence through the successful completion of an education program in needle acupuncture approved by the Council, and
ii. meets the additional requirements for continuing competence related to needle acupuncture established by the Council, and
iii. has received notification from the Registrar that their needle acupuncture authorization is indicated on the appropriate register; **may**, in the practice of chiropractic and in compliance with the regulatory requirements be authorized to perform and supervise the restricted activity of cutting a body tissue or performing other invasive procedures on body tissue below the dermis or mucous membrane for the purpose of needle acupuncture.

Setting or Resetting Simple Fractures

8. A regulated member
a. on the general or courtesy register:
who has successfully completed a specialty program in orthopaedics:
i. approved by the Council,
ii. who meets the additional requirements for continuing competence related to setting or resetting of simple fractures established by the Council, and
iii. who has received written authorization from the Registrar that the orthopaedic specialty, which includes the setting of simple fractures, is indicated on the appropriate register; **may,** in the practice of chiropractic and in accordance with the Regulatory requirements, perform the restricted activity of setting or resetting of simple fractures of a bone;
b. on the general register and in their training must be supervised in the restricted activity of setting or resetting a simple fracture of a bone in a program of training of orthopaedics:
i. approved by the Council, and
ii. who is supervised by a regulated member authorized under section 3(a-b) or 7(a), and
iii. who has received written authorization from the Registrar; may**,** in the practice of chiropractic and in accordance with the Regulatory requirements, perform the restricted activity of setting or resetting a simple fracture of a bone, only with direct supervision.

Supervision Requirements of Regulated Members

9. A regulated member who is on the general register, who is competent in the restricted activities to be supervised, may supervise the performance of activities in sections 6, 7 and 8 of this Standard of Practice, and must:
    a. prior to providing supervision, obtain written authorization from the Registrar as a supervisor for regulated members on the general register in accordance with the requirements set by the Council, and
    b. provide direct or indirect supervision to regulated members on the general register, according to the requirements for supervision in sections 6, 7 and 8, and
    c. in consideration to section 5(b), and in compliance with sections 6, 7 and 8, determine for the patient the safest supervision on the spectrum from direct to indirect supervision, with
    d. consideration for the level of skill and competence of the regulated member they are supervising, and
    e. the complexity of the patient condition, and
    f. comply with all applicable provincial legislation and regulatory requirements.

Supervision Requirements for Students

10. A regulated member who is on the general register, who is competent in the restricted activities to be supervised and has obtained prior written authorization from the Registrar may directly supervise a student who is enrolled in a program of chiropractic studies approved by Council, in the performance of the restricted activities in section 2 of this Standard. The preceptor must:
    a. provide direct supervision to students as authorized in the performance of restricted activities; and
    b. secure written consent from the patient on whom the student is to perform the restricted activity; and
    c. consider the level of skill and competence of the individual they are supervising, and
    d. consider the complexity of the patient condition, and
    e. comply with all applicable provincial legislation and regulatory requirements.

SP 5.0 Patient Health Records

Adopted 05/2012, Revised and Effective 11/2016

Purpose and Objective
To make clear the responsibilities of a chiropractor in the creation, maintenance and retention of patient health records, regardless of media (i.e., written or electronic), to ensure appropriate care and control of all patient information.

Chiropractors must be certain all Electronic Medical Records (EMR) systems are compliant with the requirements for the protection, privacy, and security of the electronic records as set out in the *Health Information Act.* Chiropractors should also have policies and procedures in place to administer the requirements of the *Health Information Act*.

Under the *Health Information Act record* means: "a record of health information in any form, and includes notes, images, audiovisual recordings, x-rays, books, documents, maps, drawings, photographs, letters, vouchers and papers and any other information that is written, photographed, recorded or stored in any manner, but does not include software or any mechanism that produces records."

5.1 Record Keeping Requirements

Adopted 06/2006, Revised and Effective 03/2018

Patient health records must be dated, accurate, legible and comprehensive. All services provided by the chiropractor must be documented by the chiropractor and entries must be clearly identifiable as having been made by the chiropractor.

The documentation of services provided by members of the clinical support staff and/or unregulated health care providers must be provided in the chiropractor's patient file, by the individual providing the service. This documentation is the responsibility of the chiropractor.

All patient health records must include the following documentation:

Personal Information

- Patient's name, address, phone numbers, date of birth, gender, personal healthcare number
- Note: All patients accessing the Alberta health system are required to uniquely identify themselves with at least two pieces of supporting documentation. If the patient is accessing Alberta Health Care, this information must be confirmed and confirmation specifically recorded on the patient record. No copies of the identifying documentation should be retained on the patient record.

History

- Accurately documented facts about the patient's personal health history

Physical exam findings

- Both positive and negative results
- Findings that support the diagnosis

Written diagnosis

- Working diagnosis and/or index of suspicion

- If Vertebral Subluxation Complex (VSC) is used, it must identify the segmental level(s) and components of the "complex"
- If International Statistical Classification of Diseases (ICD) codes are used, they must have a two-digit, post-decimal point descriptor code that identifies segmental level(s) and tissue(s) involved

Written treatment plan

- All proposed treatment methods

Appropriate progress notes

- Dates, subjective information, objective information, assessment notes, and treatment rendered and/or proposed (e.g., SOAP notes)

5.2 Clinical Relevance of Treatment Recommendations

Adopted 04/2005, Revised and Effective 03/2018

There must be a direct and rational connection between the patient's presenting complaint, the diagnosis and the recommended treatment.

The patient health record will clearly and completely demonstrate the chiropractor has:

- Elicited and documented an appropriate case history.
- Performed and documented an appropriate physical examination and other relevant investigations congruent with the presenting complaint.
- Derived and documented a diagnosis congruent with the presenting complaint.
- Derived and documented an appropriate treatment plan, consistent with the diagnosis and congruent with a treatment protocol taught at a CCE accredited chiropractic institution (or technique systems approved by Council).
- Documented the expected health benefit of any treatment (services or products) that is provided or recommended by the chiropractor.
- Identified and documented clear progress markers or milestones in association with the treatment plan.

5.3 Custodianship of Health Records

Adopted 04/2001, Revised and Effective 11/2016

A chiropractor, as a custodian of health records, is responsible for the care and control of the health records in their practices as required by the *Health Information Act* of Alberta. A custodian of active chiropractic files must be under the custody or control of an active, registered member of the CCOA.

Note that under the *Health Information Act*, a chiropractor may disclose files to another custodian who is not a chiropractor, and only a chiropractor may have custody or control of chiropractic files. Chiropractic files disclosed to a non-chiropractor should no longer be considered chiropractic files.

A custodian must implement technical and physical safeguards to protect the confidentiality of the information and privacy of individuals as well as protections against reasonably anticipated threats to the security or integrity of the information. A custodian must also defend against unauthorized uses, disclosures or modifications of the information. Safeguards must be periodically assessed and documented in policies and procedures.

A custodian must maintain a process for confirming patient identification when accessing patient information, for example, photo ID, PHN.

Chiropractors in a group practice must determine custodianship arrangements of patient records within that practice so that:

(a) if a chiropractor leaves the practice, custodianship of patient records will be clear to all parties and to the patients of the departing and remaining chiropractors, and
(b) the departing chiropractor and their patients have reasonable access to the relevant patient records.

Examples of custodianship situations:

- Custodianship may be defined via contract agreement that specifies the custodian of the health records. A contract agreement must identify a qualified individual to be the custodian (a corporate entity is not permitted). It would also establish which chiropractors are acting as an affiliate in accordance with (Section 1(1)(a) of the *Health Information Act)*. For example, where a chiropractor hires other chiropractors to provide health services, the employer chiropractor would be the custodian.
- In the absence of a contract agreement, the custodian will be deemed the chiropractor who is or was the active care provider (as defined by the patient). Interim care provided by another chiropractor does not shift the custodianship of the health record unless agreed to by both patient and chiropractor.
- In the absence of a contract agreement, a custodian who is departing a clinic has the obligation to continue the custodianship of their health records and to take these records with them unless there exists a written agreement with another qualified custodian to transfer the custodianship of these health records to that qualified custodian.
- Professional Corporations are not eligible custodians.
- The *Health Information Act* holds the custodian accountable for the health information for as long as the custodian has care and control of the record. This includes situations where a chiropractor may engage the services of a records management company.

It is the professional responsibility of the custodian to provide reasonable and sufficient notice to those patients affected by a change in the location of the patient's care provider or of the patient's health record. This includes specific notice to active patients as to when the care provider is leaving the current practice, where the care provider can be contacted and how access to the health record will be available to the patient.

5.4 Health Records Retention

Adopted 03/2006, Revised and Effective 01/2014

A chiropractor is required to ensure the availability, retention and disposition of patient health records.

As custodians, chiropractors have a responsibility to ensure access to patient health records is available to patients (current and former) and other appropriate parties. A chiropractor may charge a fee as

permitted by the *Health Information Act* for a patient's request for access to or a copy of his or her record.

Patient records must be maintained for a minimum of 10 years from the date of last entry or, if the patient was less than 18-years-old at the time of the last entry, 10 years from the date the patient became 18 (until the patient turns 28).

Any records stored off-site must be in a safe and secure facility where access is only available to authorized personnel. Records stored at an off-site facility must be inventoried with the name of the patient, date of the last visit and date the record was sent to storage. Access to these records must be available to the custodian.

For any records stored in an off-site storage facility, the custodian must sign an information manager agreement with the storage facility. This agreement must meet the requirements specified in sec 7.2 of the Health Information Regulation.

When appropriate, patient health records must be destroyed by secure and confidential means, e.g., shredding.

Upon the transfer/sale of a practice, or upon the closure of a practice, patient files must remain under the care and control of a qualified custodian. Patient file custodianship may be transferred to another qualified custodian, en masse, through the execution of a written agreement between the current custodian and the new custodian. This agreement must simply acknowledge the transfer of custodianship from one individual to the other individual and indicate the date of the transfer. Both parties should retain copies of the agreement.

5.5 Electronic Health Records

Adopted 12/2013, Revised and Effective 11/2016

A chiropractor who uses an electronic patient record must ensure the system has additional safeguards to protect the confidentiality and security of information, including but not limited to, ensuring:

1. An unauthorized person cannot access identifiable health information on electronic devices.
2. Each authorized user can be uniquely identified.
3. Each authorized user has a documented access level based on the individual's role.
4. Appropriate password controls and data encryption are used.
5. Audit logging is always enabled and meets the requirements of section 6 of the Alberta Electronic Health Record Regulation.
6. Where electronic signatures are permitted, the authorized user can be authenticated.
7. Identifiable health information is transmitted or remotely accessed as securely as possible with consideration given to the risks of non-secured structures.

8. Secure backup of data.

9. Data recovery protocols are in place and the regular testing of these protocols.

10. Data integrity is protected such that information is accessible as stipulated in SP 5.4 Health Records Retention above.

11. Practice continuity protocols are in place in the event information cannot be accessed electronically.

12. When hardware is disposed of that contains identifiable health information, all data is removed and cannot be reconstructed.

A chiropractor who engages the service of an information manager, as defined under the *Health Information Act*, to manage electronic health records under the custody or control of that chiropractor, must first enter into a written agreement with the information manager.

The agreement between the chiropractor and the information manager must comply with the requirements of an information manager agreement as specified under section 7.2 of the Health Information Regulation.

The information manager may use or disclose information for the purposes authorized by the agreement and must comply with the *Health Information Act* and regulations, and the agreements entered with the chiropractor. The chiropractor continues to be responsible for the compliance with the *Health Information Act* and regulations, including protecting the records.

Chiropractors practicing in a group practice setting must have an information sharing agreement in place between the practitioners. The information sharing agreements shall set out the purpose of the agreement, the scope of the agreement in terms of patient file access, and the policies that govern the access to, sharing of, and the security for the patient information, consistent with the requirements of the *Health Information Act*.

A chiropractor who discloses or contributes information to a shared electronic health record operated by another custodian that facilitates access to the information by multiple custodians must first enter an information sharing agreement with the custodians participating in the shared electronic health record that sets out how duties under the *Health Information Act* will be met.

The agreement must address:

- Clarifying when another custodian may use and disclose records the chiropractor has contributed to
- Process for responding to patient access and correction requests
- Process for responding to disclosure requests (e.g., research requests)
- Shared responsibilities for protecting the records

A chiropractor who works in this type of practice arrangement is expected to fulfill all obligations respecting the completion of patient records, the maintenance of security of patient records, the

confidentiality of the information contained in the patient records and comply with the requirements of the *Health Information Act.*

5.6 Electronically Communicated Health Record Information

Adopted 03/2015, Effective 11/2016

Chiropractors who choose to communicate health record information via electronic means must ensure these systems employ safeguards to protect the confidentiality and security of patient information. These systems may include, but are not limited to fax, email, and shared Electronic Medical Records.

As email is not a secure means of communicating individually identifying health information, additional steps must be taken to ensure the information is protected when transmitted via email, such as encryption or the use of a secured messaging solution.

Ensuring reasonable safeguards are in place to protect against reasonably anticipated risks to privacy are the sole responsibility of the chiropractor; this risk cannot be transferred to the patient through a consent/release form. See the OIPC's FAQ on Email Communication for more information.

A record of all electronic communication of health record information must be included in the patient's record. All electronic communication of health record information must meet requirements as set out by the Canadian Anti-Spam Legislation.

Chiropractors who choose to integrate email addresses into new or existing EMRs must first complete or update their privacy impact assessment (PIA).

Chiropractors must not communicate health record information through any electronic method (other than email), including SMS/text (either phone, web or other mobile communication system), messenger apps or social media.

5.7 Disclosure of Health Record Information

Adopted 03/2015, Effective 11/2016

A custodian may disclose individually identifying diagnostic, treatment and care information without the consent of the individual who is the subject of the information, only as set out in the *Health Information Act*, s. 35, 36.

For all other cases, a custodian may disclose individually identifying health information to a person other than the individual who is the subject of the information only if the individual has consented to the disclosure and has provided authorization for the custodian to disclose the health information specified in the consent, in accordance with the *Health Information Act* s. 34.

The authorization must include:

i. the date the consent is effective, and the date on which the consent expires, if any,
ii. the purpose for which the health information may be disclosed,
iii. the identity of the person to whom the health information may be disclosed,

iv. an acknowledgment the individual providing the consent is aware of the reason(s) why the health information needs to be shared, and the risks and benefits to consenting or refusing to consent,
v. a statement the consent may be revoked at any time by the individual providing it; and
vi. an authorization for the custodian to disclose the health information specified in the consent.

SP 6.0 Professional Boundaries with Patients, Including Dating and/or Sexual Relationships

Adopted 04/2019, Effective 04/2019

Purpose and Objective

To inform regulated members of the expectations and requirements related to the conduct of chiropractors in their relationship and engagement with patients to ensure a common understanding of the appropriate professional boundaries of the doctor-patient relationship. This Standard outlines the conduct and activities that may lead to a breach of this Standard and which may also constitute a finding of "unprofessional conduct" under the *Health Professions Act* ("HPA") in relation to "sexual abuse" or "sexual misconduct." The HPA does not make a distinction between clinic, non-clinic, office hours and after-hours settings. This Standard applies regardless of setting.

6.1 Professional Boundaries with Patients

Adopted 04/2019, Effective 04/2019

Regulated members must always maintain professional boundaries with patients.

Professional boundaries in patient care are physical and emotional limits of the therapeutic relationship between the patient and the regulated member. The regulated member's responsibility is always to act in the patient's best interest and to manage the boundaries within the doctor-patient relationship. Additionally, regulated members must recognize that each patient's boundaries will be unique to their own experiences, including their culture, age, values or experiences of trauma.

6.2 Definition of a Patient

Adopted 12/2022, Effective 01/2023

A dating and/or sexual relationship with a current patient is prohibited even if the regulated member believes that the patient is "consenting." The HPA does not recognize such alleged "consent" as a valid defence because of the existence of the inherent power imbalance that exists in the regulated member-patient relationship.

For the purposes of this Standard and complaints of sexual abuse or sexual misconduct made under the HPA, an individual is considered to be a current patient for twelve months after the last clinical encounter.

- For the purposes of this Standard, a "clinical encounter" means any and all professional services provided by the regulated member and includes conduct ranging from verbal consultation to actual physical treatment. Additionally, the terms "care," "consultation," "patient care" and "treatment" are considered equivalent terms used to describe a clinical encounter.
    - An introductory consultation that is 1) exploratory in nature for the patient and 2) does not include any provision of professional services or the expectation of continuation of any professional services is not considered a clinical encounter.

- For the purposes of this Standard, a regulated member who has engaged in any clinical encounter with a patient who is a minor is permanently prohibited from engaging in any dating and/or sexual relationship with that individual.

- If a regulated member had a dating or sexual relationship with an individual prior to the intent to begin a doctor-patient relationship, the regulated member is prohibited from having any clinical encounter with the individual.

- For the purposes of this Standard, spouse has the same meaning as an adult interdependent partner as defined in the Adult Interdependent Relationships Act or as a person who is married.

Limited Exceptions to the Definition of a Patient

This Standard does not preclude a regulated member from engaging in clinical encounters with a spouse.

While regulated members are not prohibited from engaging in clinical encounters with a spouse, they should be cognizant of the risks of doing so. All complaints of sexual abuse or sexual misconduct against the regulated member is (i) investigated by the CCOA as required by the HPA, and (ii) where appropriate, the CCOA will refer the matter to a formal discipline hearing.

If a regulated member becomes separated from their spouse, the regulated member is prohibited from engaging in clinical encounters during the separation period. The separation period is defined as the time lived separate and apart.

6.3 Commencing a Dating and/or Sexual Relationship with a Current Patient

Adopted 04/2019, Effective 04/2019

A regulated member is prohibited from commencing a dating and/or sexual relationship with a current patient. If a current patient suggests or attempts to develop a dating and/or sexual relationship, a regulated member shall promptly:

- Inform the patient of the legal restrictions and prohibitions described in this Standard concerning a dating and/or sexual relationship and communicate proper boundaries for the doctor-patient relationship
- Discharge the patient if the above actions do not resolve the situation
- Document all actions in the record of personal health information

If the patient requests referral to another chiropractor or the regulated member, for continuity of care or clinical reasons, determines a referral to another chiropractor is necessary, it is recommended the regulated member make that referral to another regulated member external to their own clinic whenever possible.

6.4 Commencing a Dating and/or Sexual Relationship with a Former Patient

Adopted 04/2019, Effective 04/2019

A regulated member may commence a dating and/or sexual relationship with a *former* patient providing that both of the following requirements are met:

1. The regulated member has not engaged in any clinical encounters with the former patient for a minimum of 12 months.
2. The regulated member did not engage in any clinical encounter with the former patient when the former patient was a minor.

For the purposes of this Standard, a patient is deemed discharged and to be a "former patient" if there have been no clinical encounters with the regulated member for a minimum of 12 months. However, it is incumbent upon the regulated member to ensure the former patient understands they have been discharged from care. Whenever possible, it is highly recommended the regulated member:

- Terminate the care of the patient verbally and with a formal letter of discharge to the patient
- Give a copy of the formal letter of discharge to the patient
- Maintain a second copy of the formal letter of discharge in the file

Regulated members are reminded they have an ethical obligation not to exploit the trust, knowledge and dependence that develops during the doctor-patient relationship. It may never be appropriate for a regulated member to have a dating and/or sexual relationship with a former patient. For example, it would be inappropriate if there is a continued power imbalance between the regulated member and the former patient, or the former patient is physically or emotionally vulnerable, has diminished capacity, has impaired decision-making, is economically disadvantaged, is suffering from addictions or is experiencing homelessness.

Even if the aforementioned circumstances do not exist, a regulated member must think and act cautiously when determining the appropriateness of a dating and/or sexual relationship with a former patient. Any regulated member who engages in a dating and/or sexual relationship with a former patient runs a risk the conduct may be considered inappropriate and unprofessional conduct.

6.5 Evidence of a Doctor-Patient Relationship

Adopted 04/2019, Effective 04/2019

Evidence of a doctor-patient relationship includes, but is not limited to:

- Record of personal health information includes, but is not limited to:
    - Formal letter retaining the patient
    - Patient history
    - Patient consent
    - Physical examination
    - Consultation
    - Diagnosis
    - Plan of management/treatment planning
    - Prognosis

  - Diagnostic imaging reports
  - Written record of treatment
  - Informed consent to treatment
  - Billing information
- Provision of a professional service
- Commencement of billings, including billing to third parties, such as insurance companies
- Financial records
- Letters of consultation, letters of referral to and from other health professionals
- Written communications or statements referring to an individual as a patient
- Formal letter of discharge

6.6 Sexual Abuse

Adopted 04/2019, Effective 01/2019

Under section 1(1)(nn.1) of the HPA, "sexual abuse" means the threatened, attempted or actual conduct of a regulated member towards a patient that is of a sexual nature and includes any of the following conduct:

- Sexual intercourse between a patient and a regulated member
- Genital to genital, genital to anal, oral to genital, or oral to anal contact between a regulated member and a patient
- Masturbation of a regulated member by or in the presence of a patient
- Masturbation of a regulated member's patient
- Encouraging a regulated member's patient to masturbate
- Touching of a sexual nature of a patient's genitals, anus, breast, or buttocks by a regulated member

Sanctions for Findings of Sexual Abuse

A regulated member found guilty of unprofessional conduct relating to sexual abuse of a patient, in Alberta or another jurisdiction, whether in whole or in part, will be subject to the following mandatory sanctions:

- Immediate suspension of practice permit
- Permanent cancellation of a practice permit
- Publication of discipline proceedings will remain on the public register indefinitely
- Financial obligations, such as paying for therapy and/or counselling for the victim and reimbursing the CCOA for legal and investigative costs

6.7 Sexual Misconduct

Adopted 04/2019, Effective 04/2019

Under section 1(1)(nn.2) of the HPA, "sexual misconduct" means any incident or repeated incidents of objectionable or unwelcome conduct, behaviour or communication of a sexual nature by a regulated member who knows, or ought reasonably to know, will or would cause offence or humiliation to the patient or adversely affect the patient's health and well-being but does not include sexual abuse.

Examples of sexual misconduct include**:**

- Gowning or disrobing practices that reflect a lack of respect for a patient's privacy and dignity
- Inappropriate sexualized comments about the patient, for example:
    - Making sexual comments about a patient's body or undergarments
    - Comments of a sexual nature about weight, body shape, size or figure
    - Making sexual or sexually demeaning comments about a patient's sexual orientation
    - Requesting clinically irrelevant information such as sexual history, likes or dislikes
- Socializing with a patient in the context of initiating a sexual relationship
- Sending, sharing and/or distributing inappropriate or offensive communications of a sexual nature to or about a patient. This includes but is not limited to:
    - Texting flirtatious messages
    - Sharing graphic content, images or pictures via social media
    - Distributing sexual comments online
- Initiation of, or involvement in, clinically irrelevant conversation regarding sexual problems, preferences, experiences, habits or fantasies
- Offensive, risqué jokes, innuendos, taunting or kidding about sex or gender-specific traits
- Suggestive or insulting sounds such as whistling, wolf-calls or kissing sounds
- Pseudo-medical advice with sexual overtones
- Staged whispers or mimicking of a sexual nature about things, such as the way a person walks, talks or sits
- Kissing patients or hugging of a sexual nature

For the purposes of this section, and as set out in section 1(1)(nn.3) of the HPA, "sexual nature" does not include touching, behaviour or remarks of a clinical nature appropriate to the professional service provided. However, it is incumbent upon the regulated member providing any professional service of a potentially sensitive nature that could be misconstrued as sexual misconduct to satisfactorily demonstrate, via documentation in chart notes, that they fully described the professional service to the patient and that the patient provided informed consent to the regulated member prior to providing the professional service.

Due to the invasive nature of certain therapeutic treatments, specific written informed consent using the CCOA-provided consent form is required for the following treatment before the clinical encounter can proceed:

- An internal coccygeal adjustment

Sanctions for Findings of Sexual Misconduct

A regulated member found guilty of unprofessional conduct relating to sexual misconduct relating to a patient, in Alberta or another jurisdiction, whether in whole or in part, will be subject to the following minimum sanctions:

- Immediate suspension of practice permit
    - A hearing tribunal will determine the length of time for a suspension, and has the discretion to cancel the practice permit because of sexual misconduct.

- If the practice permit is cancelled because of sexual misconduct, the regulated member is prohibited from applying for reinstatement for at least five years.
- If a person's application for reinstatement is refused, the person must wait a minimum of six months before making a subsequent application to have the person's practice permit reissued and registration reinstated.

- Publication of discipline proceedings will remain on the public register indefinitely
- Financial obligations, such as paying for therapy and/or counselling for the victim and reimbursing the CCOA for legal and investigative costs

6.8 Conviction of Criminal Code Offences

Adopted 04/2019, Effective 04/2019

If a regulated member is convicted of one of the Criminal Code offences specified in section 45 of the HPA, the CCOA may treat this information as a complaint and initiate the complaints process under the HPA.

- If the matter is referred to a hearing, the hearing tribunal must determine whether the regulated member's conduct constitutes unprofessional conduct.
- If the alleged victim is a patient, the mandatory penalties of either cancellation for unprofessional conduct involving sexual abuse or suspension for unprofessional conduct involving sexual misconduct would apply.
- If the alleged victim is not a patient, the hearing tribunal has the discretion to impose a range of sanctions if the conduct of the regulated member constitutes unprofessional conduct in addition to the new mandatory penalties.
- If a conviction under one or more of the enumerated sections of the Criminal Code was part of the basis for cancellation of the regulated member's practice permit and registration, the regulated member cannot apply for reinstatement of their practice permit and registration in the future.

6.9 Other Key Definitions

Adopted 04/2019, Effective 04/2019

1. **Regulated Member** – a healthcare professional currently registered with the College and
   a. is eligible for registration as a regulated member as specified in Section 33(1)(a) of the HPA and in accordance with the Regulations;
   b. pays the fees and other charges which are prescribed in the Regulations or by the Council, for licensing and membership**; and**
   c. includes a previous regulated member whose last day of registration with the College is within the immediately preceding two years.

2. **Adult Interdependent partner**[4] – a person is the adult interdependent partner of another person if:

[4] Government of Alberta. (2002). *Adult Interdependent Relationships Act*. Edmonton: Author. Available at: http://www.qp.alberta.ca/documents/Acts/A04P5.pdf

a. the person has lived with the other person in a relationship of interdependence
    i. for a continuous period of not less than three years; or
    ii. of some permanence if there is a child of the relationship by birth or adoptions; or
b. the person has entered into an adult interdependent partner agreement with another person but does not include a former adult interdependent partner.

3. **Adult interdependent partner relationship**[1] – a relationship outside of marriage in which two people:
    a. share one another's lives;
    b. are emotionally committed to one another;
    c. function as an economic and domestic unit.

    A person who is a spouse cannot be part of an adult interdependent relationship.

4. **Professional Service**
    a. For the purposes of this Standard, "professional service" shall have the meaning set out in section 1(1)(ff) of the HPA which states:

        "(ff) "professional service" means a service that comes within the practice of a regulated profession;"

    and shall include the practice statement for chiropractors in section 3 of the Chiropractic Profession Schedule to the HPA which states:

    "Practice
    3 In their practice, chiropractors do one or more of the following:

    (a) examine, diagnose and treat, through chiropractic adjustment and other means taught in the core curriculum of accredited chiropractic programs, to maintain and promote health and wellness,

    (a.1) teach, manage and conduct research in the science, techniques and practice of chiropractic, and

    (b) provide restricted activities authorized by the regulations.**"**

SP 7.0 Fitness to Practice

Adopted 11/2012, Revised and Effective 01/2014

Purpose and Objective
To ensure chiropractors fulfill their professional obligation to maintain a safe and trustworthy clinical environment by addressing any issues, concerns or personal situations that may cause patient care to be compromised.

7.1 Incapacity

Adopted 08/2005, Revised and Effective 01/2014

Incapacity refers to a situation in which a chiropractor may be suffering from a physical or mental condition or disorder that would compromise patient care. Incapacity is inclusive of any cognitive or physical condition or pattern of use of alcohol and/or drugs (illicit, over the counter or prescription) which interferes with an individual's occupational, social, legal, financial, emotional or physical functions.

Chiropractors must only act in a manner that would be seen as providing safe and competent services. Chiropractors must not misuse or abuse alcohol, illicit drugs, or over the counter or prescription medication.

Chiropractors are required to understand all side effects of their own medication and ensure any cognitive or physical impairment they may experience does not impinge on the provision of safe and competent services.

If a chiropractor is aware they are incapacitated for any reason, they are required to cease providing professional services until the reason for the incapacity has been eliminated.

Reporting Obligations
As set out in the CCOA Code of Ethics and the *Health Professions Act s.118*:

A chiropractor shall inform the CCOA when a serious injury, medical condition or any other condition has either immediately affected or may affect over time, his or her ability to practice safely and competently.

A chiropractor has an ethical obligation to urge impaired colleagues to seek treatment and a chiropractor with first-hand knowledge that a colleague is practicing chiropractic when impaired has an ethical responsibility to report such information to the CCOA.

Implications of Practicing while Incapacitated
In situations where patient/public safety is identified as a clear and present concern, the chiropractor may be directed, by the CCOA Complaints Director, to cease or limit providing professional services until resolution of the situation has resulted in the re-instatement of a safe clinical environment.

SP 8.0 Diagnostic Imaging

Adopted 01/2013, Revised and Effective 01/2014

Purpose and Objective
To ensure chiropractors demonstrate clinical relevance and accountability in the ordering and applying of diagnostic imaging.

8.1 Diagnostic Imaging Studies for Adults

Adopted 03/2007, Revised and Effective 01/2014

Chiropractors may order conventional investigative diagnostic imaging in support of differential diagnosis for adults, 18 years and older:

- To preclude potential treatment contraindications
- For the investigation of trauma, significant biomechanical abnormality or instability
- Or, in the absence of a manifest structural and/or developmental indicator or disease, where such condition is suspected

Upon receipt of clinically significant diagnostic imaging findings, the chiropractor who requisitions the study is responsible for reporting the results to the patient, as well as referring the patient to another health care practitioner, if indicated.

8.2 Advanced Diagnostic Imaging Studies for Adults

Adopted 07/2007, Revised and Effective 01/2014

Studies such as computed tomography (CT), magnetic resonance (MR) imaging, ultrasound imaging and radionuclide bone scans that are occasionally indicated in addition to conventional radiographs for adults, 18 years and older.

Chiropractors must consider advanced imaging when documented patient history, examination or prior tests indicate the presence of a clinically significant condition including, but not limited to:

- Progressive neurologic deficit
- Infection or neoplasm
- Suspected occult fracture

Chiropractors must be able to demonstrate through documented patient history, examination notes or prior tests the clinical relevance and indications for advanced imaging.

Upon receipt of clinically significant advanced diagnostic imaging findings, the chiropractor who requisitions the study is responsible for reporting the results to the patient, as well as referring the patient to another health care practitioner, as indicated.

Chiropractors must give due consideration to females with reproductive capacity.

8.3 Diagnostic Imaging for Children

Adopted 06/2004, Revised and Effective 01/2014

Children are particularly sensitive to the untoward effects of ionizing radiation; therefore, chiropractors must always have a clear clinical indication of the need for diagnostic imaging of children (birth to 18 years).

Diagnostic imaging for children from birth to 10 years of age

The clinical examination and history is of the utmost importance in determining the clinical indication for the use of diagnostic imaging in this age group. Chiropractors must consider the overall justification for radiography in this demographic is low due to the high radiosensitivity and juvenile appearance of ossification of the spine.

Indications that radiography in children in this age group is appropriate include**:**

- The presence of developing or idiopathic scoliosis
- Developmental or congenital defects producing aberrant spinal curvatures
- Marked locomotor disturbances of the spine and pelvis
- Suspicion of pathology
- Significant trauma including suspected fracture or abuse

Routine screening examinations or re-examinations are contraindicated without positive clinical indications.

Radiography in children 10 to 18 years of age

Indications for radiography in children in this age group include:

- Marked spinal pelvic locomotor defects
- Idiopathic or developmental scoliosis
- Marked inter-related spinal lesions or development defects
- Congenital abnormalities
- Suspicion of pathology including the epiphyseal or growth centre diseases
- Significant trauma including suspected fracture
- Multiple symptom complexes
- Altered spinal curvatures
- Suspicion of pathology

Routine screening examinations or re-examinations are contraindicated without positive clinical indications.

8.4 CCOA Radiation Health and Safety Program

Adopted 10/2022, Effective 04/2023

In compliance with the *Occupational Health and Safety Act* and the Occupational Health and Safety Code of Alberta, where ionizing radiation based diagnostic imaging equipment is owned by a chiropractor, the chiropractor must:

- Register the equipment with the CCOA
- Register all users of the equipment with the CCOA

- Operate (and ensure all users operate) the equipment in accordance with the CCOA Radiation Health and Safety Program

SP 9.0 Patient Based Clinical Research

Adopted 07/2007, Revised and Effective 05/2019

To ensure all patients are treated safely, ethically and with dignity while engaged in a research project with a chiropractor, a chiropractor must obtain an ethics review approval for all patient-based clinical research.

Any disclosure of research information must comply with the *Health Information Act*, Division 3, Disclosure for Research Purposes.

The ethics review approval must be obtained from an Alberta based Ethics Review Board associated with an accredited Alberta university, or another academic institution or the Health Research Ethics Board of Alberta and recognized by Council.

Chiropractors must provide their research proposal along with the written approval from the Ethics Review Board to the Registrar prior to initiating their research project.

SP 10.0 Continuing Competence Program Requirements

Adopted 10/22, Effective 04/23

1. The CCOA Continuing Competence (CC) program requires regulated members on the general register participate in the following:
    a. self-directed professional development, and
    b. assessment of a regulated member's competence through practice visits.

2. Regulated members on the general register must complete self-directed professional development as part of the CC program as follows:
    a. regulated members must comply with the CC program requirements established by Council and published in the Continuing Competence Program Manual in the completion of their self-directed professional development;
    b. regulated members must acquire the number of program credits established by Council in the Continuing Competence Program Manual; and
    c. regulated members must annually demonstrate by submission of verified attendance at, or participation in, College-approved or required activities as part of their self-directed professional development, to be eligible to file their practice permit renewal application.

3. A regulated member on the general register of the College must participate in the practice visit program for the assessment of a regulated member's competence, conducted by the Competence Committee, as established by Council, and published in the Continuing Competence Program Manual.
    a. If the results of a competence assessment are unsatisfactory, the Competence Committee may direct a regulated member to undertake actions as established by Council in the Continuing Competence Program Manual that may include one or more of the following:
        i. to complete specific continuing competence requirements within a specified time, or
        ii. to complete any examinations, testing, assessment, training, education or counselling considered by the Competence Committee to be advisable, or
        iii. to practise under the supervision of another regulated member on the general register, or
        iv. to prohibit the regulated member from supervising other regulated members or students providing professional services, or
        v. to correct any problems identified in their competence assessment, or
        vi. to submit to additional competency assessments.

4. Regulated members are accountable for participation in the Continuing Competence Program established by Council and published in Continuing Competence Program Manual. Regulated members may be referred to the Complaints Director when the regulated member
    a. has failed to complete the requirements of the self-directed professional development in section 2; or
    b. has failed to comply with an assessment of a regulated member's competence in section 3; or
    c. has intentionally provided false or misleading information; or
    d. has displayed a lack of competence that has not been remedied by participation in the continuing competence program; or

e. may be incapacitated; or
f. has displayed conduct that constitutes unprofessional conduct that cannot be readily remedied by means of the continuing competence program.

5. The Registrar and Competence Committee administer the Continuing Competence Program and may recommend rules or amendments to Council regarding changes to the Continuing Competence Program or Continuing Competence Program Manual.

SP 11.0 Concluding a Patient Relationship

Adopted 10/22, Effective 04/23

The chiropractor/patient relationship is a central part of health care in the practice of chiropractic in Alberta. This relationship is built on trust, respect, communication, and a common understanding of both the doctor and patients' expectations. Despite the establishment of a chiropractor/patient relationship there are times when it is reasonable and expected to conclude that established relationship. Just as a patient can conclude that relationship by stopping care, regulated members can conclude this relationship for any reason, except for those reasons listed in section 1, provided notice to the patient, pursuant to section 2 of this Standard, is completed.

1. A regulated member **must not** conclude a patient relationship based on a prohibited ground of discrimination as published in the *Alberta Human Rights Act* or the *Canadian Human Rights Act.*

Alberta Human Rights Act

No person shall (a) deny to any person or class of persons any goods, services, accommodation or facilities that are customarily available to the public, or (b) discriminate against any person or class of persons with respect to any goods, services, accommodation or facilities that are customarily available to the public, because of the race, religious beliefs, colour, gender, gender identity, gender expression, physical disability, mental disability, age, ancestry, place of origin, marital status, source of income, family status or sexual orientation of that person or class of persons or of any other person or class of persons.

Canadian Human Rights Act

For all purposes of this Act, the prohibited grounds of discrimination are race, national or ethnic origin, colour, religion, age, sex, sexual orientation, gender identity or expression, marital status, family status, genetic characteristics, disability, and conviction for an offence for which a pardon has been granted or in respect of which a record suspension has been ordered.

2. When concluding a relationship with a patient, a regulated member **must**:
    a. provide the patient 30 days' written notice of the intention to conclude care and provide a timeline that is commensurate with the continuing care needs of the patient; and
    b. when there are continuing care needs of the patient, those needs must be considered and provided for; and
    c. advise the patient in writing of the reasons for conclusion of the chiropractic-patient relationship unless disclosure of the reasons could be expected to:
        i. result in immediate and/or grave harm to the patient's mental and/or physical health or safety,
        ii. threaten the mental health and physical health or safety of another individual, or
        iii. pose a threat to public safety;
    d. make a record on the patient's clinical record of the reasons for conclusion of the patient relationship; and
    e. establish a process for the transfer of the patient's health information in response to future requests by the patient or an authorized representative; and
    f. provide an immediate and full refund to the patient of any funds received by the regulated member for services not yet rendered to the patient.

3. Despite section 2, the 30 days' notice may be abridged if the reason for concluding a patient relationship is due to circumstances beyond the regulated member's control including:
    a. personal circumstances (e.g., sudden illness, death, revocation of practice permit, suspension). In these cases, CCOA, patients and individuals or agencies must be notified as soon as is reasonably possible given the circumstances;
    b. the patient or an individual poses a safety risk, is abusive, or fails to respect the professional boundaries of office staff, other patients, or the regulated member. In these circumstances, the regulated member may immediately conclude the patient relationship.

4. If the regulated member cannot complete any, or all, of the steps outlined in section 2-3 when concluding a patient relationship, the regulated member **must** seek documented guidance from the Registrar, or their designate, of the CCOA, prior to concluding the relationship with any patient.

Breakdown of a Professional Relationship

In the event of a breakdown of a professional relationship between regulated members, the terms of Standard of Practice 5.3 Custodianship of Health Records apply to the management of patient records. A regulated member must not conclude a patient relationship for another regulated member unless the requirements of Section 3 of this Standard of Practice apply.

SP 12.0 Prohibition, Prevention, and Reporting of Female Genital Mutilation

Adopted 5/23, Effective 5/23

Female genital mutilation as defined in the Act s.1(1)(m.1), means "the excision, infibulations, or mutilation, in whole or in part of the labia majora, labia minora, clitoral hood or clitoris of a person, except where valid consent is given, and

(i) a surgical or other procedure is performed by a regulated member under this Act for the benefit of the physical health of the person or for the purpose of that person having normal reproductive functions or normal sexual appearance or function, or
(ii) the person is at least 18 years of age and there is no resulting bodily harm;

Female genital mutilation, also referred to as female genital cutting or female circumcision, is internationally recognized as a harmful practice and violation of women's and girls' rights to life, physical integrity, and health. The immediate and long-term health risks and complications of female genital mutilation can be serious and life-threatening.

Female genital mutilation is classified as aggravated assault under section 268(3) of the Criminal Code of Canada. Under the Criminal Code, any person who commits an aggravated assault is guilty of an indictable offence and is liable to imprisonment for a term not exceeding 14 years, including healthcare professionals and family members.

1. Section 1.11(1) of the Act establishes the following prohibition:
    a. A regulated member shall not procure or perform female genital mutilation.

2. Section 127.2 of the Act requires the following of regulated members:
    a. If the regulated member has reasonable grounds to believe that the conduct of another regulated member of any college constitutes the procurement or performance of female genital mutilation, the regulated member must report that conduct to the complaints director.