

Stakeholder Feedback on the Chiropractic/Podiatry Referral: The Current Model of Foot Care in Ontario

Part I: Surveys Submitted Online

Note:

The responses within have not been edited by the Health Professions Regulatory Advisory Council (HPRAC). HPRAC is not responsible for any errors and omissions found on the submissions. The stakeholder comments are posted according to access to information guidelines (for guidelines visit, <http://www.hprac.org/en/privacy.asp>)

Health Professions Regulatory Advisory Council (HPRAC)



Table of Contents

Introduction.....	1
Table 1: Responses from Individuals	3
Table 2: Responses from organizations.....	70
Canadian Podiatric Medical Association	70
Feet for Life Medical Foot Care Ltd. & Feet for Life School of Podiatric Nursing Inc.	71
First Choice Foot Care	71
Giselle's Foot Care.....	72
Independent Business Specialty Interest Group of the RPNAO	73
The Michener Institute of Applied Health Sciences.....	73
North East Local Health Integration Network	73
North Shore Family Health Team.....	74
Ontario Community Health Centre (unspecified).....	74
Ontario Medical Association, Sport & Exercise Medicine Section.....	75
Ontario Physiotherapy Association	75
Prosthetics Orthotics Barrie.....	78
Rexdale Community Health Centre.....	78

Introduction

On June 28, 2007, the Minister of Health and Long-Term Care directed the Health Professions Regulatory Advisory Council (HPRAC) to "review issues relating to the regulation of chiroprody and podiatry and provide advice as to whether and how there should be changes to existing legislation regarding these related professions". The Minister asked that the Council include "an analysis of the current model of foot care in Ontario, issues regarding restricted titles, and whether the existing limitations on the podiatrist class of members should continue."

To provide context for an upcoming analysis of the regulation of chiroprody and podiatry, and to address a broad component of the Minister's referral, an initial consultation session was held on the current model of foot care in Ontario¹. Consultation opened on April 4, 2014 and closed on July 4, 2014.

The objective of the consultation session was to gather information on how foot care is delivered in the province; and learn more about the issues facing foot care providers, patients and other involved Ontarians. Participants were asked the following question:

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

A link to an online survey was posted on HPRAC's website and stakeholders submitted comments through this route; or by completing the survey and manually sending it into the HPRAC office; or by providing their views in the form of a letter.

HPRAC's consultation process is expected to crystallize broad themes and unanticipated issues; it is not viewed as a quantitative source of stakeholder interests or concerns.

By the close of consultation, 198 stakeholders made submissions to HPRAC:

- 178 submissions were submitted online in the form of the survey. Part I of the stakeholder feedback focuses on these submissions.
- 21 submissions were mailed, faxed or emailed to the HPRAC office, in the form of the survey or in the form of a letter. Part II(a) & Part II(b) of the stakeholder feedback focuses on these submissions.

In total HPRAC received 199 submissions.²

¹ A second consultation session will be held later in 2014 to address the remaining aspects of the Minister's referral.

² One organization made two submissions.

The following organizations provided a submission to HPRAC on the current model of foot care in Ontario:

- ALYL Inc./Footloose
- Canadian Association for Prosthetics and Orthotics
- Canadian Federation of Podiatric Medicine – Submission A
- Canadian Federation of Podiatric Medicine – Submission B
- Canadian Life and Health Insurance Association Inc.
- Canadian Podiatric Medical Association
- College of Chiropodists of Ontario
- College of Nurses of Ontario
- College of Pedorthics of Canada
- Feet for Life Medical Foot Care Ltd. & Feet for Life School of Podiatric Nursing Inc.
- First Choice Foot Care
- Giselle's Foot Care
- Independent Business Specialty Interest Group of the RPNAO
- The Michener Institute of Applied Health Sciences
- North Bay Regional Health Centre
- North East Local Health Integration Network
- North Shore Family Health Team
- Ontario Association of Medical Laboratories
- Ontario Association of Prosthetists and Orthotists
- Ontario Chiropractic Association
- Ontario Community Health Centre (unspecified)
- Ontario Medical Association, Sport & Exercise Medicine Section
- Ontario Orthopaedic Association
- Ontario Physiotherapy Association
- Ontario Podiatric Medical Association
- Ontario Society of Chiropodists
- Prosthetics Orthotics Barrie
- Pedorthic Association of Canada
- Registered Nurses' Association of Ontario
- Rexdale Community Health Centre
- South West Local Health Integration Network

Table 1: Responses from Individuals

Question 1: Tell us your (or your organization's) view on the current model of foot care in Ontario. What do you (or your organization) see as the major issues facing patients, practitioners, and others?
Submitter 1
Major factor in Ontario is the confusion of the professional names. There should be one title, one profession Podiatry. The universal recognition of podiatry would allow uniform delivery of service identification.
Submitter 2
<p>Confusion with the names of podiatry and chiropody amongst my patient population.</p> <p>Chiropodists and podiatrists both practice podiatry.</p> <p>We both are trained in all aspects of foot and ankle health care. However currently, podiatrists are U.S. trained and are also trained in bony surgery. This model of foot care is not conducted in Canada as orthopaedic surgeons are the ones conducting bone surgeries.</p> <p>If we are relegated to the same scope of practice, then the name should be the same. I recognize the training for U.S. podiatrists extends to bony surgeries but that is essentially the difference between podiatrists and podiatric surgeons in all other Commonwealth countries.</p> <p>The name should be universally PODIATRIST and those who conduct surgeries should be PODIATRIC SURGEONS who are PODIATRISTS as well.</p>
Submitter 3
The public as well as other health professionals do not know the extent of our scope of practise and knowledge base in regards to foot health. Therefore we are not considered as an important health care team member and are not funded to provide foot health care to our patients even when they are considered high risk for amputation and/or infection such as those with diabetes, PAD, neuropathic, on dialysis, etc. We are overlooked in regards to referrals from other practitioners, government funding, bank loans to set up private practises and from patients themselves as they have not even heard of the profession yet most are familiar with the term podiatrist.
Submitter 4
<p>I am both a Chiropodist and Wound Specialist; and have been practicing for over 3 years both in private and public sector. I have my own practice and work with an ID specialist; our specialty is Diabetic Wound Management and Salvage Therapy. Some of the problems we have faced in the last few years are the following:</p> <ul style="list-style-type: none"> - as a wound specialist I find it hindering to my job as a Chiropodist when my specialty is Salvage therapy, yet my scope of practice by the College of Chiropodist only allows me to do sharp debridement subcutaneous. The unfortunate event is that Canada does not believe in Salvage Therapy, and 80% of amputations do not need to occur if treated properly. There are so few Podiatrist left in Ontario that can still 'touch' bone, and none of them want to do it because

there is no money in it and it is high risk. But if trained properly Chiropodist can be the ones to save limbs. The rate of Diabetes and related amputations are continuously going higher, and we need to do something to stop this! We are the feet people!

- The second problem I have faced in my clinic is that there are some individuals that really do need Chiropody services, but are not getting it because they do not have the funds. I believe if you are Diabetic and over 65, and do not have an income you should get to see a Chiropodist 6 times a year at \$40 per visit.

Submitter 5

As a chiroprapist, I feel that there are several issues that are preventing the advancement of the profession to a position where the public's health interest is best served.

Currently, the College of Chiropodists of Ontario regulates both Chiropodists and Podiatrists in the province. Ontario is the only region globally to still use the outdated Chiropody title. This is confusing to patients and even other physicians as I am commonly asked what the difference is. The original model of footcare in Ontario was based on the British model, where they have also recently gone through a name change from Chiropody to Podiatry. In the US, the name change was done back in 1957 where the National Association of Chiropodists was renamed to the American Podiatry Association. As such, our colleagues down south have advanced the practice of Podiatry significantly within the past 6 decades.

In Ontario, we have regulated members that have completed their training from the US and UK. The scope of practice in the US varies from state to state, but in general the 9 podiatric medical colleges place much more emphasis on invasive surgery training from bunionectomies to rearfoot reconstruction. A 4 year podiatric medical education is followed by residencies that are now a minimum of 3 years in a hospital based setting. Many podiatrists also have hospital rights, expanded lab requisition, bloodwork and X-ray rights. These are very important tools to utilize in practice to help diagnose skin lesions, infection, osseous deformities and fractures. Currently in Ontario we have received training in this (which in my opinion also needs to be more in depth) but are required to refer back to the family physician to have lab work ordered, causing greater delay in patient care and increased healthcare costs. US podiatrists often work in collaboration with orthopaedic surgeons, infectious disease and vascular specialists to help combat the rising costs of treating complications that arise from diabetes. US podiatrists are often employed in government funded public institutions or private practices, and daily scope of practice can vary from each individual, from routine general podiatry, biomechanics & orthotics to complex surgical cases.

The UK model is slightly different in that following a podiatric medical education, one can pursue further masters level studies in order to acquire more specialize training in surgery. However many also choose to practice basic general podiatry without pursuing further surgical rights. Here in Ontario the chiropody education and training has just recently become a post-undergrad entry program at The Michener Institute (as of 2009). A positive step forward, but we have much work to do to catch up to global standards.

One thing that separates the practice of chiropody/podiatry in Ontario is that we have been influenced by the US and UK models of footcare. Several provinces in Canada (Alberta, BC,

Quebec) have adopted the US model and partnered with podiatry schools in the US for residency training. I am entering my 5th year of practice now and have grown frustrated with the amount of in-fighting amongst my peers that have been detrimental to the growth of this profession. For one, there are two associations to represent Chiropractors and Podiatrists, the Ontario Society of Chiropractors (OSC) and the Ontario Podiatric Medical Association (OPMA). Each side has attacked one another more than partake in healthy mutual dialogue. This rift has existed arguably for decades with limited collaboration between the two. I believe the roots of this problem arise from the OSC being fearful that US trained podiatrists would threaten their practices, and hence an unfair cap was placed on them since 1993. Unlike many chiropractors, I am opposed to this limitation placed on our US colleagues and believe that many of them should be welcome into the province to help further the advancement of podiatry education and training of future practitioners. I experienced this myself during my years at The Michener Institute as I had the opportunity of being educated by 3 US trained podiatrists and gained significantly from their knowledge. Another root to the problem is the OPMA's perspective of superiority to Ontario trained colleagues. Part of their frustration is from the outdated education and training currently available in Ontario in comparison to the US. This may have also been fuelled by the limitation placed back in 1993, and several of their newsletters have attacked Ontario trained peers which does not help create unity, peace and collaboration between the two.

I believe that there needs to be ONE association that is united that will represent ONE Ontario Podiatrist title for the profession. This should coincide with a renaming of the college to the College of Podiatrists of Ontario. In order for this to happen all members registered under the chiropractor title will need to be grandfathered over in any training should they elect to pursue. Currently, after a study from the University of Waterloo over the history of pharmaceuticals training amongst members of the college, older members do not have prescribing or surgical rights whereas more recent members do. Education requirements also need to be revamped so that podiatry medical training is done at a University, preferably in conjunction with other medical specialties (much like dentistry or optometry in Ontario). Opportunity for further surgical skills enhancement also needs to be established (much like dental surgery training after general dentistry training). Having ONE title would help to eliminate confusion within the public and other physicians as to who the primary foot care specialist is. With the rising epidemic of diabetes, I believe it would be very beneficial from a provincial healthcare savings perspective if major hospitals had a small team of podiatrists on staff, where many of the moderate to severe infections from foot ulcers can be prevented, and resulting costs from inevitable amputations of untreated cases can be avoided. All members of the newly established college in Ontario should also have the benefit of OHIP billing so that an increased percentage of the public can at least receive yearly foot screenings to help ensure mobility, and help prevent burdening disability costs. Foot specialists help keep the public walking with good foot health. Being able to retain mobility is critical in having an individual find and retain work, and be a contributing member to the economy. Currently only a few of my older peers have 16% OHIP billing for their consultations. This also needs to be addressed for all members. Another issue that I have found to affect the profession is the abuse of the custom orthotics and orthopaedic footwear industry that can be a large part of a chiropractor's/podiatrist's practice. Many private clinics are unregulated, and owners of clinics or the directors of an incorporated practice are not required to be regulated professionals as they are in several states in the US. This opens the door to many clinic owners and operators not being held accountable for their clinical operations, and abusing

privatized insurance through over-billing, and advertising incentives (such as free footwear or gift certificates) to patients. This can be frustrating to all members of the college as occasionally I have patients that refuse to see me as a result of the practice refusing to give out any incentives or over-billing their insurance as they have with another clinic in the past. I believe one of the roots of this issue is the non-regulation of prescription orthotics. Privatized insurance somewhat regulates this through requiring certain regulated health professionals' prescription for reimbursement (such as physiotherapists, orthopaedic specialists, chiropodists/podiatrists). However, the system is still subject to abuse and I believe the only way to help prevent this is to regulate certain billing codes under OHIP for prescription custom orthotics, similar to the current ODSP coverage for custom orthotics that require assessment and prescription by a chiropodist/podiatrist. Private insurance companies would hopefully follow suit. I hope that these thoughts were informative to the Ministry of Health, and I hope that going forward we can all keep the public's interest in mind through the evolution of this great profession.

Submitter 6

I'm in private practice and am severely limited because I cannot order fungal cultures, blood tests, and x-rays.

Also, there are unregulated groups of people performing podiatry scope with no consequences.

Submitter 7

Need for diagnostic / lab test to be able to fully practise current scope of practise. No need for more foot surgeries. Need more Chiropodist in the community providing funded preventive foot care to the residence of Ontario. Patients cannot access Chiropodists. Practitioners cannot refer patients. Long wait list, closed clinics to new patients. Name confusion. need name standardization to avoid public confusion and to be consistent with other Provinces. Like: the college of Nurses, all nurses different classes.

Submitter 8

Current model of foot care in Ontario would provide the needed services to the people of Ontario if as a chiropodist would be able to practice our scope of practice.

Currently the chiropodist scope is lacking diagnostic tests.

The diagnostic tests include blood, wound culture, biopsy, fungal specimen as well as x-ray and diagnostic ultrasound.

The current model of foot care is designed to prevent complication and keep patients out of emergency rooms. This is difficult to accomplish if patients have to be sent back to their family doctor for a requisition for a diagnostic test. This delay in treatment can and does cause complications that can be prevented.

A second major issue is funding for chiropody care in CHC for people living with diabetes. As with eye care foot care -(chiropody) should be funded for people living with diabetes. Current model of foot care with chiropody services prevents complications and limits the number of emergency visits.

The third issue is name standardization. As in every other province the name should be standardized to podiatry. (Eg. with the College of Nurses - there may be classes as to the type of provider class of member).

Please note that as chiropodist in Ontario one is able to move to PEI, Nova Scotia or New Brunswick and call oneself a podiatrist. A chiropodist practicing in Ontario can also register with the PEI podiatry association as a podiatrist.

The title for a foot care provider (specialist) in any other jurisdiction is PODIATRIST.

Submitter 9

Would like to see one title for the sake of the public now that education/training equal

I have practiced over 25 years with this double standard in title only

Submitter 10

I have received foot care from a podiatrist for many years. I received excellent care and I am fortunate that my employer's health plan covers all the expenses. The current model works (private clinic) works well for me.

Submitter 11

Present model is not accessible to all who need foot care. Usually a fee is associated with the care, as it presently has a private practice based focused.

Foot care is not provided in an integrated team approach. Chiropodists are not routinely a member of a hospital based multi-disciplined team. it should be in (wounds, emergency care, orthopedics and rehabilitation)

Long wait times for hospital based soft-tissue and bony types of foot surgeries.

Some surgeries are presently in our scope of practice and we are limited as to what can be performed due to our restricted access to hospital facilities.

The educational program is not associated with a University or teaching hospital and as such, we do not generate new research or care protocols for foot complaints.

Lastly, the professional members elsewhere in the world have changed their name from Chiropodist to Podiatrist. In Ontario, we still use the antiquated title of Chiropodist for our members.

I want the new foot model to provide evidence based, comprehensive short term (conservative), mid term and long term (surgical) care/management of all foot conditions for all ages of patients.

Submitter 12

Current model of foot care in Ontario has 2 classes of podiatrist and chiropodist

Podiatrist are able to partially bill OHIP. Large majority of podiatry practises are in the GTA. A male dominate profession.

Podiatrists were grandfathered into the Chiropody act.

Podiatrist scope of practise includes forefoot bone surgery, however the College of Chiropodist does not have competencies nor does it have standards for osseous surgery for this class of

members. Public protection is at risk and compromised.

All podiatrists were grandfathered to prescribe oral antibiotics and NSAIDS. Concern remains regarding their competency.

Submitter 13

I am a chiropodist, working in an under-serviced area of Ontario, although I am only an hour north of Toronto. At present I am working at my highest level that the present 'Chiropody Act' allows. I have traveled to England to undertake further training and education, because at present nothing more is available to me in Canada. The present legislation as it stands has glaring omissions. I can surgically remove tissue from your body, stitch you up and provide you with antibiotics and pain medication, but I cannot send the tissue to histology, do a swab to verify the proper antibiotic coverage and most striking of all not tell you why I did these things because I cannot communicate a diagnosis. If the chiropody/podiatry review goes forward as presented, these omissions in the old act will be fixed. But more importantly for practitioners like myself, we will be able to provide better care to our patients, without placing any stress on the OHIP system, in fact lessen it. I will no longer need to send patients back to their family physicians, if they have one, to have radiographs, or perform blood-work. More importantly my local emergency will not be burdened with these patients as many in my community are so called 'orphaned' patients who moved north from Toronto, but failed to find a family physician. For myself it will allow me to grow as a practitioner and more importantly do training here in Canada and not have to travel outside of my own country to improve my training. And of greatest importance to the 600 Ontario trained Chiropodists, change the name from one that has been lost to time and is no longer used anywhere else in the world, to the accepted title of Podiatrist, solving the problem of confusion for patients and government/businesses who work with these highly trained practitioners. Please support these changes.

Submitter 14

It is important to standardize the name to podiatrist as this is a major issue facing patients and the current model of foot care in Ontario

If one views the Prince Edward Island Podiatry Association website many College of Chiropodists council members are listed as podiatrist and hold a doctor title outside the province of Ontario.

Current president of the College of Chiropodists - vice president - as well as other council chiropodist .

In Ontario - these individuals are registered as chiropodist and in PEI they are listed as podiatrist with a DR. title

Practicing foot care should reflect in the name of the profession and should be consistent across Canada.

As with College of Nurses of Ontario - all members are nurses but their class varies.

Submitter 15

I am a practicing podiatrist in New Jersey, USA. I am originally from Toronto, Ontario. I would love to come and practice podiatry back there with a similar scope to what we have here in the US. From what I hear from people back home in Toronto, it takes weeks, even months to see an orthopaedist for a problem such as a bunion, flat foot, or even something simple as a hammertoe.

These can all be treated surgically if conservative treatments fail fairly quickly. To have the population suffering from foot pain for months is almost barbaric. We need to lift the cap, expand the scope to include the ankle for ankle fractures and other such trauma. This will relieve the burden from the orthopaedists a great deal. I am willing to help in any way I can in this process. Nothing would make me happier than delivering the full scope of foot/ankle care to the city/province that raised me.

Submitter 16

1. The current model is too complicated for the general public to understand in many ways. The dual terms chiropody and podiatry are not well understood and the distinction is not clear - also the term chiropody is often confused with chiropractic. Another confusing aspect is that current scope of practice means that a patient may need 3 specialists to treat their foot problem - soft tissue (chiropodist), bone surgery forefoot (podiatrist), bone surgery rearfoot (orthopaedic surgeon) - perhaps one name (podiatry) which practitioners practicing to their level of expertise is a good start

Submitter 17

I believe that the major issue is the confusion with the name. All foot care specialists should be under one title, Podiatrists, and governed by their own education in regards to scope of practice. The world has adopted one title, Podiatrist, as the term chiropodist is antiquated. The two titles is very confusing with patients, other health care providers and insurance companies. In Ontario, Podiatrist, seems to refer to American trained foot care specialists only but the term is not one that is denoted by the type or scope of education by the individual. For example, in the UK the term podiatry has been adopted for many years (over 10 years) and the scope of practice/education program varies from that in the US. Our footcare needs should be determined by the unique needs of Ontarians and the Ontario Health care system..not by the US system. We need to develop our own model of care that meets the needs of the Ontario people, not adopt the model that is currently being proposed (ie. the Alberta model) which is the American model exactly. We do not have infrastructure to adopt this model (residency programs for example) and do all footcare specialists need to be trained to the level of bone forefoot surgery.

Submitter 18

Current model of foot care in Ontario requires name standardization one College one name for profession.

Current model does not allow chiropodists to sit on HARP committee, although the legislation states a chiropodist with a '4 year program of chiropody. Very confusing to public as well as government officials.

The same holds true for OHIP, as the fees are for 'chiropody services' that a podiatrist may bill for.

It is difficult for the chiropodist member of the college to advocate for any changes as they are not permitted to sit on any committees.

Submitter 19

Currently there is a battle between Chiropodists and Podiatrists. Unfortunately this is only hurting the patients. If you ask the College how many complaints are filed from one party to the other over advertising, I am sure you would be astonished. Rather than time and effort spent on patient care it is spent on turf wars. I believe the true injustice right now is the podiatry cap. It

does not make sense to me why a government would limit available resources to their communities. US trained podiatrists have the capability of providing conservative and surgical care for foot and ankle ailments unable to be treated by a chiropodist. Orthopedic surgeons have a wait list which limits their abilities to provide these services. Currently there is only one 'wound care specialist' in London. How can this be? US trained podiatrists treat wounds and can also provide this needed service.

Submitter 20

Chiropodists charge for service which is not affordable for all clients who have diabetes. Diabetes Education Nurses are taking a variety of foot care courses and then start to do foot care on clients with diabetes.

There is no Standard for foot care courses. It seem that some foot care courses are someone's private business. As there is no provincial STANDARD for foot care courses, the attendance certificate does not state what an RN can or cannot do when it comes to foot care on a client, after the course. Nurses I notice are 'winging' it and are practicing without policies or procedures in organizations to guide their practice.

There is no one auditing of foot care centers so it is unknown if a STANDARD for infection control is maintained.

In one diabetes foot care centre, I observed that equipment was not changed between clients and I considered this to be cross contamination of one client to another, especially as one diabetic client had a wound on which the used equipment was used.

There needs to be college of nursing and RNAO directives for foot care by nurses, what instruments they can or cannot use, how to use the instrument and the infection control procedures for each instrument used by nurses. As nurses are not taught how to sterilize equipment in their nursing programs, this also needs to be part of the training procedures.

I have also observed that chiropodists are practicing without policies or procedures, in their place of practice and that the clean - sterile fields are right next to dirty instrument handling centres. I have observed that dirty instruments are handled by hand when they are removed from a chemical wash, before they are handled to be put into the sterilizer.

This is all b/c there are no clear provincial directives for FOOT CARE CLINICS. I am aware of the Infection Control Guidelines in the Canada Communicable Disease Report of 1997 and have been sharing this document with Chiropodists and Foot care RN.

I have also observed that an RN who performs foot care is not compensated for this work. She is paid her regular salary by the organization budget where she works. There should be extra compensation for an RN to take on this extra liability. A Chiropodist can charge \$40.00 - \$60.00 per client, and is not paid by the complexity of the client. So, basic toe nail clipping is the same price as is more complex wart or corns removal.

I think it would be more cost effective for an RN to receive standard training and certification in the province, with clear guidelines of what procedures she/he can or cannot perform and the

clean infection control measures used for each instrument used. The foot care RN should receive compensation by the province for doing this work.

The Chiropodist should be picking up the workload of where and RN practice stops. The Chiropodist should be performing more complex foot care. NOW, I notice that Chiropodists have filled schedule obligations in community health centers, (where clients do not have to pay for services) doing routine toe nail clipping on repeat clients every 10 - 12 weeks for the life of the client, while other people with more complex diabetic foot care problems cannot access their services. The province of Ontario should be providing more clear guidelines for who should be seen by a foot care RN and who should be seen by a chiropodist.

Some other provinces have foot care standards and Ontario should too.

Submitter 21

The main issue with our profession is the existence of the dichotomous titles, chiropody and podiatry. Chiropody was the first term used to describe our profession. The problem lies in that this term is outdated and largely unknown to the public. Even in the United Kingdom, where the term chiropody originated, the profession has changed to use the more widely familiar and accepted term podiatry. The existence of these two titles decreases the general public's accessibility to services because the majority are unaware that foot care services can be provided by practitioners with either professional title. By and large, the chiropody title is commonly overlooked when foot care services are searched. We hope that this HPRAC review will help to remedy this situation by unifying us under one scope and one title, podiatry.

Submitter 22

Currently there is no organized system with respect to foot care. There are many qualified professionals (both regulated and unregulated) who provide care however, there are many people who provide care without specific education regarding foot care or foot biomechanics, who provide care that is outside of their professional scope of practice and who refer to themselves without oversight (conflict of interest).

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

Major issues facing patients: confusion about where to go, conflict of interest (practitioner referring to oneself and charging patient for cost), poor referral system (For example with diabetic foot ulcers patients see a physician, wound care nurse/chiropodist and Certified Orthotist. The pathway between professionals should be seamless.)

Practitioners: unclear roles. Encroachment by unqualified persons.

Submitter 23

College of Chiropodists should be audited by the Ontario Auditor General to ensure college is run properly. (Finances and governance) The college should be more accountable to the Chiropodists who are paying the highest membership fees in the Province of Ontario to run this organization that is mandatory to belong to. These fees are a financial burden to Chiropodists.

Submitter 24

College of Chiropodists has allowed and is currently working with an individual that has sued a chiropodist member for questioning the transparency and possible conflict of interest of this submission from the College.

HPRAC has to ensure Chiropodists are safe from law suits when questioning Colleges policies and submissions. Not only from the college but also profession associations, companies and individual that work for the college. This ensures that a fair process is in place and all view points are considered and addressed. This college supports the silencing of members that challenge them, very undemocratic.

Submitter 25

one title, one profession, one scope for foot care .

It does not matter where you get training or education, both chiropodist and podiatrist are doing the same thing, and should do the same thing. if a chiropodist lack some competence to do something (like order X ray etc), then set up mandatory program to upgrade their skills. The current titles (Chiropodist and Podiatrist) really confuse most of my clients) in my clinic, A lot of clients do not know what a chiropodist can do for them, which really stop them from seeking appropriate foot care.

Submitter 26

The current model of Foot Care in Ontario is seen on two levels. One level is the Podiatrist and Chiropodist who provide more complex cares including some surgical interventions depending on their education. The other level is the Foot Care Nurse RN or RPN (regulated) with specialized education which provides general foot cares, and non-invasive treatments and cares. The major issues noted by clients include finding podiatrists or qualified providers and paying for services. Major issues for Podiatrist ar the concern that the majority of the duties they provide can be completed by Specially trained nurses. The main concerns from the Nurses are that they are not recognised by insurance companies and their services are not covered for reimbursements to the clients even though their charges are many times half the charges of Podiatrists.

Submitter 27

Over 75% of the 50 practicing Ontario Podiatrists presently do not perform bone surgery. Over 40% of American Podiatrist do not perform bone surgery in their clinics at present. There is a crisis in the States where a large percentage of graduating Podiatrists cannot obtain Surgical Residencies. We have had only a handful of patients consult us in the last 13 years who required bone surgery of the foot. We are extremely busy with 4 Chiropodists and one Registered Nurse working at my foot clinic and the vast majority consult us for routine foot care (warts, corns, calluses, ingrown toenails, custom orthotics, fungal infections, fungal toenails, heel pain, achilles pain, forefoot pain, strains, sprains, etc.).

Whether we are known as a Podiatrist or Chiropodist makes no difference to our Foot Clinic as we have a waiting list of several weeks. The status quo works fine for us and we do not need the 'Podiatry Cap' removed. Ontario Chiropodists are doing a great job at managing Foot Care for Ontario citizens at the present time.

I watched a video presentation made for the HPRAC Council by the College which is a pipe dream as the vast majority of private foot clinics will never invest in these private operating rooms, nor would have the need to.

Submitter 28

The current model is working relatively well for diabetic patients , with diabetic nurses identifying patients for foot care . There is a large group of in need adults such as seniors who are not diabetic with serious issues that have little to no access to service. In my area there is one functioning wound clinic that is team orientated, one physician only, and CCAC which operates on paper well , but in reality , due to minimal oversight and limited field experience of some of the nurses is questionable . Note that I have had patients sent for minor footwear mods or orthotics needing immediate serious medical intervention.

On the other side of the coin I have had patients come to me with appliances that are not needed or totally incorrect for there problems prescribed and dispensed by the same individual . There needs to be a separation of these two functions and not just an arms length one.

Submitter 29

As a practicing chiropodist at [a hospital] one of the challenges is to offer direct referral to specialists. A roadblock to patient care is having the patient either go the emergency department to facilitate a consult with a specialist such as an infectious diseases specialist, a vascular surgeon, an orthopedic surgeon etc. or have the patient book an appointment with their general practitioner. This adds costs and time to the process.

Chiropody/podiatry care is essential in our aging population. Most often, a general practioner will advise their patient to receive foot care. One of the issues is that there can be confusion in the level of care provided by different health professionals for footcare. How does the individual or referring physician know the difference between chiropody, podiatry, pedorthists, foot care nurses etc.?

Custom foot orthoses are widely used and prescribed. The fabrication and dispensing of a prescription device should be regulated. It is very difficult for patients to navigate through the system and know if they're seeing a regulated professional of a pop-up clinic that only has their financial bottom line in mind.

Also of note, it would be valuable to be able to order culture and sensitivity tests prior to the prescription of antibiotics for a more precise prescription. Having the right to order X-Rays to confirm disease processes such as Charcot Arthropaty would also be quite valuable in order to proceed with the right treatment plan and communicate the diagnosis to other physicians.

To finish, the term chiropody is antiquated and not known by the general population. Even worse is the French translation of chiropodist to 'podologue' which when translated back to English is podologist which refers to a specialty within esthetic care. This causes more confusion and misuse and mis-representation of the French term 'podologue'. The term podiatry is widely understood and used around the world.

I hope the information collected from all the surveys will help in the facilitation of this process. Thank you for taking valuable time reading this letter.

Submitter 30

There are many issues facing patients regarding the current model of foot care in Ontario.

- 1) Many patients don't know where (or who) to go to for foot related issues. The average Ontario citizen does not know the term 'chiroprapist' or what foot care they can provide.
- 2) If a GP does recommend continued foot care - many do not know what a Chiropodist actually does and the benefits to the patient vs Nursing or Pedorthics.
- 3) Gaps in Chiropody scope impacts patients negatively. A need for radiograph requisitions, C+S requisitions, and some prescriptions require the patient to go back and forth between GP and Chiropodist causing delays to patient care.
- 4) Wound care guidelines (RNAO, CAWC, etc) all state the importance of Chiropodial care for offloading and debridement, yet there is still a disconnect between referrals for care and lack of funding. OHIP covers for Infectious Disease and antibiotics, CCAC dressings, Vascular Disease procedures and amputation but not removing the cause of most ulcerations - pressure and the offloading and debridement that Chiropodists provide.
- 5) Translated 'Chiropody' means 'esthetician' in French. As a large portion of Ontario citizens identify French as their primary language this can create a large misconception.
- 6) Custom Foot Orthoses are not regulated in any fashion. Therefore, patients can be misled into purchasing inappropriate devices that could cause further injuries.

Submitter 31

The government and agencies who are unfamiliar with our regulations, practice and the importance in foot care are creating pricing wars and creating 'drive by foot care'a dehumanizing experience for the aging population. Large industry are hiring non-nursing marketing/finanal.They will admit they are unconcerned with the clients and force foot care on reluctant individuals on their terms. The large industry financial individuals are pocketing the money and sometimes use bullying techniques on nurses. Agencies expect nurses to pay for the overhead expenses of pricey quality equipment plus work for slave labour.

Submitter 32

Inability of client to get to a foot care clinic, because of disability or unable to drive.

Cost of in home foot care is a deterrent

Lack of a way to let in home workers, PSW's know who provides foot care in the community.

Not all insurance companies pay for footcare..(those who have extended health insurance)

Social service,disability, welfare clients cannot afford the fees.

Foot care nurses don't always know who to refer clients to for services they cannot provide.

Malpractise insurance cost.

Cost of disinfection/sterilization methods for instruments and equipment elevate the cost to the client.

Gas prices elevate cost to client.

Submitter 33

As the majority of the baby boom population ages and the diabetes and other diseases progress, most of the Elderly are unable to bend and take care of their feet, many people are in pain and unable to work. All of this could be prevented if proper education and treatment were available. The foot care nurses who had special training/education (me) are very much in demand, working together with the podiatrist and refer the client to the podiatrist if beyond their scope of practice. The public is in great need of these foot care nurses and the services they provide. The government should encourage the foot care nurses there should also be some grants available for them to upgrade their equipment, because the tools needed are very costly. There is so much to talk about and so much need.

Truly, if you would like to hear more, please feel free to contact me.

Submitter 34

I think it sucks. Sorry I do. The current model is more likely to chop off a lower limb than to be proactive and preventative.

The costs, if nursing foot care average clinic costs is average \$35.00 per treatment. Six treatments per year would be \$210.00. Over even thirty years \$6,300.00. Not nearly the cost of chopping off a lower limb. Think of the cost savings.

Nursing Foot Care is both preventative and cost saving. However, if you take the average senior who lives on a fixed income \$35.00 is hard to fathom. If the government covered the costs a lot of lower limbs could be saved. How? By simply finding the problem before it gets too big. By following the plan of care set forth by both the nurse and the client, and the Doctor.

Each nurse should be providing a full assessment at the first visit. Develop a plan of care with the client. Client makes contact with their MD to acknowledge they are seeking out professional care for their feet. The nurse then follows the client for sometimes years before they would have any trouble. If they do develop a problem the nurse will handle it if they can or refer to other regulated health care professionals before the lower limb requires removal.

Issues facing clients, costs, access to foot care providers their knowledge that nurses are out there to look after their feet

Submitter 35

My view on the current model of foot care in Ontario is that there is a wide scope of practitioners who provide this service. I feel the major issues facing patients and practitioners presently are finding qualified professionals to provide the proper form of treatment and services that are required by the patient.

I am a Certified Orthotist who has been educated in a post graduate program through George Brown College, as well as completed an extensive 2 year residency program and passed my Board Certification Exams (CBCPO). Through our schooling, we are educated on the body and its biomechanics, as well as its physiology. We learn various pathologies and conditions that need to be treated orthotically. Orthotic bracing and design is taught for various conditions and

presentations, all of which are custom to each individual.

As a Certified Orthotist, I require a doctor's prescription in order to treat a patient and provide my services of custom bracing and or orthotics. Orthotists are not able to self prescribe or prescribe medical intervention. I feel that this is key in providing unbiased treatment to a patient population. I am not able to decide whether or not a person requires my services, a doctor justifies me treating a patient. We are also held accountable by the Assistive Devices Program which is run through the Ontario Ministry of Health and Long Term Care. We are the only providers allowed to provide treatment and devices through this funding system for Orthotics (foot orthotics are not part of this funding model). With a medical prescription from a doctor, I am able to assess a patient and provide custom bracing to that patient. My assessment is one which provides a static and dynamic analysis. A custom casting technique is used to capture the negative. I provide modifications to the casts, or rectify the casts, prior to the custom fabrication of the orthoses or custom foot orthotics. Various designs of orthoses are available, and depending on the medical requirements, particular materials and or brace/orthoic designs are chosen and used. The custom orthosis is fit to the patient or the custom foot orthotic is interfaced with the patients footwear and a wearing schedule is indicated. Follow-up appointments are scheduled and there is a continuance of working with the patient until she or he receives relief, and or comfort and correction from the custom orthoses we have provided. Due to the fact that our laboratory is on site, we are able to provide adjustments for our patients on an as needed basis.

As an orthotist, I am writing in the hopes that you will recognize that a Certified Orthotist is also a qualified person to provide care in the current model of foot care in Ontario. We provide a substantial amount of care within the current model of foot care in Ontario (the foot care model is directly related to the entire body; the foot is the foundation for the joints above it), and we would not like to be overlooked. We would appreciate being recognized within this model.

Submitter 36

Government and public need to know the roles and the definition of a Footcare nurse. We are not beauticians! We can trim and file hand nails yet not a manicure. Our education is including our nursing... therefore we need more pay. Look at the costs of instruments and travel ... Find subsidy and we are honoured under nursing care for some insurance companies.

Submitter 37

Needs standardized certification for foot care nurses

Submitter 38

There is limited regulation of foot care nurses in Ontario. I used to teach foot care nursing to RNs & RPNs through or local college & covered an area from Fergus to Goderich & Owen Sound to Chatham. Some places had nursing aides doing foot care as part of routine care on even residents with complicated diabetes & peripheral vascular disease with limited knowledge s to the disease process or as to the complications that foot care could cause. Other Homes would let Podiatrists or Chiropodists do their foot care.

Insurance companies may or may not cover RNs doing foot care but refuse to cover RPNs. This is confusing to me as we all take the same courses and treat the same kinds of patients. Perhaps there was a difference between the two professional 25 years ago but RPN upgrading has eliminated that difference.

Submitter 39
<p>Foot care for Diabetics and Seniors should be OHIP covered. In the long run, money will be saved and hospital wait times will be lessened due to less complications and amputations. Chiropodists are thoroughly trained Foot Specialists that are not allowed to practise their full scope. Their pay does not reflect the skill level nor the responsibility of their role. Hopefully, The Government will make some big changes for the sake of all the Diabetics and the growing number of Seniors. The current Podiatry/ Chiropody model is very unfair!</p>
Submitter 40
<p>As a footcare nurse in Independent Practice I provide an alternative to individuals in the community that are unable to care for their own feet. This is proactive care particularly with those with compromised circulation, diabetes etc. Along with the care of feet I provide health teaching as well. It would save the Ministry of Health money if OHIP covered the cost of this care to be done by qualified nurses. Our charge is less than chiropody or podiatry. By identifying problems early there will be immediate care and less complication due to neglect of care. Thus reducing the cost of medical care including hospitalization.</p> <p>Also encouraging Insurance companies to recognize Footcare nurses as a viable service to their clients and cover the cost of this service.</p>
Submitter 41
<p>A great number of people are at risk for compromised health because of the lack of funded footcare in Ontario. People with health issues have eye care because of the risks involved. Proper preventative footcare would help alleviate a lot of costs to Ontario Health Care. For example it is very expensive to care for people when they have an amputation due to complications of diabetes. Proper preventative care is much less expensive.</p>
Submitter 42
<p>Many people require advanced foot care, at home, in long term care or while hospitalized. Registered Nurses with advanced foot care training can provide that care. That care should be covered under OHIP. The current model requires the client to pay for services so those that require foot care are often going without.</p>
Submitter 43
<p>In Ontario our aging population need better and more realistic access to foot care. There are many seniors that are struggling as they try to age in place (in their homes) who can't get out to have foot care done and need a visit in their home to have this service provided. Chiropodist and podiatrist will sometime make visits but the cost is often prohibitive. But most often they do not make home visits. Caring professional and affordable foot care is needed in the comfort and convenience of the client's home.</p> <p>Foot care nurses provide care to clients in many settings including homes. Providing good basic foot care allows seniors to be mobile and active. Well maintained nails and skin care prevents complications like ulcers, and ingrown toe nails. Nurses are often the first to alert other health care professionals that a at home senior has a issue and make sure they get a referral to the appropriate person (Dr. Chiropodist, Podiatrist etc.)</p> <p>Health teaching is also one of the things nurses take the time to do. Often inappropriate shoes and even socks can be a problem. Proper shoes help to reduce the chance of falls, and help prevent corns and callus. Proper socks do not constrict legs that have edema, and leave pressure</p>

on toes from thick seams. When compression stockings are order by the Dr. it's often the nurse teaching how to put them on and how to get them off to help the client comply in using important aid.

Experience foot care nurses provide this care and our professionals needs to work together so these needs can be met and the nurses out doing the home visits are recognized.

Submitter 44

Cost of footcare as many of our patients are seniors on limited incomes. Nurses do a lot of the front line (day to day) footcare but funding seems to go to chiropodists who we refer our patients to. Most of us are self-employed which is also a problem sometimes.

Submitter 45

Providers of foot care to the elderly beside DCh and DPM giving medical foot care:
Right now foot care nurses will clip nails, do padding and strapping for deformities and do wound care

Aestheticians with ADVANCED education in foot care give full service foot care at the level of the epidermis - many clients are happier with this complete service compared to the mini-service/nail clipping of foot care nurses. these practitioners are taught when to refer to for medical assistance

NASP - North American School of Podology gives this advanced education which, unfortunately, is not yet recognized by the government

Submitter 46

cost to clients
no subsidy
increased health care costs
amputations
increased wound care

Submitter 47

Major issue for patients: There are no chiropody/podiatry services in the northern/smaller regions of our province. Currently in our community, patients need to drive 2 1/2 hours to the nearest city to receive this service. Many senior citizens can not afford these services

Submitter 48

for patients how do they know who is qualified to do foot care advanced foot care is a must with so many diabetics, so many people don't understand why they should have foot care

For practitioners why isn't foot care covered/ paid for the elderly, either by private insurance or government coverage

getting up to date information on changes to foot care requirements a lot is out dated

healthy feet

foot care needs to be seen as part of staying healthy and active

Submitter 49

I would like to see more collaboration among all foot care providers and better understanding of

all our roles. As a self employed RN who provides foot care I really value my other colleagues in foot care.

Submitter 50

As a Foot Care Nurse I see that many of the Insurers will cover the cost of their clients care if it is done by a Chiropodist ,in a clinic setting, but not by a Foot care Nurse. Many of these individuals need care in their homes or need care in the Nursing home and these are the places the Foot Care nurse will go.

Submitter 51

This my opinion.

I retired from Prosthetics two years ago, but my observations are current.

Seeing clients too late in the cycle means gps don't have enough knowledge.

Clients getting all types of devices from custom shoes to short walking casts to full air casts for the same pathology. Many are not effective.

An algorithm with some guidelines may help some well meaning professionals with this.

A nutritionist needs to be involved with every client.

Prescribing MDs should be at arms length from for profit dispensing clinics.

Submitter 52

Profession as an Orthotist working with bracing and foot orthotics and prescription footwear. Our profession does not self prescribe any of the devices we make, fit, or modify. This is the same for therapeutic, orthopedic and custom footwear. Patients who come to us must have a referral or prescription from a medical doctor. This is our referral source. This is also patient's safety check: we stand to lose referrals if work not done right.

Self prescription by the Chiropody and Podiatry groups provide no check system to ensure that proper device made or prescribed. If patient not happy with device there is nothing he/she can do. (other than complaint to the college, but that takes a very long time). In my practice we have seen custom made foot orthotics and shoes prescribed that do not work or have caused extensive problems.

Submitter 53

I am a certified orthotist. I think foot are needs to be made more readily available to those in need. I deal with many diabetics who don't seem to be getting appropriate foot are, often because they can not afford it.

In my practice I only deal with supplying orthotic devices, I would like to see ADP cover foot orthotics and orthopaedic and/or custom footwear in some situations, because unfortunately some people do without for financial reasons, and later end up as amputees, likely costing the healthcare system a lot more than they would have, had they been treated preventatively earlier on in their disease progression.

Submitter 54

Public confusion as to 2 different names for basically 1 profession. Only in Ontario is the

antiquated name of Chiropody still used, whereas in other jurisdictions the more appropriate term Podiatry is used. Not only is the general public confused on this matter but also many other health practitioners. Another issue is that it makes no logical or financial sense to provide primary care and yet be unable to provide or order necessary tests, biopsies, x-rays etc., that would benefit the patient. Currently they would have to be referred back to their general practitioner for these tests, thereby increasing OHIP costs. Chiropodists can play such a huge part in preventing escalating medical costs by means of simply providing quality footcare, education and screening, especially to the ever increasing diabetic population.

Submitter 55

As a Certified Orthotist (under CBCPO) there are a few major issues in the current foot care model in Ontario that are facing practitioners and patients. The two most significant issues facing our field is conflict of interest pertaining to the ability to self-refer within certain designations and the inadequate treatment of the diabetic foot.

The first is simpler to describe and simpler to address. In the current model Chiropodists and Podiatrists have the credentials to write a prescription for and dispense foot orthotics. They then receive reimbursement usually from insurance companies. This is an overlooked conflict of interest with an obvious potential for fraudulent activity. This combined with a lack of oversight and governance makes this an area of great concern. It is not unheard of for a practitioner with one of these certifications to go into a large manufacturing plant and prescribe and dispense foot orthotics to a percentage of the employees that is disproportionately greater than the general population. With increased oversight and tighter regulations there would be less chance for this type of activity to occur. As Certified Orthotists and Podiatrists are required to have a prescription from a Medical Doctor the chance for this type of fraud to occur is much smaller. Equivalent requirements across each profession would not only be fair but ethical as well.

The second issue is the treatment of the diabetic foot within Ontario. Countless studies have shown the economic burden of the treatment of diabetic foot ulcers. A report put out by the Registered Nurses Association of Ontario in March of 2013 titled "Assessment and Management of Foot Ulcers for People with Diabetes" (http://rnao.ca/sites/rnao-ca/files/Assessment_and_Management_of_Foot_Ulcers_for_People_with_Diabetes_Second_Edition1.pdf) had the following to say regarding causes, prevention and treatment of diabetic foot ulcers:

Elevated plantar pressure is a significant risk factor for foot complications (Lavery, Armstrong, Wunderlich, Tredwell, & Boulton, 2003). The plantar surface of the forefoot is the most common location for foot ulcer development (CDA CPG Expert Committee, 2008; IWGDF, 2011)...

Physical examination of a person with diabetes should include an assessment for foot deformities (IWGDF, 2011; Royal Melbourne Hospital, 2002). Foot deformities include hammer toe, claw toe, hallux deformity, pes planus, pes cavus and Charcot arthropathy. These structural foot deformities alter the gait or mechanics of walking, and can result in abnormal forces on the foot, poor shock absorption, and shearing and stress to soft tissues (RNAO, 2007; Shaw & Boulton, 1997). Furthermore, the risk for elevated plantar pressure is directly associated with the number of foot deformities (Lavery et al., 2003)...

In a large prospective study, Abbott and colleagues (2002) found that 55% of ulcerations assessed were attributed to pressure from footwear. Foot ulceration has been associated with constant or repetitive pressure from tight shoes over bony prominences on the dorsum of the lesser toes, at the medial aspect of the first metatarsal head and the lateral aspect of the fifth metatarsal (Lavery et al., 1998)...

Offloading devices, such as foot orthoses, aid in reducing plantar pressure in the diabetic foot. Foot orthoses are custom-made shoe inserts that serve to correct or relieve misalignment and/or pressure areas of the foot. A systematic review by Spencer (2004) found that in-shoe custom orthoses were effective at relieving foot pressure and resolving calluses in people with diabetes.'

A recent report titled "Arizona Medicaid Study: Exclusion of Podiatric Physicians and Surgeons Adversely Impacted Diabetic Patient health, Program Finances" concluded that when funding was reduced to the Medicaid patients to access doctors of podiatric medicine the overall costs due to complications, namely hospital stays and amputation due to diabetic ulceration, increased dramatically. It was found that for each \$1 that was "saved" in budgetary cuts resulted in an actual increase in costs of \$44. This result in and of itself is staggering, not to mention the additional suffering and hardship on behalf of the patient.

In 2014 a study titled "Direct medical costs of complications of diabetes in the United States: estimates for event-year and annual state costs (USD 2012)" was released detailing costs of individual procedures that happened as a result of diabetes. The cost of each amputation was on average \$9048 and the cost of each diabetic foot ulcer was \$2147. The cost of foot orthotics currently generally ranges from \$450-\$550 and the cost of diabetic footwear costs approximately \$150-\$250. Once an amputation occurs the Ontario government through the Assistive Devices Program will contribute 75% of a maximum towards a prosthesis. These costs are also in the multiple thousands. Ironically, the Assistive Devices Program will cover 75% of the cost of a foot orthotic if a portion of the smallest toe has been amputated as it is now considered a prosthetic device but will not fund the orthotic that could have prevented it or other more intensive consequences. In a report titled "Reducing foot complications for people with Diabetes" again published by the Registered Nurses Association of Ontario in 2004 (Revised in 2011) a recommendation was made that "Organizations should advocate for strategies and funding to assist clients to obtain appropriate footwear and specialized diabetes education. For example, the inclusion of funding support through the Assistive Devices Program (ADP) for appropriate footwear and orthotics." This is not meant to be a complete literature review but is a selection of the evidence that greatly promotes preventative measures in lieu of more extensive reactive measures. This would not only save the Ontario government millions of dollars but would also reduce the suffering of many of these patients that cannot afford these treatments on their own. I would be happy to discuss further these issues with anyone or to help in any other way that I can.

Submitter 56

Some patients unable to afford foot care service due to lack of funds.
Clients with any diabetes, pad, pvd, macular, obesity, lack of mobility and over 65, should receive foot care under Ontario Health Act
Foot care nurses should be able to bill OHIP directly
Foot care nurses need more recognition and should all follow best practice guidelines

Submitter 57

I am a family physician by training but practice diabetic foot and wound care, exclusively, now for the past 15 years. I believe that the ministry should be examining the true need for diabetic foot care as a way to mitigate the costs associated with diabetic foot disease. Diabetic foot disease is the most prevalent complication in diabetes but gets very little attention. In fact most physicians don't really believe it part of medicine! They think that the (diabetic) foot should be looked at by someone else, a chiropodist or podiatrist or nurse. They also believe, erroneously, that diabetic foot care is comprised of getting someone to cut toenails and pare down callus. The problem is that this approach not only minimizes the significance of diabetic foot disease but also places this extremely important aspect of diabetic care in the hands of clinicians who do not have the expertise to really deal with the complexities of the condition. In addition, it costs the patient money. Most patients are unwilling or unable to pay for such care and because the care is not embraced by physicians in the traditional OHIP model, the patient then believes that it is not an essential aspect of diabetic care, since they are being asked to seek out nonmedical people for this care and pay for it out of the pocket. In the minds of the patient, it appears that the physician does not believe that this is an important aspect of their diabetic care and that sentiment is then passed on to the patient. The patient's subsequent lack of focus on the health of their feet then translates into neglect, ulceration and amputation.

If the patient was seen by an allied health professional experienced in foot care such as a chiropodist or podiatrist, they would be hard pressed to find many that are qualified to provide wound care. It is essential that foot specialists of any kind, who are providing diabetic foot care, be well versed in not only identifying wounds in the diabetic foot but also treating them or having a mechanism in place by which these patients get immediate care. Instead, what often happens is that the patient is poorly treated for their wounds by inexperienced or misinformed chiropodist/podiatrists. On top of all of this, they then charge the patient for a service that is covered by OHIP. The wound care in this setting does not even come close to standard of care for diabetic wounds.

Providing ministry money for podiatry care may be helpful if there is some real oversight by someone who knows what is necessary to provide quality foot care to people with diabetes. This approach has been successfully demonstrated in other countries with extremely good results. In Ipswich, England, Dr Gerry Raymon, a diabetologist, instituted a diabetic foot program that stratified diabetic patients into low, medium and high risk. The family physicians in Ipswich were educated on how to screen their diabetic patients for diabetic foot risk. Once the stratification process was implemented the family physicians took on the care of the low risk patients with yearly screening and then referred the medium risk patients to the medium risk diabetic foot clinics for more advanced diabetic foot care. These clinics were staffed by diabetic foot nurses, chiropodists or podiatrists. At the medium risk clinics the staff would follow the patients on a regular basis, according to standardized guidelines and identify any patients who may become higher risk or who developed wounds. These patients would then be sent immediately on to the high risk diabetic foot clinics. The high risk patients were immediately sent to the high risk diabetic wound clinic staffed by a multidisciplinary team (comprised of chiropodists, podiatrists, endocrinologists, physiotherapist, orthotists, vascular surgeons and orthopedic surgeons and others) that were trained in wound care. Throughout all of the low, medium and high risk interactions, there was an interprofessional and interdisciplinary

collaboration that allowed for efficient movement of these patients through the system in order to get timely and effective care. This efficient movement in an interdisciplinary setting resulted in a 50% reduction in amputations over a 5 year period.

This is an undertaking that requires coordination but certainly is doable in the current family health team structure. It makes perfect sense to implement this at this time because the family health network structure is so well established. Education would need to be championed by individuals who have experience in the diabetic foot but once the program gets rolled out it can be replicated in different locales. Tracking can take place because the vast majority of medical centers within the family health team structure are computerized and therefore valuable data can be collected to accurately track the success or failure of the program as well as look at outcome measures such as ulceration and amputation rates in addition to successful wound healing. Ultimately, all of this translates to saving money for the ministry. Diabetic foot disease is an extremely costly venture for the ministry of health and no real concerted effort has been implemented to attack this enormous health care cost, in an efficient manner. A focused approach to the diabetic foot will guarantee a reduction in the health care costs associated with the treatment of diabetics by at least 20%. This has been shown in many studies in the United States as well as abroad. It is well known that the cost of the diabetic foot to the health care system accounts for about 20-40% of the total costs of treatment of diabetes. By tackling this issue in a constructive and an efficient way, the ministry will have tremendous cost savings as well as have a model system that can be the showcase for other provinces across Canada.

Submitter 58

access barriers, poor benefits coverage for services

Submitter 59

Making referrals for OHIP clinics, hard to find clinics that take new patients
Chiropodists should be able to provide comprehensive care to patients, I understand that they need co-signature for x-ray blood work etc this makes no sense to me.
Also they should have the ability to make referrals to other providers such as Physio, Derm, Ortho not being able to sets barriers for patients and the provider, the current system should be expanded as the population is aging. Why does a chiropodist need to refer back to a family doctor when they need a referral to another specialist? This slows down patient care, adds to costs since now they have to pay me again to make the referral.

Submitter 60

Facing patients: Chiropody services not very easily accessible, awareness to this service is not made known. Private practice is not very affordable.

As there is such an increase in Diabetes and complications, wound and ulcers have to be addressed. Educating the public and bringing awareness to address these issues, is key to the general well being.

Submitter 61

I am a member of the Podiatric Association of Canada and I believe that the current foot care model is lacking in the recognition of Podiatrists as a valued member of the 'Foot health team' of health practitioners. As a podiatrist I am trained not only in the casting and distribution of foot orthoses but also in the assessment manufacturing of such devices. This is unique to our profession and in my opinion is an asset to understanding the construction and the endless possibilities of features that can be incorporated into a foot orthoses to ensure that each device is

unique to the patient and their condition. Without this background knowledge on manufacturing we run the risk of seeing 'typical or standard' devices being made for severe cases (eg. Diabetes, Charcot arthropathy, Charcot-Marie-Tooth etc.). Pedorthists also have unique training in footwear fitting and modification which is an essential part of any treatment plan for patients who suffer foot pain.

In addition to running the risk of harm to our patients, without proper recognition of the Pedorthic Profession we also run the risk of fraudulent activity. As we are not a regulated health profession the title "Pedorthist" is not protected from those with inferior qualifications posing as pedorthists. This is damning to our own profession and poses a significant risk of harm to the public.

By including Canadian certified Pedorthist in the model of foot care in Ontario it will ensure that patients are able to receive cost effective (avoidance of costly surgeries) and well rounded treatment to allow them to return to their activities of daily living in an efficient manner.

Submitter 62

Accessing the necessary care in a cost effective and accessible manner. The skill set that each provider has may limit the success of the required treatment, either long term or short term. Inclusion of all foot care providers who are willing to abide by an accepted set of principles, standards of practice and code of ethics that is enforced, either by an existing regulatory college, one in the near future, or by a national college (like The College of Pedorthics of Canada), will allow patients in all areas of the province to have access to the unique skill set that affords cost effective, timely treatment to all patients.

Submitter 63

My greatest concern is in regard to the unregulated practice of dispensing orthotics. Without regulation on this act, there is great opportunity for insurance fraud and patients receiving improper care. There are many clinics and professionals throughout the province that practice dispensing orthotics primarily for financial gain and are not consistently providing a quality or functional product for their patients.

As a Canadian Certified Pedorthist (C.Ped(C)), I am bound by my code of ethics in regard to proper billing and providing products for medical reasons. This prevents me from offering 'deals' such as 2 for 1 products, free shoes etc.

A Canadian Certified Pedorthist is educated in the assessment of the biomechanics of the lower limb, the design and the fabrication of custom-made orthotics, footwear modifications etc. Many of us also fabricate the orthotics we dispense at our respective clinic. This ensures that the products are truly custom-made and that adjustments are easily accessible to our clientele.

Without provincial regulation for the act of dispensing orthotics, this practice regulated only by insurance coverage. There are many professionals that abuse client coverage for financial gain. Most insurance companies have recently changed the stipulations for custom-orthotic coverage requiring that they are dispensed by a Chiropodist, Podiatrist or a Pedorthist. I believe that provincial regulation similar to this would prevent other professionals from abusing their patients' benefits and personal rights. It would also prevent non-qualified personnel from dispensing products.

In my area there are foot clinics operating with personnel that claim to be a foot specialist without any formal education. There people are providing a service that they are not insured to do through liability insurance and patients' claims to their insurance are often denied. This leaves people with out of pocket expenses of around \$500.00. Having the act of dispensing orthotics would prevent these 'specialists' from misleading the general public on services they claim to be able to provide.

Although there is not a great risk of personal injury with the use of orthotics, there is currently a large amount of insurance fraud surrounding these devices. With time, I believe that insurance companies may cease to provide coverage. This would leave many people without access to products they need for medical reasons. If our province regulates the act of dispensing orthotics, similarly to how acupuncture has been regulated, it will decrease our insurance fraud in Ontario. I ask that you review current literature from the major insurance companies in Ontario and make a similar provincial regulation on this act to protect peoples' rights and benefits.

Manulife:

[http://groupbenefits.manulife.com/canada/gb_v2.nsf/LookupFiles/DownloadableFileOrthotics-MemberGuide/\\$File/Orthotics_memberguide.pdf](http://groupbenefits.manulife.com/canada/gb_v2.nsf/LookupFiles/DownloadableFileOrthotics-MemberGuide/$File/Orthotics_memberguide.pdf)

SunLife:

http://www.sunlife.ca/Canada/smallbusiness/Focus+news/Past+issues/2008/Understanding+orthotics+and+orthopaedic+shoes/Member?vgnLocale=en_CA

Submitter 64

I see regulation as a key feature to avoid the scammers and unethical people attending the plowing matches and fall fairs to sell people their wares and then leaving town with no forwarding address.

Submitter 65

I am presently employed as a Certified Pedorthist (C.Ped.C) at [a hospital] in Toronto. I work very closely with several Chiropractors, Podiatrists and Specialized Foot Care Nurses. Each member of this multidisciplinary team plays a specific and vital role in caring for patients with foot problems.

The primary issues and concerns that I see with the current foot care model in Ontario are as follows;

- 1) There are several practitioners (some regulated and some not) that provide overlapping services. This is not necessarily a negative, but it can lead to public confusion as to who provides what service. This can also lead to concerns regarding accountability.
- 2) Risk of harm/ Risk of Fraud - As a Canadian Certified Pedorthist I am registered with the College of Pedorthics of Canada and I am bound by a strict code of ethics and scope of practice. In Ontario that are a few different groups that present themselves as Pedorthist, or even Podiatrists who are not held accountable to a governing body. This places the public at risk.
- 3) Risk of Fraud - As mentioned above, there are many organizations that claim to provide foot care services. Without appropriate regulation and title protects the public and/or insurers can easily be misled.

Foot care is a complex and multifaceted area of health care. In order to provide our patients with the highest level and standards of care I feel that it is necessary to clearly identify the roles and responsibilities of each member of the foot care team (i.e Podiatrists, Chiropodists, Pedorthists and Foot Care Nurses).

Submitter 66

I am a Canadian certified pedorthist (C. Ped(C)) and member of the Pedorthic Association of Canada. I feel that our profession should be recognized as an integral part of the foot care model as we are experts in the assessment and conservative management of gait-related disorders, and accountable to a professional college with high standards of practice ensuring patient safety, ethical practices and successful outcomes. We bring value to the foot care model by providing cost-effective modalities of treatment that are held to higher standards recognized by insurance companies. Recognition of our profession will also reduce fraudulent practice by those posing as experts or using the term 'pedorthist' without being a member of the Pedorthic Association of Canada or adhering to the standards of the College of Pedorthists of Canada, thereby reducing the risk of malpractice and further improving patient outcomes.

Submitter 67

One of the most urgent issues for our Pedorthic patients is the lack of coverage (since 2013) for ODSP users. Compression hose, braces, custom foot orthoses, orthopaedic footwear with or without modifications are all no longer covered. I am already seeing an impact of poorer footwear choices in this high risk population.

Submitter 68

The present system is broken, When an Pt can issue out a pr of orthotics that has next to no training in the foot and is unsure on how to cast a foot correctly is placing the public at risk, The only item they are interested in is the item of money. When they advertise a free pr of safety boots (Ottawa) with ever pr of orthotics does not seem right. They (Pt) are also using a 2D scanner to scan the foot and then the company that they are using makes a 3D orthotic, makes one wonder how effective the actual orthotic works. There are lots of examples out there of this happening. Granted they are taking a foam box impression and saying that they use this, however the casting is so poor that it is physically impossible for the cast to be corrected and the company is using a generic version. This putting a lot of patients at risk while lining the pockets of certain companies. After reviewing a British study that shows that if a group of people are allowed to prescribe and and dispense and item(orthotic) there was a 30% increase in the amount of that orthotic being dispensed. I do not see why this practice is allowed to continue as this is not in the best interest of the patient. I have seen enough amputations due to improper footwear that there has to be regulation set in place. While I do not have the latest cost of each amputation I do know from personal experience that a proper full contact orthotic has saved many a foot each yr. This has saved the Ontario Government hundred of thousands of dollars over the years and the patient must pay for this service. Maybe a pro active service should be set up. Other countries have set up such a system. The only way for this to work properly is that the person that casts the foot must make the orthotic or there is a disconnect between the person that sees the foot and the orthotic being made. They can say whatever they like, I have seen the difference. While this may come across as a rant and not properly written out, I can explain and show you the difference in person more clearly and invite you at any time to come and visit me.

Submitter 69

Being a Certified Pedorthist - it is important for the profession to be regulated to protect the

public, to meet the the highest standards of care, and to also protect the profession.

Submitter 70

1. Pedorthists, within the “foot care” world, possess a unique skill set that other foot care professionals don't possess. (The biomechanical correction or accommodation of the foundation of human mobility.) 2. In using the C. Ped (C), COFS, or C. Ped MC title, we have each voluntarily agreed to be accountable to the highest standards of practice by The College of Pedorthics of Canada. 3. We bring a specific value to the foot care model including: i. Cost effective solutions often avoiding surgery or debilitating injuries ii. Full spectrum of care from assessment, to prescription of what is needed, to the fabrication or modification of shoes and/or orthoses, resulting in better patient outcomes. iii. Pedorthists have set standards that most insurance companies recognize and often adopt in their own insurance policies. 4. Risks of harm that exist for the public with pedorthists remaining unregulated: i. Risk of fraud – as we are not a regulated health profession, the title “Pedorthist” is not protected from those with inferior qualifications posing as pedorthists. This is damning to the profession and poses a significant risk of harm to the public. ii. Risk of harm – some type of legislation or registry is required to ensure greater public safety and protection from harm – especially for patients in high-risk populations such as those with Diabetes, Charcot Arthropathy, Charcot-Marie-Tooth Disease, age related balance issues, and other medical conditions benefiting from pedorthic treatment. iii. Risk of elimination of pedorthists - Discriminatory practices and perceptions based on the fact that we are not regulated in Ontario through legislation threatens the existence of our profession. However, our profession is an essential and valuable part of the foot care model for all the reasons listed above. 5. Our recommendations and requests to HPRAC: i. Recognition in their report of our profession and its importance to the foot care model in Ontario; ii. recommendation that government work with pedorthists to find a solution that would enable some form of regulation or controls to safeguard against fraud and public harm

Submitter 71

As a Canadian Certified Pedorthist [C.Ped (C)] practicing in Ontario, I believe we bring a unique set of skills when it comes to foot care. However, the public are still unaware of how C. Ped (C)s can help their issues. As C. Ped (C)s, we bring a very large value to the foot care model in Ontario and is being fairly easily overlooked with the regulations of Chiropractors and Podiatrists in Ontario. With C. Ped (C)s, we bring forth a very rewarding value not only for the public but also the province of Ontario. Here are a few examples: (1) Our treatments are extremely cost effective solutions to avoiding surgery or debilitating injuries (2) We're able to provide a full spectrum of care from assessment, to prescription of what treatment is needed, to behind the scenes of fabrication or modification of a shoe or orthoses, which will yield in better patient outcomes and feedback. (3) We're widely recognized by large insurance companies to our C. Ped (C) standards set by the College of Pedorthists of Ontario and have often adopted them in their own insurance policies. Unfortunately, as 'Pedorthists' are unregulated, there are many individuals with the title 'Pedorthists' that may be harmful for the public. 'Canadian Certified Pedorthists' and 'Pedorthist' may sound similar but the educational and placement requirements to achieve either designation is substantially different. C. Ped (C)s go through intensive full-time education, internship, and individual clinical and workshop experience, prior to sitting for a 3-hour written examination and 3-hour practical examination to achieving the designation of C. Ped (C). Hence: (1) There is a risk of fraud, as we are not a regulated health profession, the title 'Pedorthist; is not protected from those with inferior qualifications posing as 'Pedorthists'. This is damning to our profession and it poses a significant risk of harm to our public. (2) There is a risk

of harm, as some type of legislation or registry is required to ensure greater public safety and protection from harm - especially patients in high-risk populations such as those with Diabetes and Arthritis, who benefits from Pedorthic treatments. Ultimately, my goal as a C. Ped (C) here is to state my current views on our professional expertise, which may be a tremendous value or addition of the profession C. Ped (C) to the already established foot care model of Ontario to safeguard Ontario against fraud or public harm. But with that being said, our main interest as C. Ped (C)s is still the wellbeing of our patients.

Submitter 72

The current model of footcare does not include the positive health benefit effects offered by Canadian Certified Pedorthists, which specialize in lower limb bio-mechanics, manufacturing of custom made orthotics and modified footwear. The talents and skills of these professionals are integral to the well being of the problematic foot, yet un-recognized the designation is abused by individuals whome are less interested in the quality of care. C. Ped (C)'s are a a highly educated group who currently care for the diseased, injured or problematic foot, who educate local physicians and nurse practitioners yet require a written referral from these same professionals in order to follow through on treatment. Their standards of care are of the highest level and they take great pride in the quality of services offered to the public. Their education and understanding of the human foot and foot mechanics is undoubtedly of the highest standard, as they continue to research and attend learning seminars on an annual basis. I feel these individuals should be considered as a part of foot care model of Ontario as they continuously provide relief and education to the general public. The member number is constantly increasing and the group offers un-measurable benefits to foot health.

Submitter 73

Pedorthist are a cost effective and patient response element of the foot care model. I have worked with Pedorthists for 20 years and have found them to be responsive to patient needs in timely fashion, extremely professional and caring individuals, and demonstrate knowledge beyond any front line foot care professional. Access to Pedorthist in my area is fast and cost effective providing services and advice in line with standard retail pricing with a level of expertise not found else where. My concerns with the current model is the lack of continuity of care, the lack of skill in the provision and manufacturing of orthotics and foot wear, the out sourcing of orthotic manufacturing and poor quality control in third party provision of orthotics, and the increase in cost of the orthotics and decreased effectiveness when using mail order labs. Pedorthist are unique in the current model since most assess, design and manufacture appliances on site. This affords the practitioner to follow the results of treatment with intimate knowledge of the manufacturing of the treatment to the overall benefit of the patient.

Submitter 74

My view as a member whose ethical practice is governed by the College of Pedorthics (Canada) includes the following points: 1) Pedorthists who MUST have the CPed(C) qualification in order to be members of the above college should be regulated. This would eliminate those who continue to work in Ontario, bill insurances and call themselves 'pedorthists' but they are certified in the USA not Canada. This would protect the public in Ontario from those who practice via a back door loophole that permits an American certificate to compete with our Canadian standard which are significantly higher. 2) In addition to the above, regulation would further protect the public who suffer from debilitating disorders where incorrect orthotic/pedorthic management could cause harm. Such disorders include Charcot-Marie-Tooth , PVD, Diabets, Charcot Joints, and Arthritis in all its presentations. 3) Canadian Certified

Pedorthists are the only Canadian profession who are trained and examined on orthopaedic shoe fitting. Again the regulation of the fitting and customizing of these items would eliminate others who do so often without shoes on the premises. Ill fitting footwear and poorly made orthoses can render harm to the aforementioned groups of patients.

Submitter 75

I am in Alberta, but across North America foot care for ORTHOPEDIC PATHOLOGY should start at basic non-invasive attention to footwear choices and insole/Orthotic considerations. Also, basic physical therapy via manual techniques and exercise prescription is very effective. Footwear choices, insole/orthotic considerations and physical therapy are well supported in the literature.

Submitter 76

I am a patient, and I had continuous problem with my feet making me unable to go to school. I was fortunate enough to see a chiropodist in my community clinic and got the necessary care. This was not covered by OHIP nor does my father have insurance. I was fortunate again to get a chiropodist that was covered by the clinic. My father is now in need of footcare and is need by can't afford it needs to see a chiropodist. I hope that this can be covered by OHIP because the feet is a neglectful part the body yet without having proper care can affect your general health and responsibilities. I think it is important that this area of the body should be covered by OHIP since I have this experience that tells me how much we need healthy feet.

Submitter 77

Canadian Certified Pedorthists are specifically trained in the bio-mechanics of the feet and lower limbs. We are trained to assess, design, and fabricate custom foot orthoses as well as orthopedic footwear, compression hose and bracing. In using the C. Ped (C) title we have each voluntarily agreed to be accountable to the highest standards of practice by The College of Pedorthics of Canada. We bring a specific value add to the foot care model including: i. Cost effective solutions often avoiding surgery or debilitating injuries ii. Full spectrum of care from assessment, to prescription of what is needed, to the fabrication or modification of a shoe or orthoses results in better patient outcomes. iii. Pedorthists have set standards that most insurance companies recognize and often adopt in their own insurance policies. The risks of harm that exist for the public with pedorthists remaining unregulated: i. Risk of fraud – as we are not a regulated health profession the title “Pedorthist” is not protected from those with inferior qualifications posing as pedorthists. This is damning to our own profession and poses a significant risk of harm to the public. ii. Risk of harm – some type of legislation or registry is required to ensure greater public safety and protection from harm – especially for patients in high-risk populations such as those with Diabetes, Charcot Arthropathy, Charcot-Marie-Tooth Disease, age related balance issues, and other medical conditions who benefit from pedorthic treatment. iii. Risk of elimination of pedorthists - Discriminatory practices and perceptions based on the fact that we are not regulated in Ontario through legislation threatens the existence of our profession. However, our profession is an essential and valuable part of the foot care model for all the reasons listed above. Our recommendations and requests to HPRAC: i. Recognition in their report of our profession and its importance to the foot care model in Ontario; ii. recommendation that government work with pedorthists to find a solution that would enable some form of regulation or controls to safeguard against fraud and public harm

Submitter 78

As a pedorthist, I have had the opportunity to improve the quality of life for many of my patients. Many of these patients were at a loss in terms of seeking help for their lower limb related pain

and discomfort. It has been a pleasure to see the transformation that occurs when someone in pain free and the improvement in their quality of life. Pedorthic care is not only effective but it is also affordable. I have had patients who have no longer had to have surgery because the treatment they received from me was helping them a great deal. The Pedorthic profession is unique in that not only are we fully trained in the assessment of the lower limb, we are also skilled fabricators of our own orthotic devices for each individual patient, thereby maintaining full control of the process from start to finish and ensuring that each patient is provided with the right treatment. In addition, our assessments are very thorough. In fact, I have had a myriad of comments from patients who have been to other foot care professionals who have said they have never had anyone take so much time to assess and educate them on their condition.

We are governed by The College of Pedorthics who sets standards for us that we take very seriously and implement in our daily practice. These practices are recognized by insurance companies and are often used as the gold standard (ie. 3D casting etc)

It is imperative that the Pedorthic profession be regulated. Without regulation anyone can call themselves a Pedorthist! This is not acceptable as the public is put in jeopardy by receiving treatment from someone without the necessary qualifications. We deal with several high risk populations such as those with Diabetes. Without regulation we also risk elimination of pedorthists. The success we have in our clinics is proof that we are essential and valuable to the Foot Care Model in Canada.

Lastly, we need recognition in the report of our profession and its importance to the foot care model in Ontario; recommendation that government work with pedorthists to find a solution that would enable some form of regulation or controls to safeguard against fraud and public harm.

Submitter 79

The major issue is one of CONFLICT OF INTEREST. Both Podiatrists and Chiropodists can presently PRESCRIBE and VEND (sell) foot care products such as Custom Foot Orthotics and Orthopaedic Footwear. This is a blatant CONFLICT OF INTEREST and the patient is at risk and the mercy of the practioner. I see many cases where people has been prescribed and then sold foot care products by the same person, and in fact the products were not medically required at all. Also the fact that both of these professions can prescribe at all contravenes the Canada Health Act.

Submitter 80

As a practising pedorthist certified in Canada by the College of Pedorthics of Canada, I generally support provincial regulation of our profession, beginning with Ontario, working in concert with allied health professional in the best interest of our mutual clients / patients. However, I must bring to your attention the following and strongly urge the Ontario pedorthist to rework and reconsider their approach to regulation accordingly. In a document widely circulated and which gave rise to being invited to this survey, I received the following excerpt:

'Below is a brief synopsis of our perspective as we move into discussions with the HPRAC and the MOHLTC. We would ask that you remain as objective in your opinions as possible and really focus on the positive role of pedorthists and the integral role we play within the "foot care" world.

Key points to consider when completing the survey:

The unique skill set that pedorthists possess within the “foot care” world. In using the C. Ped (C) title we have each voluntarily agreed to be accountable to the highest standards of practice by The College of Pedorthics of Canada.

We bring a specific value add to the foot care model including:

- i. Cost effective solutions often avoiding surgery or debilitating injuries
 - ii. Full spectrum of care from assessment, to prescription of what is needed, to the fabrication or modification of a shoe or orthoses results in better patient outcomes.
 - iii. Pedorthists have set standards that most insurance companies recognize and often adopt in their own insurance policies
- ...etc...'

Point 'ii' above is absolutely untrue and reflects - at the least - a real misunderstanding of the nature and training required for prescribing, which includes a diagnosis. Only 8 medical professionals are allowed to diagnose world wide, that I am aware of, and pedorthists are NOT one of them. Nor should we be. We are very good at what we do and what we offer... specialized even... but we are not podiatrists nor are we physiotherapists, who can each prescribe in a limited fashion within the scope of their training and practice and sometimes refer to us. Instead, pedorthists most often rely on an actual medical doctor's referral of a patient to our services. If a physician provides a preliminary diagnosis and feels a person needs to see us so we can assess further on their behalf, then both we and the patient are covered.

Submitter 81

Extensive fraudulent behaviour. Too many businesses make claims for custom orthotics or compression socks which are never dispensed - instead they dispense a non-custom product and/or shoes or gift cards instead. I believe this harms the patient, insurance companies, and those of us who are acting ethically by not committing fraud.

Submitter 82

Out of control spending by the college below is information coming from the Ontario college of Chiropodists summer newsletter.

Possible Fee Increase:

The College Council will be discussing the possibility of a fee increase at their next meeting in June. The Executive Committee has had no choice but to recommend raising the membership fees to \$1,700.00 annually. The College has been operating in a deficit position for the past 2 years. Luckily, the reserves that had been built up over the previous years have been sufficient to cover these deficits. However, if the fee remains the same as it is currently at \$1,300.00, the reserves will be depleted by the end of 2014. This is not a position the College wishes to be in. If the fee increase is approved in principle, the draft amendment to the fees by-law will be circulated to you for your comment. The reason for the fee increase is directly related to the general increase in costs in running the College. Specifically, the Complaints & Discipline processes are extremely costly and are an important component of our core business. The greater the number of complaints and referrals to discipline, the higher the College's costs. The Regulated Health Professions Act mandates that the College must process every complaint that is received – we have no discretion to not process a complaint. It is up to the ICRC to determine

what happens with the complaint
Submitter 83
Concerned that current Ontario trained Chiropodists are leaving the Chiropody profession in great numbers, before retirement age. The number of Podiatrist leaving the profession in Ontario is nill only decrease in numbers is due to death.
Submitter 84
<p>Major issue facing the practioner in current model Below is a diredt quote from- Newsletter 2014 Spring College of Chiropodists " Drug Regulation Many members have asked the Registrar why the College is not amending the drug regulation and the list of drugs and substances that it contains. The most important reason is that the Regulated Health Professions Statute Law Amendment Act, 2009 amended the Regulated Health Professions Act, 1991 (RHPA) and relevant health professions Acts to allow for a new framework for amending lists of individual drugs/substances that regulated health professions may prescribe/administer in Ontario. This amendment to the RHPA provides for the creation of a drug authorities approval framework that:</p> <p>a. Avoids the requirement for frequent regulation amendments to change lists of individual drugs for professions with drug-related authorities (i.e., prescribing, administering, dispensing, selling, compounding and/or using) by allowing that only classes of drugs be specified in regulations; b. Mitigates risk from identifying only classes of drugs in regulation by establishing Drug Lists outside of regulation that would specify individual drugs within the classes of drugs; and c. Gives the Drug List the force of law through ‘incorporation by reference’ of the Drug List into the regulation (i.e., the Drug List is named in the regulation). A key component of this framework is the establishment of an Expert Committee (EC) that will create or approve the Drug List outside of the regulations. The EC would be established/named under section 43.2 of the RHPA. While the EC’s purpose will be to create or approve the Drug List outside of regulations, consideration is being given to also recommending that the EC provide expert advice to the ministry regarding drugs and substances which may be set out in regulations. In August, 2011, the Ministry of Health and Long Term Care was looking to set up a working group with health regulatory colleges to help inform the structure of the EC that will be established under section 43.2 of the RHPA. This meeting was not to actually set up the Expert Committee but rather to set up a working group which would include: •EC members’ qualifications; •The frequency of EC Drug List reviews; •College Drug List submission requirements; •The Drug List submission and review process; and •Any additional functions of the EC in support the new drug authorities approval framework. Two of the College’s Council members - Colin McQuistan and David Roth - attended an initial meeting hosted by the Ministry in 2011. This was an inaugural meeting of the working group. Nothing further has occurred since then as it is the Ministry’s responsibility to move forward with this initiative. In addition to convening this RHPA working group consisting of representatives of relevant regulatory colleges, the ministry was also supposed to conduct a jurisdictional scan and literature review of regulated health professional drug authority approval processes across Canada and internationally. An overview of the findings of the jurisdictional scan and literature review was to be shared with the working group once the results were compiled. This was to have occurred in early fall 2011. The College has heard absolutely nothing further. Until this new process is put into place, the government will not entertain amendments to any drug lists as there is no mechanism to approve amendments to any College’s list of drugs and substances. Therefore, the fact that amendments have not been made to the drug list is not due to the College. In fact, the College’s Standing Drug Committee has created an amended list of drugs and substances but until there is an approval mechanism in</p>

place at the government, we have nowhere to go with these proposed amendments. The College would be happy to proceed with an amended list and rather than have the drugs listed individually, to list them according to classes. The government has not approved classes of drugs and still only accepts individual drugs. Remember – if a drug or substance is NOT on the drug list, you cannot prescribe or inject it into the foot. This includes both topical drugs as well FORMULA 3 officially became available in Ontario as of December 2013. It will only be offered in professional offices, so our members can prescribe it and sell it. The components are on our drug list. CAUTION: If a drug does not have a DIN number you cannot sell, dispense, use or administer it in Canada. If you do so, you can be fined and it would also be deemed to be professional misconduct. An example of such a drug is FFNctf. CE CREDITS and CE Supply CE Supply Ltd provides distance learning for professionals. It came to the College's attention that CE Supply had sent out information to our members indicating that their courses had been accepted by the College as Category A courses. This was not in fact the case and the College clarified this fact with CE Supply Ltd. The College does not pre-approve programs for Category A credits. If you attend a conference and you are randomly selected to provide your CE log to the College, the QA committee will determine if a course on your log is appropriately within the Category A list of credits."

Submitter 85

continue of Summer newsletter from Ontario College of Chiropractors:
The HPRAC referral process is also very expensive and given the fact that HPRAC now foresees completing the review in 2015 as opposed to 2014, our costs in relation to the review will continue into the next budget year. If we are successful in the review, the costs will continue as we work with government to change the legislation to reflect any of the changes suggested by HPRAC.

The College watches its finances very closely. It does not take an increase lightly. However, given the size of the membership and the work that the College is currently dealing with, the recommendation of the Executive Committee to Council is totally unavoidable.

Submitter 86

Foot care for all ages and specifically for seniors with pre-existing health problems affecting circulation to their feet need affordable and easily accessible professional care . right now many consider a pedicure in a spa setting what they need or all that there is. Foot care Nurses provide an excellent treatment and assessment option and are trained to refer to a Chiropractor or medical Dr as needed. Keeping seniors mobile helps all aspects of their physical and emotional wellbeing

Submitter 87

Ontario Ministry of health directly funds The Michener to train Chiropractor in Ontario. A need exists for preventative foot care. Out in the community there is a high demand for foot care services. A lack of funding exists for Chiropractic service provided by a Chiropractor. Ontario residence are having to pay out of pocket for foot care. Chiropractic services are not funded in CCAC and Long term Care. We are not listed as providers in legislation.

Submitter 88

A Canadian Certified Pedorthist or C.Ped(C)

Submitter 89

As a Chiropractor I received mail advertisement to attend a Podiatry conference held by the Ontario Podiatry Medical Association. The mail was sent to my personal home address and not to my mailing address, provided to the College. A breach of personal information occurred at the

Ontario College of Chiropractors. A letter was sent to the College to address this breach. However the College did not inform the Ontario Privacy Commissioner of the breach; or the Chiropractors who had personal information breached; or disclose how this breach occurred and who was responsible. The only action taken by the College was to write a privacy policy and then have council approve it.

Submitter 90

Employed as a Certified Pedorthist

View of Current Foot Care Model

Welcome the opportunity for review of the current model as Pedorthists have a skillset which forms a crucial role in the quality of foot care.

Major Issues facing patients:

1. Patients should have solutions available which avoid and/or delay the need for surgery or further debilitating injuries
2. Opportunity for comprehensive care; from assessment, to prescription of what is needed, to the fabrication or modification of a shoe or orthoses results in better patient outcomes.

Major issues facing Insurance companies:

Sorting out who's qualified to prescribe and dispense devices. What sorts of devices and products to cover. What are the reasonable sets required to assess the need for said products. What are the acceptable methods by which they are constructed. What are the reasonable lengths of time before products and services should be renewed/re-evaluated. Do certain products preclude others (ie. if an orthotic and shoe is prescribed, should both be covered or does one negate the other).

Pedorthists have set standards that most insurance companies recognize and often adopt in their own insurance policies.

Issues Facing Pedorthists

Being unregulated, leaves us unprotected, discriminated against as a profession, threatened with the potential for elimination from the foot care model. Under qualified practitioners negatively affect perceptions of the public, allied practitioners etc. Unregulation creates barriers to insurance coverage and causes secondary strains on patients in need of services. Unqualified competition undermines our attempts to safe guard the public from predatory business practices, upholding codes of ethics and high level patient care, while leaving patients vulnerable to potentially negligent or low level interventions - all without the threat of recourse against a practitioner whom is not accountable to any regulatory association.

Submitter 91

The current model of foot care in Ontario is disconnected and because it isn't controlled better there are many people getting poor care and being taken advantage of. I see so many patients who were put at risk because they were dispensed poor orthotics, orthotics they didn't need, orthotics that were not custom but told that they were. I hear from patients the fraudulent things that their orthotics providers did for them in the past and fraudulent things that happened to them without their knowledge. It is ridiculous that professions like Podiatry and Chiropractic should be able to prescribe an item that they then can turn around and dispense and make money from. It is

a complete conflict of interest and puts the public at risk. I know many from these profession who see footwear and especially orthotics as a money maker; to the point that they no longer do their actual nail and skin care work any longer because it is 'messier' and isn't as lucrative. If a physician writes a prescription but could also sell the drug themselves would we not worry that this would cause a huge problem? There should also be a prescriber and dispenser in the case of foot care items.

Submitter 92

Standard of Practice- Infection Control Policy Approved by Council on March 1 2013.
Poorly written and worded document. Very confusing not clear. Appears to be written by people who have little knowledge of infection control practices and guidelines. Ontario Public Health should have oversight and ensure that the policy is in keeping with Ontario Infection Control standards. Chiropodists need clear guidelines that are easy to read and understand to incorporate into daily practice. The college does not listen to or act upon stakeholders comments. The college is failing to protect the public.

Submitter 93

As a pedorthotist in Ontario, I see how needed we are to offer the public outlets to the most appropriate foot care available. we are highly educated people that offer a unique and beneficial service.

Submitter 94

Public confusion regarding use of title 'chiropodist'.

Current model of foot care in Ontario is outdated in scope and by the continued use of the title 'chiropodist'. Needs to be in line with the rest of the international podiatry community.

Inability to requisition blood work and imaging (x-ray and ultrasound) restricts the practitioner from treating the patient in the most effective and timely manner. Having to refer to the family doctor or emergency department to have this done is unnecessary and increases the cost to the health care system.

With the aging population and the diabetic population rising these changes are necessary now and will present savings to the health care system as well as reduce the burden on the family doctors and emergency departments."

Submitter 95

The term Chiropodist is and has been very very confusing for patients for many years and absolutely needs to be standardized to the term Podiatrist to reflect the current scope of practice in relation to the rest of the world. Ontario is the only jurisdiction that uses the antiquated term Chiropodist. The two different terms have created a division in the professions that has resulted in a stagnation of the profession with infighting and lack of cooperation. The inability to provide X-rays and request lab tests for patients results in inefficient care and a waste of OHIP dollars as patients must be referred back to family doctors for these tests. I am strongly in favour of the new foot care model for Ontario as it will benefit both the patients and practitioners of Ontario.

Submitter 96

Very confusing for the public. The podiatry/chiropody titles should be united. Like any other profession there are those specializing in different areas some do surgery some don't. Podiatrist (combining chiropodists and podiatrists without bone surgery residencies) and podiatric surgeon titles under one united profession would be easier for the public to understand and know where

to go to for services.

The chiropody drug list makes no sense - other professions have categories not specific named drugs. When a new drug comes out there is a serious lag in when it is added to the list. for instance Jublia - it is not added to our list yet, so we now have to tell our patients to make an appointment with the family doctor for and RX - what a waste of resources and time for everyone. More preventive care for diabetes publically funded would save millions of dollars in preventable amputations and the rehab and loss of productiveness for the individual that goes along with it.

Submitter 97

Although many health care providers provide some level of footcare, in the patient interest a practitioner ie: Podiatrist should be the practitioner who is recognized and regulated as a foot specialist, now as it stands both antiquated title Chiropodists and Podiatrists are Foot Specialists, this provides a level of confusion to the public and for some (podiatrists) a mindset of Superiority, we need to be recognized as the rest of Canada, practitioners of Podiatry (not as it stands Both Chiropodists and podiatrists practice CHIROPODY. This I believe is the most important issue. All practitioners must continue to be accountable and governed, each should practice to there level of competency as defined by there registration and education. One Profession Podiatry and one Scope will clearify all these misunderstandings. I believe all Chiropodists are in agreement.

Submitter 98

The current model of footcare does not allow a continuity of care. Lack of diagnostic testing and drug prescription limitations causes poor patient care. Several practitioners must be involved when it would better serve to be treated in one place.

Submitter 99

The major issue facing patients is the use of the antiquated name for our profession. The general public are generally unaware of 'chiropody' and are more familiar with the internationally used name for our profession, 'podiatry'. Being unfamiliar with our professional title has resulted in limitations in access to professional foot care for the public of Ontario.

Furthermore, the confusion with the title has also lead to financial stress for our patients as some extended health care providers have refused payment of claims for chiropody services but allow for podiatry services!!

From a professional perspective, it is becoming increasingly more frustrating to deal with the dual terminology in Ontario, both with our patients and with the Insurance Industry.

As well, the inability to perform and requisition certain lab tests and diagnostic examinations has been frustrating for us, for our patients and for family doctors and the health system in general as it has lead to duplication of services, multiple appointments for patients and a general delay in their care at an ultimately higher cost.

Ontario has to move forward in support of an Ontario Podiatry model of care for our citizens and our professionals so that we can at least be on par, if not beyond, the rest of Canada and the International Foot Care Community. This is long overdue!

Submitter 100

confusion re names chiropodists and podiatrists scopes of practice , need to unify the name to podiatrists allow a base level of practise for all members with the ability to expand practise scope

Submitter 101

There is a barrier to chiropractors being able to provide optimal patient care as we are unable to communicate a diagnosis, take necessary x-rays of the foot and ankle to aid in diagnosis and treatment, or order culture and sensitivity tests.

There are too many other health professionals that are slowly trying to take over services that we provide, (I.e. Foot care nurses are providing foot care, orthotics are being made by all types of health care professionals, etc)

Submitter 102

The difficulty with naming the profession, great confusion among the general public regarding perceived differences between chiropody and podiatry. There is a need to have one class of practitioner recognised by government and the public at large to address the model of footcare in Ontario.

There is in my opinion a need to address high risk footcare under the OHIP system, at present I feel many high risk patients, brittle diabetics etc do not receive the full spectrum of available care.

Submitter 103

Current model is limiting the scope of practice of the most practitioner even though they have been educated and trained to use them such as x rays, ultrasounds, lab,etc. Being able to practice to the full scope would eliminate waiting and would decrease stress on emergence services. Currently patients have to wait from 6-8 hours for a simple x ray requisition and this could have been done as a part of initial visit.

Submitter 104

Inconsistency / confusion in title of foot care specialists. Inconsistency of scope and coverage.

Submitter 105

Currently I see that there is a limitation in the multiple names associated with 'Foot Specialist'. Many patients are confused about a Chiropractor vs. Podiatrist. I believe one unified name would reduce the confusion, if not get rid of it completely. I have also found that many patients are uninformed regarding the sale of orthotics. I believe there should be tighter government regulations regarding the sale and prescription of orthotics, currently anyone can dispense an orthotic without any training.

I also believe there are limitations to prescription and surgery rights to practicing Chiropractor.

Submitter 106

Chiropractors have a limited scope of practice eg biopsies can't be sent to a lab, and we are not allowed to x-Ray--wasting more time in treatment for patients, having to refer them back to GP--who is overloaded and frustrated that we can not handle all this.

The continued confusion over the Chiropody/Podiatry title (I graduated in 1991 and it was an issue then!). Canadians are more familiar (as are other health professionals) with Podiatry (to treat the feet) as opposed to Chiropody (to treat the hands and feet)-an antiquated term 30 years ago!

Our practices are busy, we are efficient and effective team players who are front line workers in battles against obesity, diabetes, aging and trying our very best to keep people active. It took 5 years to establish my practice in Ontario, and to this day people are unsure of our scope and

specialty.

I love this profession, but my career has been filled with in-fighting between Chiropody and Podiatry members that have kept the profession back in my view. We must educate and network alone in our respective communities to build the groundwork so that we may be utilized to the fullest potential by the patients who need us most. Poor public education initiatives, if any, by our organizations.

Patients still do not get services from us quickly due to- lack of awareness, -lack of referral/awareness,- cost of our services.

Most of my patients have full coverage of my fees through their extended health insurance . Still, they complain that they should have been referred sooner, but the physician said 'well you will have to pay'!! They would also have to pay at the dentist! There is poor education regarding our profession by other health professionals

Submitter 107

As a solos practitioner who has worked in the public sector but now work in private practice with 22 years of clinical practice in Ontario, the following is what I consider the most pressing issues in helping ontario patients seek and receive the foot care they require on a timely basis.

- 1) educating the public / health care professionals - The two tier / two name scenario is not working. Moving to a 1 name 1 profession will without doubt clear the public confusion regarding our profession
- 2) educating physicians about what we do and who we are as the primary care / family physician is the largest referral source
- 3) expanding our scope to include x-rays, a slightly broader array of medications and begin the process of allowing a greater scope of invasive forefoot surgery (hammer toe etc).

Submitter 108

I believe the current foot care model in Ontario will need to be to be amended in order to respond to the demand for foot care services in Ontario. Within the current model, a patient that may suffering from high risk complication such as osteomyelitis will need to be referred back to their family physician in order to receive a diagnostic confirmation, creating delay care and extra cost on the health care system and unfortunately in some cases, life threatening complications.

As primary care practitioners, the scope of practice must be unified and expanded to include the ability of all practitioners under the Chiropody Act to be able to 'communicate a diagnosis' to their patients, order and interpret diagnostic tests such as blood tests, culture and sensitivity of infections, diagnostic radiology and practice under one title, 'Podiatrist'.

Submitter 109

People need to be made aware what services Chiropodists offer. Transitioning to the title 'podiatry' makes our services more recognizable to the general public.

There are hundreds of Ontario trained chiropodists. As a recent graduate I have to say that in my opinion the education is very thorough. We are trained to administer conscious sedation and have been approved to practice this though no training program has been approved. We received lectures and clinical experience in soft tissue surgery along with lectures in bony surgery. We are

trained to recognize drug to drug interactions, to know contraindications, and to know the mechanism of drugs that we are not approved to prescribe. This allows us to better treat our patients.

The chiropody act of 1993 is far out dated. New graduates are prepared for more responsibility. There are limitations of our current prescribing list. Limiting the NSAIDS and antibiotics that we may prescribe means that our patients either have to be given a less than ideal drug, or wait for a referral back to their GP. This creates poorer outcomes for our patients and creates inefficiencies in the health care system.

One of the biggest problems that I have seen has been with diabetic foot care. The prevalence of diabetes is increasing and this will be a growing problem in the future. Part of my training involved treating high risk diabetics with wounds. The current system in place for these patients is woefully inadequate. General practitioners often don't even bother to look at their patients feet but when they see a problem they refer to CCAC nurses. These nurses are an important part of the patients recovery as they provide dressing changes either in the patients home or at a local clinic. These services are covered by OHIP.

What is lacking in the current model is offloading and debridement; things we are trained to do. Chiropodists identify the etiology of the wound and work to either correct biomechanics or temporally compensate so that there is less pressure on the wound and it can heal. Debridement also reduces pressure on the wound as well as clearing away necrotic tissue, reducing bacterial load and giving us a clear picture of the progress in the healing process. We have a lot of success with patients that seek regular treatment.

A big problem is that many of our patients cannot afford this much needed treatment. Neither OHIP nor ODSP cover costs for these high risk patients. Often our patients that need treatment the most do not have private insurance or pay out of pocket. At the rehab Centre [redacted] we either seek funding through a charity [redacted] or we provide free treatment for these patients, taking a loss on our materials and labour.

My point is that Ontario is not taking care of these patients in need of help. They end up in the emergency room often in need of urgent care to address infection or expensive surgery leading up to amputation. We can do more for these patients but too many clinics choose not to because it is simply not profitable to treat wounds.

Ontarians deserve better. They deserve OHIP coverage to ensure that they receive the treatment that they need. It is far less expensive to catch and treat a problem early than it is to wait until the patient is in the emergency room. Ontarians deserve to know who chiropodists are and what services we provide. Using the title podiatrist would go a long way to making our services more accessible. Ontarians deserve foot health practitioners that can prescribe the drug of choice for a given condition rather than the next best thing.

It is my hope that we can build a healthier Ontario together. Thank you for your time.

Submitter 110

The current model is flawed. Both chiropodists and podiatrists should be merged together and

form 1 college. This should be the College of Podiatrists of Ontario. Look at UK and other Commonwealth countries to see how they have modeled foot care. The Chiropodist currently practicing are working at the level of American Podiatrists however chiropody needs to have its scope expanded to meet the demands of the profession and to allow them to practice there full scope. The chiropody program also needs to evolve out of a diploma program and into university program. The College should also be merged as a branch of the college of Physicians and Surgeons.

Patient Issues:

Ease of access, cost of treatment,

Practitioners:

Require the ability to order lab test xrays etc. This will allow Chiropodists to practice to there full scope.

To end the confusion of chiropody /podiatry. These are the same profession. All other countries including the USA changed the name from Chiropody to Podiatry to end this confusion. Ontario trained Chiropodists should be allowed to practice in any province in Canada. It is discriminatory that an Ontario Chiropodists cannot treat patients in Vancouver. Chiropody/Podiatry are the leaders in foot care around the world the current model needs to be improved. There are alot of other professions that have an agenda to increase there scope to conduct foot care. Why? The Chiropody/Podiatry model was developed many years ago by the MOH to meet the foot care demands of the citizens of Ontario. Allow Chiropodists to evolve and practice to there full scope. This will significantly decrease the overall cost of foot complications for the province. The evidence is out there you only need to read it.

Submitter 111

As a Chiropodist I am frustrated with limitations on my scope of practice. These limitations include:

1. Our set drug list, as new meds become available in similar classes we are unable to prescribe
2. Unable to order diagnostic tests to help us formulate our diagnosis and provide treatment. Often I am sending my patient back to their GP for further diagnostics before I can provided treatment. For example if I suspect a plantar fibroma vs plantar fasciitis I need a diagnostic ultrasound before I can inject with corticosteriods. If I suspect osteomyelitis I need an x-ray or bone scan in order to prescribe the appropriate antibiotics and treatment plan, again this requires a trip back for the patient to his/her GP. If I suspect a lesion to be suspicious I cannot biopsy and send to pathology I again need to send the patient back to their GP.
3. Most patients and physicians are confused with the use of the two titles Chiropodist and Podiatrist.

Submitter 112

awareness of the public and other health professionals about who they should be seen by or referred to for their problems with foot health.

Submitter 113

The name Chiropody should change to podiatry for universal recognition. Confusion in the public sector has always been a source of frustration.

Submitter 114

Major issues in the Chiropody profession continue to be lack of access to diagnostic tests, X-

Ray, CT Scan, Blood Tests, Pathology tests on biopsy's. Another challenge to to our proffession is a lack of knowledge in the public and other health professionals (including GP's) of the services we provide. Cost is a concern to patients that do not have extended health care insurance

Submitter 115

It simple dollars and cents. You have a group of practitioners who are in the minority in terms of both practitioner numbers and the amount of patients whom the treat. Holding on to a title that is recognized world wide as the provider for 'foot care' and not willing to relinquish it as they did in the 1950's to avoid confusion with chiropractic care. The title provides these individuals with an advantage of simple recognition to persons who are in need of treatment.

Submitter 116

It seems the largest issue is not necessarily with the scope, per se, but the awareness of the current breadth of foot care in Ontario. As superficial as it sounds, the greatest benefit that could come to chiropody would be that of a name change to podiatry, if not strictly for the larger awareness. It is not unreasonable to believe that a 2 tier (podiatrist-D.Ch/podiatric surgeon-DPM) or 3 tier (podiatrist/podiatric physician/podiatric surgeon) would be extremely beneficial to the profession and foot care as a whole in Ontario, as this system has been proven to work internationally.

It appears that the main entity preventing this change is the government, due to what may amount to be false beliefs in a financial model that depletes podiatry of its resources and allots them to physicians and orthopedic surgeons. This is the reason why the cosmetic change (to podiatry) and the skill set change (of expanding the scope) need to be welcomed.

The reliance on orthopedic surgeons to be the sole surgeons of boney tissue in the foot seems largely irresponsible, as it is no secret that these surgeries are low on the priority (read:financial) totem pole. Current DPM trained in bone surgery should be allowed to practice their scope. The hope would be that this would usher in a novel view that within Ontario orthopedic surgeons could co-exist with DPMs practicing in their full capacity. Ultimately, the need for this expanded scope of footcare in Ontario would lead to the creation of a Ontario based university podiatry program, complete with hospital privileges and surgical residencies.

Of course, this is all in an ideal world. An ideal world we do not live in.

However, an ideal model of foot care is available to practitioner and public, alike. It will be the responsibility of the Ontario government to acknowledge that the time to accept this ideal situation for foot care is right now.

Submitter 117

My name is [redacted], doctor of podiatric medicine currently practicing in Michigan due to the foot care model in Ontario. I was educated in both the Canadian and American system; however, I am unable to return to my city of birth (Toronto) and provide much needed care fellow Canadians. I was educated at Michener Institute for chiropody and then continued my education at Temple University in Philadelphia. Upon completing my medical degree I went to Los Angeles for my 3 yr surgical residency. Once completed I move to the closest state (Michigan) where I would be able to practice, hopeful 1 day Ontario would open the doors to newly trained and motivated podiatrists. As a chiropodist in Ontario we are limited in scope of practice but due to the current eduation model chiropodist are NOT trained to undertake a podiatrist role in 2014. Podiatry in america is much different, we take call, we admit patients, we treat the ankle and

provide limb salving surgeries in both traumatic cases and diabetic patients.

The major issue I feel is a lack of public understanding on what a 'foot specialist' does and eventually should have 1 system similar to the American model. The chiropody program should be eliminated and a current model of podiatry should be start with a Ontario university that has an established medical program and where podiatry students are trained along side MD's/ DO. Further residency program should be started mimicking the US model with hospital and practice rotations. It all starts with education.

Most current practicing foot specialist in Ontario are not board certified in foot and ankle surgery and the Canadians that are do not enter Ontario to practice as our scope of practice is limited. Its about time change occurs in ontario and allow us Ontario citizens back to our cities and care for community.

Submitter 118

The model in Ontario is antiquated with the subdivision of Chiropody and Podiatry (based on OLD UK model).

Podiatry is now the accepted title of foot specialists WORLDWIDE. This has always been confusing to the public and other health professionals and insinuates a second tier of care. The unification and grandfathering of the title will streamline the regulatory system and the perception/understanding of the public.

Access to the FULL SCOPE of the Podiatry class based on education/training will enhance foot care provided to the public in particular osseous surgery. Currently patients are waiting 2 years simply to be consulted by Orthopedic Surgeon for BASIC forefoot surgery. Patients have to access diagnostic tests via their primary care physician further adding cost and time burden to the system.

Submitter 119

There is much confusion about what each individual footcare provider does. There are also too many people providing some type of footcare (specifically orthoses) that do not have the proper knowledge to provide adequate followup after the product had been dispensed. There should be some type of guarantee to the patient that if they have a problem with the orthose, they can return to the provider to have them may appropriate adjustments. There is also too many providers that entice patients to use there services because they offer them free products to use that provider. These free products are often inappropriate for the patient, or the patient did not need the orthoses in the first place, but used the insurance coverage to obtain the free product.

Submitter 120

As a private practitioner I feel that both the general public as well as other regulated health professionals do not identify Chiropodists as the number one foot health professional in Ontario because they are confused about the title and are not aware of our scope of practise. Other practitioners are practising our acts for example nurses, pedorthists, chiropractors, massage therapists, etc. yet as a Chiropodist I would not consider practising dentistry so why can others do my job? We only need one foot health professional in Ontario and we already exist, and have the demonstrated knowledge and skills to practise our existing scope. We require funding so the public has equal access to care, especially the diabetic and First Nations communities. One universal title, Podiatrist, one universal scope, Podiatric Medicine with access for all Ontario patients is required.

Submitter 121

Foot care to be available and affordable to all Canada. Chiropodists to be allowed not only to prescribe antibiotics and antifungals, but also x-rays and pertinent lab tests. Chiropodists to be called podiatrists as Ontario is now the only place that uses this old terminology that does not even explain totally what a specialist in this field is entitled to do. Chiropody is treating hands (chiro) and feet (podo), therefore is a misnomer. From my experience more than 80% of the population does not know what a chiropodist is and approximately the same number KNOWS what a podiatrist is.

Submitter 122

Patients or others practitioners looking for footcare providers very often does not know what a chiropodist does unless they have seen one previously. Currently nurses (including rpn and nurse aids) are providing footcare with weekend course qualification. Currently anyone can say they are footcare provider as long as they have some kind of footcare course. The population are increasingly aging and there are a lot of diabetics. It is scary to put the vulnerable feet to these so call footcare provider. Major issues we faced are poor treatment of foot infections by these unqualified providers which cause more emergency room headaches for patients and their Dr. Recently, there are an increase of leg amputations due to improper foot care. These cause billions of dollars to healthcare system. Patients can avoid amputation if an ingrown nail infection was treated properly by qualify providers with at least 4 years of training not a weekend course. Seniors population can be more active if their feet do not ache or proper gait. 60% of Canada population are senior. Mobility issue costs billions of dollars and back lock to healthcare emergency rooms and beds. Often a painful corn properly removed and proper footwear provided by chiropodist or podiatrist can get that person walking and better lifestyle. Ontario is the only place in the world that has two title for foot specialists: podiatry and chiropodist. NO where else. This has to stop. Europe has changed all their chiropodist title to podiatrist. The rest of the world uses the title podiatrist. Why is Ontario still using this title? It confuses the public and practitioners. Ontario model of footcare model should be this: Podiatry. Doctor of Podiatry Medicine. All current chiropodists title change to podiatrist. Any footcare provider treating feet should be trained under the program at accredited medical school. Why does English speaking Canada do not have a podiatry school and yet the French speaking Canada have one? Ontario have to step up now and prove to the world that we can treat feet and can decrease amputations. Dentists treat mouth. Optometrists treat eyes. Surgeons do surgery. Podiatrist/chiropodist treat feet.

Submitter 123

The limited application of the scope of practice. As chiropodists, we are educated and prepared to be able to request x-rays, diagnostic ultrasounds, prescribe a broader range of antibiotics, and ask for specific blood tests. Unfortunately, current legislation and models so not allow us to use these qualifications. By having to request these services from a medical doctor, we are putting an increased demand on the already busy general practitioners. By allowing us to practice to the ability of our full scope of practice, there would be less pressure on the family doctors, as well as the health care system as a whole.

Also, better financial aid for wound care patients. Chiropodists are go-to professionals when it comes to diabetic foot wounds and their care. Chiropodists can, and do, save the health care system thousands and thousands of dollars in wound care management. By integrating chiropodists in a better manner into provincial funding for wound care, will continue to save the

province thousands of dollars by having them seen directly by a foot care specialist, instead of having them bounce around physicians and nurses.

Regulating orthotic devices is important as well. Chiropodists/podiatrists are the only health care professionals allowed to prescribe and dispense orthoses. I believe that this should be reflected in legislation. Remove general physicians from their prescribing, and remove chiropractors, physiotherapists and other non-foot care specialists from being able to dispense, and you will have less insurance fraud, and patients with improved health by having the correct professionals looking after their area of expertise, the foot and it's function.

Submitter 124

Why did the Chiropody clinics get taken out of the hospitals where the service was covered. So many of the patients, and seniors cannot afford to pay for the patient visits. Putting chiropody in family health teams may be good for some of the patients but the salary is definitely inferior to what it was in the hospital setting for the chiropodist.

Wound care is very expensive and patients need wounds attended/treated on a weekly/daily or 3x week etc. The supplies and visits, travel, time, companion and parking at times are very expensive, time consuming etc.

So cost, is the issue for many of my patients.

Many people do not have extended health care insurance.

Foot care should be free for seniors and children, covered by the government.

Right now the Family health care team chiropodists will only see diabetic patients and can't do orthotics for the patients. So again this is not an ideal situation. Chiropody visits then need to be referred to a private practitioner. Some patients then have 2 chiropodists.

If the chiropodists had more scope then the patients wouldn't have to attend more/additional health care practitioners when one would be enough to handle the care. Another reason why health care is so expensive. Also why is there so much funding out there for the diabetes initiative model of care? Why isn't chiropody part of this model? Chiropody is vital for the diabetic patient, Why doesn't the government know this?

Submitter 125

Chiropodists have a difficult time in treating their patients. Access via our drug list is limited, and does not allow us to use the most current treatments, as we have specific drugs, not classes. It is also difficult with diagnostics, as all tests need to be referred back to the primary care physician, often to whom the patient was referred to us in the first place.

There is also major confusion of the terms chiropody and podiatry. Most of the population, including out patient population does not know what a chiropodist is or does.

Our training has provided us a much larger scope of practice then we can currently practice in Ontario, as stifled by antiquated legislation.

Submitter 126

I provide primary foot care to patients in a private clinic. I struggle daily with explaining to patient's what a Chiropodist is and why we have Chiropodists in Ontario. I see this as a barrier

to foot health in the province of Ontario because patients cannot seek proper foot care if they do not know who to seek out for their care. I believe that the biggest barrier to this is the name Chiropody itself. The name should be changed to Podiatry if nothing else. The general public understands what Podiatry is much better than they do Chiropody.

My other major concern is my inability to communicate a diagnosis to a patient. I am licensed to prescribe oral medication, perform soft tissue surgery, and inject medications into the foot, but not to communicate a diagnosis. How can I do any of those things proficiently without communicating the diagnosis? Or get proper consent for those treatments without a diagnosis? That being said, the other issue is that we often have our hands tied because we are not able to order laboratory testing or x-ray's for patients.

These issues are of the utmost importance to me in order to be able to properly treat and care for my patients.

Submitter 127

Too many unregulated people are providing foot care.
Because they are unregulated they do not have to adhere to any standards or protocol.
Since Ministry of Health funding has greatly diminished with huge job loss for Chiropodists in Hospitals, private practice is the only alternative.
I may have to give up my practice because unregulated people are providing foot care at a lesser fee.
They are taking my business.
But I still have to pay \$1300 for a licence (to allow myself to be sued essentially)
\$600-700 for Insurance, \$250 for membership
not to mention; rent, utilities, autoclave and all supplies and equipment to run a practice
The College does nothing to help us at all.
Regulate-regulate-regulate
I'm sick of it!!!!!!"

Submitter 128

The need to eliminate public confusion with the term Chiropody and Chiropractic. Unify the Chiropody and Podiatry profession's title to 'Podiatry'. Problem solved.

We need to protect the public and insurance companies from fraud and harm to patients by making the prescription and dispensing of custom foot orthotics a controlled act under the scope of the Podiatrists/Chiropodists.

We need to be able to communicate a diagnosis to our patients. We need to be able to access tests to help our patients such as radiographs, MRI, bone scans, CT and ultrasound diagnostics. This will save the health service money. We can also expedite referrals by referring patients directly to specialists rather than sending them to their primary practitioner who then refers. This will save our health service millions of dollars.

We need to have in place a future vision that enable our profession to grow and scope of practice. Long term planning should include allowance for all Chiropodists to train in surgical procedures.

Submitter 129

There is significant confusion on the role of a Chiropodist vs Podiatrist, despite the fact that we are under the same college. The name poses a predicament in terms of public education on what a Chiropodist can do. Of course any necessary educational courses required should be fulfilled by the members.

Having the ability to order testing-specifically x-ray, diagnostic ultrasound, culture and sensitivity tests and mycological tests for instance, would not only reduce wait time for treatment for the client, but also be more efficient and cost effective of the health care system, rather than sending the client back to their primary care provider to get a requisition for these tests.

Efficiency and cost effectiveness on the health care system in Ontario would also improve with increased ability to prescribe certain medications and dressings often used for treatment of foot, skin and nail disorders.

Submitter 130

As a foot care provider, I am constantly explaining the confusion around the antiquated term Chiropody. It is very unfortunate that Canadian trained individuals struggle to be recognized while our colleagues in other provinces and from around the world have already adopted the term Podiatry.

Another area in our scope of practice which must be addressed is requisitioning lab tests and diagnostic imaging. Currently, our patients must be sent back to their General Practitioners for the requisition, then the results must be sent to our office taking up tax payers dollars and considerable staff time in the process.

I realize our profession is one of many that require changes, however we are a small group that provide a necessary service for the citizens of Ontario. It has been a frustrating 19 years of practice for myself. Please consider the proposal put forth from the College of Chiropodists of Ontario to improve the healthcare and its delivery in Ontario, while providing a cost savings to the government.

Submitter 131

As a chiropodist, one of the major issues facing the profession with this current model is the lack of accountability from the our regulated health college. Not only from the financial perspective but also from the policy perspective.

Current employees of the college are - CEO, admin assistant and a complaints officer.

There is no treasurer, all finances are the responsibility of the CEO. With over \$750,000 annual College income this is of great concern. Proposed fee increase is an additional \$400.00 per member.

We do not employ a Policy advisor or professional that is knowledgeable about the current roles and responsibilities of chiropodists. Questions asked of the CEO relating to practice concerns are usually not answered for several months, if ever.

As a profession, this model does not allow us to request x-rays or blood or culture swabs neither are we included in other legislation ie. Long Term Care

Current model does not us to provide service in CCAC or long term care homes - only on a fee for service basis.

We are not listed in the ODSP - Activities of Daily Living Index as one of the persons who are registered with their regulated college.

Any time this these concerns are raised to the College Council we have been told there is an HPRAC review that will address these concerns.

Submitter 132

The current model is extremely fragmented. There is no direct connection to the one source for immediate off loading or correction of foot abnormalities such as a direct link to a certified pedorthist, certified by the College of Pedorthics Canada. These practitioners provide full spectrum of care from assessment, prescription, fabrication or modification for shoes or orthotics. The risks of harm to the public in this regard remain unregulated. The risk of fraud as we are not regulated, the title pedorthist is not protected from inferior qualifications posing as pedorthists. This is damning to our own profession and poses a significant risk of harm to the public. Risk of harm, some type of legislation or registry is required to enure greater public safety and protection from harm, especially for patients in high-risk populations such as those with diabetes, Charcot arthropathy, Charcot-Marie-Tooth Disease, age related balance issues, and other medical conditions who benefit from pedorthic treatment. Risk of elimination of pedorthists, discriminatory practices and perceptions based on the fact that we are not regulated in Ontario through legislation threatens the existence of our profession. However, our profession is an essential and valuable part of the foot care model.

Submitter 133

Recognition of Pedorthists and their importance in the foot care model. There is no other profession that has the hands on technical training and experience with respect to non-invasive treatments of the lower limb. Pedorthists not only have the training and knowledge to handle complicated foot related cases such as CMT and Diabetes, but also the onsite lab facilities to deal with these in a more 'custom' manor and provide the best possible care than a related profession who would use an off-site lab for fabrication or modification of foot related devices.

Submitter 134

Major issues-the name game between Chiropracist/ Podiatrist- should be one name for the two groups in order to not confuse the public.

Chiropracist lack of diagnostic abilities- we have a limited scope of practice, needing to send them back to the family MD to have tests ordered-This places a strain on the system and delays care required.

Limited scope of practise for perscriptions.

Submitter 135

I belong to college of pedorthics of Canada and Pedorthics association of Canada with more than 1200 members in canada . In Ontario we have more than 500 members who are certified Pedorthist. I think as a fast growing health profession in Ontario and Canada as a whole , and employing many people , Pedorthics should be a regulated profession as this will protect the public . Pedorthics should be recognized as we are specialist in custom foot orthotics , shoe

fitting , modifications , compression hose fitters as well as knee bracing specialists. We have a huge responsibility in keep the public health going. Pedorthists work hand in hand with family physicians , physiotherapists , podiatrist, massage therapists , rheumatoid and diabetic physicians. Pedorthists are also in the forefront in seeing foot related complications such as diabetic ulcers , peripheral neuropathy which we refer or communicate with patient's physician. This greatly reduces risks of amputations from diabetic complications. Pedorthic services also help in the prevention of future complications such as hip replacements, knee replacements , osteoarthritis and the like . We use custom made foot orthotics to realign structural imbalances of the body. We use orthopaedic footwear for good support. Pedorthic knowledge and leadership in this regard has become the point of consultations by all insurance companies . Most insurance benefit plans are tailored in accordance and consultations with the a pedorthic association of Canada. The general public is more educated about their foot care issues through the vast majority of Pedorthic clinics that see and treat the majority of the population in Canada. As for that reason I think Pedorthics should be considered during this important review of the foot care model in Ontario. We play a vital role in foot care and we have many patients that are very thankful of our services. Pedorthics is one of the biggest employer within the foot care services. Most of the Pedorthist are University graduates with Bsc in Kinesiology . They further study a post 3 year graduate diploma in Pedorthics from the University of Western Ontario, which involves clinicals and placement before an individual can apply to write certification exams which include theory and practical exams. So this pedorthic programme is very intensive and rigorous in terms of preparing one to be certified and be prepared for providing excellent health care services to the public. The difference between a Pedorthist and a chiropody in ontario is Peodorthist we can't prescribe drugs which is something that Pedorthics as a profession does not want our members to do anyways, as we would like to maintain a clear demarcation of duties as well as to cut down on public confusion. As pedorthists we would like to maintain our status as health services providers but we would like to be a regulated profession so as not to confuse the public as well as to protect it. Our relation with the family physicians is that of doctor and phamarcists . That's the position and the relationship we want to maintain. We work with all professions and we complement doctors in their endeavours to provide the highest standards of foot care services. Pedorthists we do not want to do calluses , warts or any other soft tissue as chiropodists or podiatrists. We are specialists in biomechanics, of the for and ankle, custom foot orthotics and footwear modifications to accommodate foot deformities and ailments, which chiropodists and podiatrists can't do. Podiatrists and chiropodists are not. Specialists in the manufacture and shoe modifications or shoe manufacturing. Pedorthists we make and manufacture patient custom mabe foot orthotics within our inhouse labs. We modify footwear in our own labs and some master craftsmanship Pedorthists make custom made foot wear for patients. Podiatrists and Chiropodists cannot manufacture or custom modify footwear for a custom fit to accommodate a foot deformity as pedorthists do. This is the void we fill within the foot care health services. Many physicians are working and refer their patients for many foot related injuries or pain such as plantar fasciitis, patello femoral syndrome, Achilles tendinitis, stiff big toes , just to mention a few symptoms we treat .

I would encourage and beg you to include Pedorthics as a regulated profession in Ontario. This will benefit the public as a whole as well and hold the Pedorthic members accountable for their deliverance of foot health services. This will also eliminate some scrupulous individuals who are taking advantage of the non regulation of the Pedorthics services to claim and mislead the public

as Pedorthists . This will also give Pedorthics in Ontario a higher status and position as a well respected profession that will further open more opportunities to a lot of University graduates who would want to find a career in the foot health services.

Thank you and hope you will consider Pedorthics are a very integral health profession in Ontario.

Submitter 136

I have been practicing chiropody over 20 years in Ontario. I am also a graduate from the chiropody program at the Michener's Institute. The College of Chiropodist of Ontario has not done its due diligence in protecting the public by ensuring its chiropodist shareholders scope of practice progresses with the advances of medical technologies of today. Something as simple as an ordering an X-ray, and access to lab tests would greatly enhance the quality of care of Ontarian who is dealing with complex chronic diseases, such as diabetes. Instead of maintaining our present limited scope of practice such as using basic topical medications used in treating warts, the College of Chiropodists of Ontario recently sent out a newsletter restricting our use of silver dressings, because this item was not originally on the approved drug list. Silver dressings like Acticoat and Silvercel are essential and common in all chiropody practices dealing with wounds in Ontario. When the College of Chiropodists of Ontario spent countless hours and money on committees to come up with the drug list and still failed to include this basic and effective silver agents. Recently our colleague had asked the College of Chiropodists of Ontario of the use of Bactigra which is a wound dressing with 0.5% w/w Chlorhexidine Acetate. Chlorhexidine is not on the drug list. The College of Chiropodists of Ontario and its panel of experts do not have an answer and did not follow up with a response.

Submitter 137

I am an America certified C. Ped. I work with clients and their Doctors to develop custom orthotics applicable to their individual needs and injury processes. The challenges I face are the Canadian certified C. Ped's lobbying insurance companies to prevent me from doing business. As a certified practitioner who has hundreds of hours of continuing education in this field as well as in gait analysis, bike fit, personal training etc. and over 17 years of experience I feel I can provide as well if not better than some of my Canadian certified counterparts. If changes are made to the regulation of this field I believe a grandfathering program should be put in place.

I hear many horror stories from dissatisfied patients regarding treatment, product, costs and education to name a few of the Canadian certified Podiatrists and Chiropodists in my area. Experience and knowledge should play a role.

Submitter 138

I am among only a handful of registered chiropodists in Ontario with a doctorate in podiatric medicine (D.P.M. degree) from the United States. Furthermore, I have completed 3 years of podiatric surgical residency training, including training at The Cleveland Clinic. Despite twelve years of post-secondary education and having successfully performed over 1500 foot, ankle and lower extremity surgeries during my training, I have not been able to use the majority of my skills on Ontario residents who are in desperate need of them, precisely because of the restrictiveness of the 'Ontario Podiatry Cap' on registrants and due to the antiquated Ontario Chiropody Act.

After graduating in 2005 I entertained podiatrist employment opportunities in several U.S. and Canadian jurisdictions but chose to return to Ontario to serve her residents, however in order to

practise in any capacity I was forced to register as a chiroprapist despite having never taken a course in chiropody. The current legislation has professionally handcuffed me and more importantly resulted in barriers to access of care for patients.

In Alberta, B.C. and in the U.S. I could receive surgical and hospital privileges with admitting rights; order diagnostic imaging studies such as MRIs, CT scans, bone scans, arterial dopplers and radiographs; order laboratory studies such as the Liver Function Tests to determine if liver damage is occurring as a result of oral anti-fungal medications or order HbA1c to monitor long term blood glucose levels in diabetic patients; refer directly to other medical specialists such as infectious disease or dermatology; perform boney surgery of the foot and lower extremity (including amputations, forefoot, rearfoot and ankle reconstructions, use internal and external fixation, setting of fractures, etc.) depending on the jurisdiction. In Ontario, as the law is currently written, I can do none of these.

As an Ontario chiroprapist, I am limited to soft tissue procedures of the foot performed only in my office, cannot perform bone surgery, cannot order imaging or lab studies, cannot directly refer to specialists but rather need to ask the patient to return to their general practitioner (if they have one) for referrals and to order lab and diagnostic studies. This is an inefficient and expensive manner to treat patients who deserve no less than those in other North American jurisdictions. This frustrating process is detrimental to quality of care and does not allow deserving patients to directly access those practitioners who are best trained to deal with these often complex medical conditions. The Alberta podiatry model of foot care most accurately reflects the North American standard and should replace the current antiquated Ontario chiropody foot care model.

Patient confusion regarding the titles 'podiatrist' and 'chiroprapist' are a daily reality in my office. Explaining that as a surgical residency trained D.P.M. (albeit registered as a chiroprapist) I have more training than a podiatrist who registered before the 1993 Ontario cap on podiatrist registrants but unlike them, I cannot perform boney surgery of the forefoot or balance bill OHIP surely becomes a convoluted sounding explanation. There should be one uniform policy regarding professional titles and OHIP billing: both pre and post cap DPMs should be able to use the 'podiatrist' title via elimination of the Ontario podiatry cap on registrants. Post cap DPMs should be granted OHIP billing numbers just like their predecessors OR no group should be permitted to bill OHIP. Eliminating the Ontario cap on podiatrists and issuing OHIP billing numbers to all DPMs would instantly clear up any confusion in title as well as government coverage of services.

The doctor title should be extended to podiatrists since this privilege is afforded to U.S. trained doctors of podiatric medicine in several Canadian provinces such as Alberta, British Columbia and in all of the United States. This is a bona fide medical degree certainly requiring training at or above that required for other professions that have this privilege including dentistry, optometry and chiropractic. In many jurisdictions including Alberta, DPMs are regulated by a College of Podiatric Physicians and Surgeons or equivalent body. Surely the acknowledgment in other Canadian provinces and the U.S. that DPMs are physicians and surgeons is proof that they are bona fide doctors and thus they should be able to use the doctor title. This simple step in Ontario would further clear up patient confusion by distinguishing those practitioners who have

earned a doctorate from those who have earned a degree or diploma.

As the population ages, the demand will grow for qualified doctors of podiatric medicine from patients seeking to preserve their mobility and enjoy a better quality of life. The first step is to remove the legislative barriers preventing podiatrists from practising the full scope of their chosen profession. For the record, I am in support of the College of Chiropodists' proposed Ontario podiatry model which is based on the Alberta podiatry model; the elimination of the cap on podiatrist registrants; a uniform OHIP billing policy for all doctors of podiatric medicine (either issuing OHIP billing numbers to post-cap DPMs or cancellation of OHIP billing numbers for all pre-cap DPMs); and permitting use of the doctor title for DPMs. I hope the H.P.R.A.C. realizes the tremendous opportunity before it and affords Ontario's residents the highest quality foot care enjoyed by residents of other provinces. This correction is long overdue.

Submitter 139

Issues facing patients:

1. ability of a model of care to provide streamlined (appropriate, non duplicating) access to affordable services provided by pedorthists
2. the amount of coverage provided for custom shoes provided by extended health plans
3. definition by extended health plans (therefore what is covered) of what is a custom shoe e.g. split sizes necessitating purchase of two full pair of shoes, adaptations (height adjustments), etc. Inconsistency exists in what is covered

Issues facing practitioners:

1. As a consumer, I have expectations of the professionalism of my pedorthotist. A National College exists for pedorthists to protect the public and to hold pedorthists accountable for the service and product they provide to clients. However pedorthists are not regulated. I question how appropriate a national college is for meeting the province specific needs and issues of consumers and pedorthists.
2. How can the provincial model support regulation of pedorthists while at the same time acknowledging their unique skill set within the service provided by the model?
3. That the model will not acknowledge and reflect the continuity of care provided by pedorthists through assessment, prescription and fabrication of custom shoes.

Submitter 140

I believe we need a clear title for foot care professional. I believe that 2 titles chiropodist/podiatrist is confusing to the public. i understand that currently the 2 classes have different scopes of practice and that would have to be made clear.

I think we could have a general podiatrist title and a surgical podiatrist title to help distinguish between the expanded scope of the podiatrist class. This is similar to the distinction in the nursing profession (RNEC, RN, RPN etc.).

I work in a community health centre with a variety of health care professionals.

I believe there is a place for all.

General Podiatrist(Chiropodsit) - general foot care, from minor surgery (soft tissue) to maintenance foot care of the more complex patient, the casting and prescribing of orthotics
Surgical Podiatrist - expanded foot care involving bone surgery limited to the foot, the casting and prescribing of orthotics

Orthopaedic surgeons - bone surgery - foot, ankle etc.
Podorthist - manufacturing of orthotics, footwear adjustments
Footcare Nurse - basic nail, callous care for the less complex patient.

Submitter 141

The issues for patients is that when they see a chiropodist, for a foot infection, the chiropodist/podiatrist has to send the patient to their MD for a swab of the infected area for a C&S.

This is also true for a suspected case of gout: the podiatrist/chiropodist sends the patient to their MD for a blood test to check the uric acid level.

When a patient has a suspected fracture, the chiropodist says, 'you may have fractured your metatarsal and that may account for the pain on the plantar and dorsal aspect of your forefoot. Now you will have to go to your MD to get an x-ray to find out if you have a fracture and your MD will tell you whether you indeed have a fracture.' Then the chiropodist thanks the patient for coming in and shows the patient the exit.

The analogy that applies to the above scenarios: the chiropodist is like a security guard and the MD is like a police officer. Anytime something suspicious happens on a property or in a retail store, the security guard nabs the suspect, holds him/her and then the police officer arrives and has to take over with a formal charge and then taking the suspect into custody, etc.

Submitter 142

There are 2 huge problems.

1. Nurse foot specialists... How come???? I don't see nurse teeth specials, nurse eyeglass specialists, nurse back specialists. Why? Well I guess the dentists, optometrists and chiropractors have a protected scope of practise. Chiropodists-podiatrists don't! Chiropodists-podiatrists need a protected scope of practise. This will stop the RNs working at large senior buildings for a good salary 8-3, M-F and then after work going door to door doing nursing foot care and charging \$20/visit.

2. Orthotics!!!! Anyone can make them and dispense them. I see them at the CNE. The 'pros' wear lab coats and guarantee their orthotics. They're a joke. Chiropractors use Foot Levelers orthotics. Physiotherapists also cast and dispense orthotics. Why don't chiropractors/physiotherapists or people wearing lab coats fit and dispense eye glasses???? The reason is that eye testing for eye glasses is restricted to optometrists.

Foot evaluation, orthotic casting and dispensing should be restricted to podiatrists-chiropodists.

Submitter 143

At the Community Health care Centre (CHC), the funding for Chiropody is government funded to the CHC not billed through OHIP. Each Chiropodist has a yearly Salary. Each CHC has a certain catchment area where they base their clients from. I've worked in the CHC setting for about 10 years. Each Chiropody clinic is over booked and full to capacity. And at my health centre there are two Chiropodists.

The cost to the client is 0\$. When I first started we accepted anyone that wanted foot care in the catchment area. But now that we are full, we have tried to gear it toward income, then to High risk health conditions such as Diabetics. At present, we are only able to see internal clients - meaning that the clients are only referred by the doctors that work in my CHC and the DECNET

team that is part of our CHC (as long as they are in the catchment area).

We no longer can see anyone with a self referral or if they are seeing an external doctor. Every year we have to refer-out or give people a list of external Chiropody clinics. Many of which are private practice, where the patient has to pay out of their own pocket, because the other government funded Chiropody clinics are full and not accepting clients or screening clients in most need or they are simply not in the catchment area.

Footcare is a service for all ages - however, a significant amount are Seniors on a fixed pension. A lot are also DIABETICS that are of risk of getting amputations, infected wounds that require daily to weekly dressing changes (often by home care) and they are also at high risk for death if the infection becomes unmanageable.

Preventative care for these clients can save Ontario health care funding a lot of expenses with decreasing the above risks.

I've done several informative Talks to Diabetic groups on taking care of their feet and making sure they at least have a base assessment from a Chiropodist. However, many of the patients say they cannot afford to go to a Chiropodist. Even a first initial visit to a Chiropodist with treatment and assessment can cost anywhere from 50-80\$, and follow up care can range from 30-50\$. The patients are seen usually every 8 weeks on average - about 6 times a year - on average \$240 per year. Or even for the one time a year base assessment visit of \$60/ per year.

However the costs for wound care service (which on average is 1-3 appointments per week for several months) , home care visits, and dressings supplies (there is a high cost for the wound care dressings themselves) is much greater than what it costs to prevent foot complications from happening.

Not only would funding or even partial funding for Chiropody foot care help with saving costs to our health care system, it would also help prevent foot complications and improve the health and well being of patients specifically diabetic patients.

Not only are diabetic Patients at risk but similarly any neuropathic or vascular compromised or immuno compromised patient are at risk for foot complications.

Presently, our CHC cannot afford to hire another Chiropodist, however we have a large amount of Patients in need of foot care from our DECNET (diabetes program) - Thus they have instead hired a part time foot care nurse. Her qualifications include a 2 week foot care course - but we are finding that we have to take time off our schedule to help her see clients and her scope of practice is less than ours. This is an inefficient way of spending funds for foot care.

Another issue I found is that due to policies, we are restricted on lab requisitions and diagnostic tests. We have to delay and send the patient back to their GP for these tests - which then the patient has to come back to us for treatment.

If we are able to Prescribe oral antibiotics we need to access lab testing so that we can send

samples off to diagnose a wound infection as soon as possible. We also need to have xrays done if we suspect there is any osteomyelitis infection when we see clients with extensive wound care. This delay in service is detrimental to the patient's foot care and health. Similarly when a patient comes in and we suspect a tumor or suspicious mass and require an Ultrasound, or if a patient comes in and we suspect a fracture. Our hands are tied if we cannot order these requisitions ourselves.

Submitter 144

the major issues:

- access to ministry funded service for those living in poverty
- understanding what chiropody is vs podiatry and the very similar scope of day-to-day practice.
- the confusion caused by other disciplines providing foot care without any specialization or understanding of complex etiologies
- limitations to xray/lab/investigations
- limitations to our prescribing list (presented as a list of drugs, not drug classes)
- our injections are limited to the foot, while it might be more appropriate to administer elsewhere.
- we are limited to practice below the ankle, where often the lower leg needs to be addressed as a functional unit.
- we assess and discuss our findings but cannot diagnose common foot pathologies but are solely responsible for treatment plans.
- the population is aging, the majority of our clients are older, there will be an increased need for qualified practitioners to deal with complex foot problems that may require surgical intervention. Orthopedic surgeons are backlogged, and the present foot care practitioners have the complex understanding of the foot and could be trained to provide this service.
- with an aging population, mobility becomes a high priority for good health outcomes. Chiropody/Podiatry is able to support this through both pain management, foot health maintenance and exercise programs.

Submitter 145

Access is the biggest problem. When I see patients in my freestanding practice, my elderly pts, diabetic pts or those with peripheral vascular disease who don't have coverage through work cannot afford to get their feet checked. There is good evidence to support regular chiropody screening and or treatment as a cost effective measure that saves limbs.

I also work at a CHC where we do have coverage, thankfully, for our patients in need. However, I know that the chiropody team is strained with work overload.

Submitter 146

The chiropody podiatry profession has evolved since the Chiropody Act 1993 was introduced. The members of the public (patients of chiropodists and podiatrists) have to go through unnecessary family practitioner visits to get x-rays or diagnostic tests such as ultrasound or blood tests. There are some oral medications which are not on our oral drug list such as certain oral anti-fungals and oral antibiotics. Because these medications are not on our list it requires a visit to the family doctor. This delays treatment. In the worse case scenario some of the patients do not have a family doctor such as in [redacted] where I practice. There is also confusion between the titles chiropody and podiatry, which will hopefully be resolved with the HPRAC review. The rest of the jurisdictions in the world have moved away from the title chiropody. Ontario is the only province that stills uses the chiropody title. The new controlled acts will be

welcomed and will benefit the people on Ontario in the long run.

Submitter 147

There is poor access for patient's to receive quality foot care by trained individuals in Ontario. Many persons can not afford to pay for foot care despite needing to access it. As the clinical lead of a Nurse Practitioner-Led clinic, I find that our patients are constantly in need of advise on what to do in regards to the care of their feet.

-Patient's do not understand the difference in providers that are available in the community even when they can afford to pay for the service.

- Not all chiropodists/podiatrists have equal skill in handling complex patients, for example those with diabetic foot ulcers or charcot foot deformity who require off-loading foot wear need to be sent to someone with specialized training above and beyond the basic certification.

-There is lack of availability in all centres currently.

-All primary care models would benefit from being funded for foot care services on site for patients to improve access.

-removing some of these practitioners from private practice would decrease some of the fraudulent claims for poorly made orthotics and 'custom shoes' that is currently burdening our system as well.

Submitter 148

As a podiatric surgery resident, bunion surgery accounts for 20% of my surgical case load. Hallux valgus is one of the most common pathologies presenting to foot and ankle specialists. A metanalysis of 76 studies found the prevalence to be 23% among individuals 18-65 and 35.7% among individuals older than 65.(1)

A patient in Ontario informed me that their primary care physician encouraged them to avoid bunion surgery because it doesn't work well. Unfortunately patients in Ontario are faced with the option of having bunion surgery performed in their primary care physician's/podiatrist's office or seeing an orthopedic surgeon with a long waitlist. When hallux valgus becomes painful, it often fails to respond to conservative treatment.

There are numerous studies reporting the outcomes of hallux valgus surgery but there are only a few studies reporting long-term outcomes and these are most valuable. A 2004 study in the British Journal of Bone and Joint Surgery reported on 112 Chevron procedures with a minimum 10 year follow-up. They found decreased joint range of motion and progression towards arthritis, however; there was significant clinical improvement. Hallux AOFAS scores improved from 46.5 to 88.8 and there was significant improvements in both pain and function ten years after the procedure. They found the procedure performed equally well in young and old patients.(2)

A 2013 study in the British Journal of Bone and Joint Surgery found similar results. They compared 2 procedures with 8-11 year follow-up. They found decreased joint range of motion. Hallux AOFAS scores with the Hohman procedure improved from 56.7 to 82.0. Hallux AOFAS scores with the Lapidus improved from 58.0 to 79.4. Again pain was significantly improved 8-11 years after both procedures.(3)

The above procedures address the hallux valgus by shifting the metatarsal head to its natural position over the sesamoids. This requires cuts in the bone and shifting the bone which is best performed with a saw followed by screw or plate fixation. Research has shown more limited

procedures that address only the soft tissue component of the deformity or the toe itself have worse outcomes and increased recurrence. My concern with the current model in Ontario is that procedures are not performed in the OR with sedation which can be very difficult for the patient. Also, this may encourage providers to perform more limited techniques such as akin osteotomies or modified mcbride procedures with worse outcomes.

This year a patient presented to our residency clinic in the US from Northern Ontario. She was informed she would have to wait more than two years in Ontario for surgical consultation for flatfoot reconstructive surgery. This could be considered an unacceptable time frame for surgical consultation as a posterior tibial tendon tear could occur and her joints could become arthritic while waiting. Some podiatric surgery residents in the US are receiving extensive rearfoot and ankle training that could help with this waitlist. Hospitals could develop requirements based on residency/fellowship logging for podiatrists to obtain rearfoot and ankle privileges and perform these procedures.

In the US, surgical training requirements for podiatry residency have improved. Current requirements for graduation from a 3 year podiatry residency includes first assist with active involvement in the procedure for 80 digital surgeries, 60 first ray surgeries, 45 soft tissue surgeries, 40 other osseous surgeries and 50 rearfoot/ankle surgeries. Further explanation of requirements can be found in document CPME 320 on www.cpme.org. Often residents will double or triple these requirements.

While Ontario already has a model for conservative foot care, there are countries such as Australia and England where non-surgical and surgical podiatrists co-exist. This may be optimal when one considers that there is a high prevalence of foot and ankle problems and some of these improve most with surgical correction.

1. Nix S., Smith M., Vicenzino B., Prevalence of Hallux Valgus in the General Population: A Systematic Review and meta-analysis. *Journal of Foot and Ankle Research*. 2010; 3:21
2. Schneider W., Aigener N., Pinggera, O., Knar K., Chevron Osteotomy in hallux valgus, ten year results of 112 cases. *Journal of Bone and Joint Surgery Br*. 2004; 86B: 1016-20.
3. Faber F, Van Kampen P, Bloembergen M. , Long-term results of Hohmann and Lapidus Procedure for the Correction of Hallux Valgus. *Journal of Bone and Joint Surgery Br*. 2013; 95B: 1222-6.

Submitter 149

My view as a member whose ethical practice is governed by the College of Podiatrists (Canada) includes the following points:

- 1) Podiatrists who MUST have the CPed(C) qualification in order to be members of the above college should be regulated.

This would eliminate those who continue to work in Ontario, bill insurances and call themselves 'podiatrists' but they are certified in the USA not Canada. This would protect the public in Ontario from those who practice via a back door loophole that permits an American certificate to compete with our Canadian standard which are significantly higher.

2) In addition to the above, regulation would further protect the public who suffer from debilitating disorders where incorrect orthotic/pedorthic management could cause harm. Such disorders include Charcot-Marie-Tooth , PVD, Diabets, Charcot Joints, and Arthritis in all its presentations.

3) Canadian Certified Pedorthists are the only Canadian profession who are trained and examined on orthopaedic shoe fitting. Again the regulation of the fitting and customizing of these items would eliminate others who do so often without shoes on the premises. Ill fitting footwear and poorly made orthoses can render harm to the aforementioned groups of patients.

Submitter 150

Being a Certified Pedorthist - it is important for the profession to be regulated to protect the public, to meet the highest standards of care, and to also protect the profession.

Submitter 151

Quality of care for patients is at risk when the prescriber is the same as the dispensing vendor. Orthotist deal with appropriate assessment and hand crafted foot orthoses with the ability to design and fabricate on site. Working based off medical practitioners Rx. We work solely on lower extremity orthoses design and not beyond our scope.

Submitter 152

Definitions are needed as to the scope of practice, products, services and education.

Submitter 153

As a Canadian Certified Pedorthist [C.Ped (C)] practicing in Ontario, I believe we bring a unique set of skills when it comes to foot care. However, the public are still unaware of how C. Ped (C)s can help their issues. As C. Ped (C)s, we bring a very large value to the foot care model in Ontario and is being fairly easily overlooked with the regulations of Chiropractors and Podiatrists in Ontario.

With C. Ped (C)s, we bring forth a very rewarding value not only for the public but also the province of Ontario. Here are a few examples:

- (1) Our treatments are extremely cost effective solutions to avoiding surgery or debilitating injuries
- (2) We're able to provide a full spectrum of care from assessment, to prescription of what treatment is needed, to behind the scenes of fabrication or modification of a shoe or orthoses, which will yield in better patient outcomes and feedback.
- (3) We're widely recognized by large insurance companies to our C. Ped (C) standards set by the College of Pedorthists of Ontario and have often adopted them in their own insurance policies.

Unfortunately, as 'Pedorthists' are unregulated, there are many individuals with the title 'Pedorthists' that may be harmful for the public. 'Canadian Certified Pedorthists' and 'Pedorthist' may sound similar but the educational and placement requirements to achieve either designation is substantially different. C. Ped (C)s go through intensive full-time education, internship, and individual clinical and workshop experience, prior to sitting for a 3-hour written examination and 3-hour practical examination to achieving the designation of C. Ped (C). Hence:

- (1) There is a risk of fraud, as we are not a regulated health profession, the title 'Pedorthist; is not protected from those with inferior qualifications posing as 'Pedorthists'. This is damning to our

profession and it poses a significant risk of harm to our public.

(2) There is a risk of harm, as some type of legislation or registry is required to ensure greater public safety and protection from harm - especially patients in high-risk populations such as those with Diabetes and Arthritis, who benefits from Pedorthic treatments.

Ultimately, my goal as a C. Ped (C) here is to state my current views on our professional expertise, which may be a tremendous value or addition of the profession C. Ped (C) to the already established foot care model of Ontario to safeguard Ontario against fraud or public harm. But with that being said, our main interest as C. Ped (C)s is still the wellbeing of our patients.

Submitter 154

I see there is a great need for foot care in our community. One of the issues is men think it's for women 'pedicures are a girly thing'. There should be more advertisement on the importance for foot care for our male, young and aging population. It's not just a pedicure, but a health issue. We only have two feet and it's important to keep them healthy. I was at a family gathering and the men there aging from 30-60 years old thought it's not manly to get your feet done. They think it's for women. It needs to be put out there that it's not just about pretty feet but that there is another side and that is to keep our feet healthy because they bare the weight of our bodies. Perhaps it should be apart of our check up at the doctor, to become a part of the routine and not just if and when a patient has a complaint. We need our names out there and letters sent so doctors know we're out there.

Submitter 155

In the province of Ontario, it is very frustrating for individuals such as myself who are Doctors of Podiatric Medicine (D.P.M.) forced to be registered and work as someone who has a diploma in chiropody (D.Ch). After completing 4 years of university, I then attended the Ohio College of podiatric medicine at Kent State University for 4 years. Following this, I completed a 3 year residency program in Podiatric Medicine and surgery focusing on primary care, surgery and on patients suffering from the side effects of diabetes. Not only do residents in podiatric medicine look at lower extremity pathology, but we also work side by side with medical doctors and medical residents focusing on all aspects of patient care. Emergency medicine, internal medicine, orthopedic and general surgery, anesthesia and infectious diseases are just a few of the many rotations done as a podiatric medicine resident.

Since deciding to return to Ontario and practice in the city I was raised in, I have been unable to use my training to its fullest extent. I blame this restriction solely on the "Ontario Podiatry Cap." A discriminating cap that does not exist in other provinces. I believe it is unfair and unjust to force any individual trained as a podiatrist to register and work as a chiropodist considering we have never actually trained in chiropody.

The limitation imposed by the chiropody cap, affects all DPMs registered as DChs both professionally and financially. This limitation also affects the quality of care that is accessible to the residents of Ontario. It is difficult for me to understand how the rules and regulations can differ between provinces. For example, I would be registered as a Podiatrist in Alberta and would be able to call myself a Podiatrist, a Doctor and have a much more broad scope of practice then that of Ontario. I believe wholeheartedly that this limitation in ability to practice does influence the quality of care that patients receive. The chiropody cap has also forced many of my highly trained colleagues to seek employment outside of Ontario.

There is a great level of patient confusion regarding the differences between a Podiatrist and Chiropodist that occurs on a regular basis in my practice. After explaining the differences repeatedly to patients, the answer I receive from them is always the same. "This just does not make any sense". The correct thing to do would be for all trained Podiatrists be able to call themselves Podiatrists since that is exactly what we are.

OHIP billing is not of great importance to me, all I want is the ability to use my title that I earned through years of hard work and dedication. I want to be able to display my degree in my office, not hide it away in a box because it says "Podiatrist" on it and not "Chiropodist."

With an aging and increasingly active population, the demand for qualified doctors of podiatric medicine will rise. The only way this demand will be met is by removing the legislative rules that prevent Podiatrists from practicing their full scope.

Thank you for your time and I trust you will do what is right for all citizens of Ontario ensuring them that they are receiving the best possible foot care available to them.

Submitter 156

With the present foot care model being as old as my grandmother's age, who died 20 years ago. I would like to see some changes on Educational and professional level. All other countries (England, Australia and other European countries) have changed and adopted the newer Chiropody / Podiatry co-exist foot care model, Canada with a sister model to England does not feel a need to change to the newer footcare model. what are the obstacles?

1. the 500 or so Podiatrist who would like to maintain their credentials (Dr.) status and do not want to share the name because it will cause public confusion. Infact every day there is atleast one person at my work who wants to know the difference between podiatrist and chiropodist because they thought they were one & the same. Totally understandable, since Podiatrist are U.S educated, graduates from Medical school, paid lot more money for tuitions than Canadian Chiropodists who are Ontario grauduates, sub-medical school (Bachelors degree from University), undergraduates who graduated on OSAP. But does this mean, we (chiropodist) are not good enough to limit foot ulcers, diabetics & Arthritic foot deformities from amputations. Actually more chiropodists work at CHC & FHT & Hospitals than Podiatrist, More Chiropodists treat infected wounds, treat un-hygeinic homeless, refugee and landed immigrants and provide foot health education - hence limiting foot deformities, complications of disabilities and amputations!

2. Chiropody Scope of practice & College of Chiropodists needs to take a long leap forward - foot nurse, osteopaths, orthotists and physiotherapist, some of these professionals are not even regulated are way more advanced and have capabilities that do not limit their practice. Chiropodist on the other hand are limited to professional foot spa centres with Nail, callus, corn, wart - foot care.

3. Laboratory investigation: Chiropodist have a full semester about Radiology, soft-tissue surgeries and dermatology. Chiropodist are not allowed to write an x-ray or send a nail/skin/ tissue sample for lab analysis. They need to send their clients on a wait list for physician's to send them to U/S, X-rays and Labs. Seems fair only if i did not spend 1 full year studying these investigative procedures and getting an A+.

Submitter 157
<p>There are far too many individuals posing as footcare health providers without any formal education. There is also a concern with regulated health care providers (e.g. Physiotherapists and Chiropractors) who do not have specific training with footcare and are still providing and dispensing foot care products (e.g. custom orthotics) without the education or training to do so. From the public's perspective, they are unaware of who the specialists in the industry are (e.g. chiropodists, podiatrists and pedorthists). Because of the lack in overall regulation of these providers, and because most of these services are not covered under OHIP, the regulation of who can provide footcare and footcare products in Ontario is left to be regulated by private insurance providers (e.g. Manulife, Sunlife, etc.).</p> <p>Pedorthists, C.Ped(C), who belong to the College of Pedorthics of Canada and the Pedorthic Association of Canada can substantially reduce the burden on our public healthcare system by provide cost effective treatment options for patients. Often, many patients in Ontario visit their family physician when they are concerned about a medical problem. The role of the family doctor is to act as a 'gatekeeper', providing recommendations and referrals to their patient on effective treatment options by other professionals. These doctors can effectively use Pedorthists to refer their patients to for quality care instead of referring to an orthopedic surgeon or rheumatologist who require long wait times, and only invasive options for care. Pedorthists can provide many effective avenues of non-invasive treatment with short wait times and little burden on our public health care system as most services and covered by private health insurance.</p>
Submitter 158
<p>The model of foot care currently being used in Ontario is episodic, reactive and task oriented primarily in CCAC nursing clinics.</p> <p>There is an urgent need for complex foot and leg wound multidisciplinary clinics that are OHIP funded for patient's to have a holistic assessment and ongoing management at early stages of breakdown.</p>
Submitter 159
<p>Major issue facing practitioners and patients is the fact that the College and the Ontario Podiatric Medical Association appear to be one voice.</p> <p>College consultant appears to the lobbyist for the podiatrist members of the association.</p>
Submitter 160
<ul style="list-style-type: none"> - lack of access to diagnostic testing (X-ray, Ultrasound, biopsy) which inhibits my ability to make an informed decision regarding best treatment plans - primary care providers but unable to diagnosis - the ability prescribe newly released medications - confusion with number of professions with similar scopes - the term Chiropody is an aging term, Chiropodists in Ontario are the only ones in the world using that term; general public uses and understands the term podiatry. <p>unregulated health professions performing unrelated acts which we also perform, however they are not subject to the same restrictive actions (ie. advertising, offering free products/services)</p>
Submitter 161
<p>As a patient who grapples every day with the the challenges of serious foot complications due to diabetes, I have a direct interest in the delivery of foot care in Ontario. In the Summer of 2013, I</p>

spent a total of 44 days in the hospital where I underwent two surgeries involving the amputation of a toe and debridement of gangrenous tissue and subsequent skin grafting. I consider myself one of the 'lucky' ones, as I narrowly avoided a below-knee amputation. Sadly, so many others are not so lucky.

Diabetes is an insidious disease. It starts slowly and stealthily and when left unchecked, it wreaks havoc on the body's systems. It is an enemy that does not let its guard down. It does not go to asleep at night and it doesn't ever take a day off. It is a formidable enemy. 'Amputation' is a word that hangs over my head like the sword of Damocles. Blindness, impotence, dialysis, depression, heart attack and stroke are other such words.

Diabetes has devastated my life. I am only 45 years old. The greatest tragedy of all is that much of it could have been prevented if I had taken control.

These are the watchwords I recommend to the policy makers: AWARENESS, EDUCATION, PREVENTION, EARLY TREATMENT, COMPASSION."

Submitter 162

One of the major issue facing patients, practitioners and other health care professionals with the current health care model in Ontario is the name. Patients/embers of the public are confused by the two terminologies; chiropody and podiatry. The evidence for this is demonstrated by patients and the members of the public asking constantly asking what the difference between a chiropodist and a podiatrist is. This confusion is further fueled by the two members of this profession as they try to portray themselves as the superior practitioner. Ontario is the only jurisdiction in the world to use the terminology chiropody in the world and it is time to move forward in to the 21st century and change the name and keep up with the rest of the world. Having one name would allow for the two professions to work together and advance forward by focusing on research and education.

The model of foot care should be one that fits the Ontario health care system and not that of a foreign model. It should also fit an interprofessional model in line with the Canadian Health care initiatives that can be both private and public. The models proposed such as the one being called Alberta model is modeled similar to the USA model which is not meeting the needs of the public in that country. Careful considering is required by the HPRAC in determining what will best suit the people of Ontario while facilitating the advancement of the profession.

The educational model for this profession should also be considered keeping in mind the needs and the systems that exist in Ontario. Certain gap analysis that have been conducted by the college compares the educational programs in the USA and Canada without any consideration given to the pre-requirements and the scope of practice that currently exists. The podiatry schools in the USA are facing their own problems and one must ask the question why? Careful analysis of the educational models in countries where chiropody/podiatry is practiced should be looked at but the model should be uniquely Ontario that is innovative and progressive. The current chiropody program offered at The Michener Institute is restricted by the chiropody act. If the Act is to change, the school with its experience education and their affiliations with several reputable universities and the hospitals will be able to provide the education required.

Health care funding for foot care should be focused to chiropody/podiatry which will free up other practitioners such as nurses who are over burdened. By doing this these practitioners can focus on the areas where health care system is facing shortage and long wait times.

Submitter 163

I am a Certified Orthotist (CO(c)) and owner of [redacted], a private orthotic clinic with full service on-site fabrication lab in Chatham-Kent. As an Orthotist, I see all types of feet to provide biomechanical correction or simply accommodative support for a wide range of pathologies or injuries. Pediatric to geriatric, diabetic foot ulcers to infants with clubfoot, Orthotists design and fabricate (usually on-site) whatever device is required to treat the patient. We often work in collaboration with chiropodists, podiatrists or orthopedic surgeons who are also treating the patient.

Lower extremity orthotic treatments – ranging from simple foot orthoses (FO) to Custom CROW AFO (Charcot Reducing Orthotic Walker) to a Knee-Ankle-Foot-Orthosis (KAFO) – begin with a full biomechanical and gait assessment and a cast of the patient’s foot (or leg if required). This negative cast is then filled with plaster to create a 3-D model of the body segment. The positive cast is modified to correct any mechanical issues and/or unload ulcerated areas or bony prominences which are at risk of ulceration. We thermoform material under vacuum around this 3-D cast to create the device that is needed. On-site fabrication allows us to provide 100% custom orthoses to every patient. These are designed and molded created using various foams, plastic, cork or even leather depending on what the treatment requires. We also do custom modifications to footwear – external lift, wedges, buttresses or even splitting the shoe to expand the internal dimensions to accommodate a pathological foot. When required, we cast for custom shoes which can then be central fabricated over the cast of the foot.

There are 99 Certified Orthotists in Ontario – some in hospitals, some in private clinics. Since we are a small, often misunderstood group, I wanted to give a brief summary of our background and training for you to better understand our role in the “Foot Care Model”. All Orthotists study Prosthetics and Orthotics as a post-graduate 2-year diploma. Accepted degrees include Human Kinetics, Kinesiology, Engineering, Nursing, Biomedical Engineering or comparable. Once graduated from the 2 year diploma we complete a 2 year residency as an Orthotist (or Prosthetist) and then complete 3-day Board exams to become a fully Certified Orthotist (CO(c)). We learn how to design and fabricate all types or orthotic (and prosthetic) devices from helmets to foot orthoses. Foot treatments represent approximately 40-60% of an average clinic’s patients. In many cases we are the only provider who assesses for, designs, fabricates and adjusts foot orthoses on-site. Most other providers assess, cast and send to a central fabricator to be made and, if necessary, send back to fabricator to adjust. Since we have all the necessary equipment (ovens, vacuums, grinders etc) and materials (EVA foam, plastic, carbon fibre, cork, rubber) on-site we are able to provide truly custom service to every patient.

The question at hand “What do we think of the current foot care model?” is an extremely broad question. Initially there was some confusion about what the current foot model is – until it was explained that there is no documentation, it is what we do every day. With this understanding I feel there are many improvements that can be made to improve foot care in Ontario. As an Orthotist, I will first discuss our portion of the foot care model – the provision of Foot Orthoses (FO’s). These are mistakenly called “Orthotics” or “Foot Orthotics” – Orthotics is an adjective

and refers to the entire field, orthosis(es) is the noun.

Since Foot Orthoses are not covered by OHIP or ADP the entire industry is unregulated, except by rules the third party insurers enforce. This lack of regulation has resulted in a wide variety of people “selling” FO’s rather than treating patients. In the vast majority of cases a mold is taken and sent to a central fabricator and then the completed FO is returned to the seller and dispensed to the patient. In most cases the seller has no ability to adjust the FO’s, either they have no equipment, no materials and / or no training in how to adjust appropriately. In addition to being unable to adjust the finished product, they have no training in casting position and typically use a step-in foam box to obtain the negative mold. This technique is quick and seems very simple but it is actually very difficult to obtain a good, biomechanically appropriate position while weight bearing especially when the patient is the one in control of the foot. This technique is appropriate in very specific situations but patient selection is important and practitioner experience is critical. The foam box impression is commonly used for accommodative (non-corrective) FO’s where the foot is easily controlled (possibly rigid) and correction is not required. Diabetic patients can sometimes be done using this technique. Many times foam box impression is the ONLY casting option a provider uses for all patients, as a result the foot orthoses are often not appropriate or effective. In other cases a computerized pressure mat is used. This uses 2-D data and applies algorithms to extrapolate the 3-D arch shape. This technique can be useful for mildly affected feet but for serious pathologies it is completely inappropriate. The most appropriate technique is a non-weight bearing sub-talar neutral or, if warranted, uncorrected position. This is usually done using plaster of Paris with the patient lying face down with the feet hanging over the end of the bed and the Orthotist/practitioner controlling the foot and arch development to obtain an accurate representation of the most congruent and stable foot position. This captures any malalignment between the rearfoot and forefoot which cause many chronic biomechanical foot and lower extremity issues. There are a wide variety of professions aside from Orthotists who are regularly dispensing FO’s including chiropractors, podiatrists, pedorthists, physiotherapists, kinesiologists etc. In my experience, the best FO’s are from practitioners who have casting technique training AND have more than one technique available to them. The gold standard is “non-weightbearing sub-talar neutral” however this position may be difficult for geriatric or disabled patients. Any qualified practitioner should be able to use this technique with the average person. As indicated, foam box impression can be used on an appropriate patient. These 2 techniques require extensive anatomical knowledge to perform effectively with consistent patient outcomes. Any facility which only uses a computer mat needs to be very selective of their patient type – the problem is that most providers who only use the pressure mat are often not qualified to determine whether it is appropriate for a specific patient and often try to treat all patients the same, including those with serious pathological conditions who are far too complex for their skill set. These facilities are more interested in making the sale then they are in referring a complex case to a “competitor”. The foot is incredibly complex and, as with many complex issues, it is a case of “the more you know – the more you realize you don’t know”, unfortunately, being unregulated, some providers lack the training to even realize they should not be attempting to treat a certain patient. In an attempt to eliminate unqualified providers, some insurance companies are now requiring the non-weight bearing plaster cast technique. Unfortunately sometimes other techniques are warranted and, in the hands of a well trained professional, can be very effective. In the worst case scenario, a provider blatantly lies about which technique they are using – since the patient is unaware of

differences in terminology they can get away with this. Another indicator of the qualifications of a provider is whether they have the ability to adjust and modify the FO's on-site. On-site fabrication is also optimal but understandably difficult for some qualified practitioners. At the very least a provider needs to be able assess the dynamic function (gait analysis) of an FO and adjust the FO as necessary. If a "seller" is not capable of on-site adjustment or does not have the ability to determine the efficacy of the treatment, they should not be dispensing to the public. As I mentioned earlier – there are many qualified professionals treating patients orthotically. Even within one regulated field (ie Chiropractors or Physiotherapists) there are some providers who are more qualified than others. Only Pedorthotists and Orthotists are specifically trained in the casting, fabrication and design processes involved with orthotic treatment for ALL types of patients. In general I find that the most successful outcomes are from practitioners with training in, and access to different casting techniques as well as the ability to adjust FO's on-site. If a provider cannot meet both of these conditions then they may not be able to treat patients appropriately, and may not even realize when they are jeopardizing patient safety. Due to the wide variety of providers it may be necessary to become a "Licensed Foot Orthoses Provider" and be able to provide proof of the necessary on-site equipment and previous training. A way to "regulate" this may be to indirectly fund the devices through reimbursement directly to the patient as long as the patient completes the necessary paperwork with questions regarding casting technique, follow-ups, adjustments and ultimate satisfaction with the treatment. This would eliminate fraudulent billing by a vendor and it would make the patient more responsible for their treatment as well as providing valuable data on outcome measures. Provision of orthoses is just one small part of the foot care model, foot care treatment needs to start in the GP's office during an annual physical. Doctor's have always been reluctant to remove shoes and socks to visually inspect the feet, I feel this is due to the lack of understanding of what the next step should be if they suspect a problem. I am hopeful that this review of the Ontario Foot Care model will result in more Doctor's being proactive about foot care and being provided a more complete database of other qualified medical professionals who can treat an issue. In order to create protocols and standards of practice we must also consider the types of patients we treat. One of the primary considerations is diabetic vs. non-diabetic. Due to obvious dangers specific to diabetes it is very important to acknowledge this diagnosis and the inevitable changes it leads to. One of the most insidious side effects of diabetes is the loss of sensation in the extremities. In many cases patients are not fully aware that they are losing this sensation and as a result the characteristics of their skin and its healing properties are changing and deteriorating. Doctors may disregard certain signs because the patient doesn't report significant pain or discomfort. The only way to ascertain that the feet are actually healthy is to visually inspect them for and test for sensory loss with a Semmes-Weinstein filament. Even if the patient reports no issues, if there is a chronic callous this is a major risk factor for amputation and should be examined by a chiroprapist and/or orthotist or pedorthist to determine if there is a biomechanical malalignment responsible for the callous. Callousing is the body's natural defense mechanism to a pathological force, FO's can help correct the cause and thereby eliminate the need for constant treatment of the patient. Even if a callous and potential underlying ulcer is resolved, the biomechanical reason for the callous needs to be addressed and unloaded in order to prevent the inevitable return. Unloading and corrective FO's become mandatory for diabetics with any type of callousing. These FO's need to be reviewed regularly by the provider to ensure in unloading is still effective, optimally this would be done with the Orthotist and Chiroprapist working together in the same facility to ensure the patient is never without the offloading device. An active ulcer requires

Careful monitoring to heal properly and the patient needs to be educated in the risks of walking or weightbearing unprotected – 10 days of successful healing can be undone in minutes if the patient walks 10 steps barefoot on the ulcer. Unfortunately since the patient usually can't feel the site of the ulcer they do not realize how damaging a short trip to the bathroom can be. Once the ulcer has healed it is equally critical to ensure the patient is regularly monitored to prevent re-occurrence. Anyone who has had an ulcer should always use custom foot orthotics to correct the underlying mechanical issue. There are many specific protocols which will need to be created to ensure at-risk patients are being monitored and treated appropriately – pro-active treatment is the most cost effective way for these preventable ulcers which may lead to amputation. Education of the Doctors and medical professionals of the qualified Foot Care Specialists in their region is critical – simply telling someone to have their nails and callouses treated is not enough when the patient has no sense of pain and therefore no sense of urgency of their condition. I appreciate the opportunity to comment on the upcoming Foot Model, I would welcome the opportunity to be more involved if possible. [Name redacted] opened in 2010 and one of my long term goals is to have a full service Diabetic Foot Care Centre on-site. My clinic is 3600 sqft and is perfectly suited for a Chiropody office on-site. This would allow Orhtotists and Chiropodists to work together to speed healing and reduce the severity of ulcers. I have been in discussion with the LHIN as well as Chatham-Kent to try and make this a reality. I would like to invite anyone from HPRAC to visit my facility to see exactly how this would work and review the cost-effectiveness of this pro-active approach. I am confident that the future of diabetic footcare will be changing in the near future, I am hoping that funding will be available and will ultimately reduce the long term costs of chronic foot conditions. If you have any questions feel free to call or e-mail me.

Submitter 164

To answer this broad question I feel I need to give background information on myself as an Ontario practitioner and my experiences with our health care system. I would like to draw attention to many issues that do not allow me to practice to my full abilities and thus treat the Ontario public as I would in another Canadian province. I will bring to the advisory council some important aspects that may not have been brought to your attention but should be further investigated.

I would say I have some unique experiences as I work in a multitude of health settings and see such a variety of patients from basic to advanced practice complex patients. I urge the person who is reading this to please help me help my patients by allowing me to provide better care.

As a chiropodist currently practising podiatric medicine in Ontario I see on average 25 to 30 patients per day. I currently work in private practice, in hospital and in an Ontario community health centre. My youngest patient has been 8 months old and my oldest patient was 105 years old. I currently work 6 days a week approximately 55 hours per week. Each setting I work in is very different and each has its own complications due to the current limitations of the Ontario foot-care model. I will do my best to explain the obstacles at each level that are causing barriers to access of care for Ontarian's and the inability for a Canadian and international trained medical professional to practice within my full scope, or as I would in another Canadian province.

Background

As far as I can tell the current issues with the current foot care model started as funded hospital

based programs closed or eliminated the general foot care offered by its global budgets. In this early setting the chiropodist worked alongside physicians and their intervention and collaboration was readily available when needed for patients, i.e. diagnostic testing, and “advanced practice”. With the closure of these funded programs, there has been the loss of this direct physician collaboration. Although some have re-opened as a fee for service program examples included Toronto East General and Rouge Valley Centenary Hospitals, the frame work that the government had set for its foot care model is no longer in place and thus the chiropodist/podiatrist cannot work to their full potential. Foot care was pushed into a private setting that has now caused a cascade effect. The loss of a team approach i.e. working within a primary health care team has caused barriers for the practitioner in private office settings, hospital, community health centres and family health care teams where there is no delegation of acts set in place. This means delays to health care, duplication of services and waste of tax dollars.

I will elaborate on each but I agree with the majority of my colleagues, associations and the Ontario College of chiropodists proposal. More specifically I am referring to our scope of practice that allows us to order forms of energy, and labs/specimens, however, there is no fee schedule set up by the government to cover these procedures. There is confusion as I hold a four year degree in podiatric medicine and the Healing Arts Radiation protection Act states

6. (1) No person shall operate an X-ray machine for the irradiation of a human being unless the irradiation has been prescribed by,
(a) a legally qualified medical practitioner;
(b) a member of the Royal College of Dental Surgeons of Ontario;
(c) a member of the College of Chiropodists of Ontario who has been continuously registered as a chiropodist under the Chiropody Act and the Chiropody Act, 1991 since before November 1, 1980 or who is a graduate of a four-year course of instruction in chiropody;”

However, if I were to try and access the ability to order x-rays or forms of energy the tests would not be covered by OHIP and the patient or I would have to pay out of pocket.

Another major obstacle is the inability to do a referral to a specialist such as neurologist, orthopedic surgeon, dermatologist or even Community Care Access Centres due to the current OHIP structure of billing. In the standards of practice set out by the College of Chiropodists it states” consultation with and/or referral to another health professional shall be made when the patient's condition is beyond the member's scope of practice, or where the member deems the referral/consultation to be in the best interest of the patient.” I currently cannot do this because the OHIP system as it is does not allow me this privilege. Further, it does not make sense that the patient is sent to me for collection of a biopsy of skin or nail but I am unable to send them to the laboratory to get tested? Please keep in mind this can happen in each setting we spoke about, hospital, private practice, or community health centre.

In most instances the patient is referred to me from a medical physician for my expertise. I provide the assessment, diagnosis, and treatment to my patient. However, should I require further testing or specialist referral I am currently impeded from doing so myself as a chiropodist. Rather, I have to refer back to the family physician, walk-in doctor, or the emergency room depending on the acuity of the situation, to request for further labs or diagnostic imaging or

emergent procedure. If I see a wound in my private office, it makes it very hard to provide the proper treatment if I am unable to order an x-ray /bone scan to rule out osteomyelitis if warranted. By having to refer back to the primary care physician, there is more delay and the patient can be put at risk. This delay and can cause loss of limb or even death. If I am properly able to treat this patient, we may be able to avoid an emergency room visit. As mentioned, under the current system I cannot refer a patient directly to CCAC for wound care in the home. Rather, I have to refer back to the family physician who can then refer the patient to CCAC. This is a duplication in the system, not only does it take away from treating time for the various health professionals involved but is a misuse of tax dollars and again causes delay in proper patient care. In summary, if I collect a biopsy it does not make sense for me to hand the specimen back to my patient to take to his/her family doctor to send out to a lab or get a co-signature for x-ray or CCAC.

Educational background/Titles My education and credentials: I am a chiroprapist graduated from the Michener Institute for Applied Health Science with an advanced scope of practice diploma i.e. a newer graduate as the school now offers a more primary care podiatric physician education. I also have graduated from a Canadian university and hold several undergraduate degrees, one of which is also in another regulated health discipline. I had to leave Canada and go to Europe to obtain a B. Sc. degree in podiatric medicine from a European university. I hold licences in two other Canadian provinces where I am known as a podiatrist and have the title 'Doctor'. Although my credentials are exactly the same, I am not recognised as a doctor as in every other Canadian province. This is unfair to me and adds to the confusion of the general public. As I have chosen to practise in Ontario as a chiroprapist I am now unable to enter provinces such as Alberta, Quebec and British Columbia. This is unfair as Ontario is the last province to change the title and the use of the restricted title 'Doctor'. Please consider uniting chiropody and podiatry into one profession like every Canadian province where chiroprapists are known as a podiatrist and the profession is Podiatry. Please consider the use of Doctor as this change will lessen confusion for the public and provide wider acceptance by the medical community which in turn will provide better care to our patients. The program in Ontario should be moved into a university degree setting, and bridging programs set into place before legislation changes occur so the Ontario trained chiroprapists have the ability to upgrade their skill set as the majority of Ontarians are seen by chiroprapists. This will allow interprovincial movement back into the above stated provinces.

Accesses to Care Currently Ontario Community Health Centres (CHCs) and Family Health Care Teams (FHC) provide free or OHIP funded foot-care. Each centre sets up entrance criteria for its foot care program which are usually composed of chiroprapists and some nursing for delivery of care. Every CHCs mandate may be slightly different depending on the specific community they are serving. Most established CHC's have wait lists or are overwhelmed with patients. This is because many hospitals have closed their funded foot care but the demand is still high for funded (OHIP) service. One major problem with this model is that some CHC's allow entrance to the foot-care program for individuals that should be seen in a private practice or a non-funded setting. By this I mean that the individual's health status accessing the free service does not warrant the OHIP covered service or the individual has private health care coverage which would pay for the above service. The covered service should be similar to that of optometry, physiotherapy and dentistry. The ministry of health should mandate who qualifies for the service and standardise this across all OHIP funded services i.e. FHT/CHC. The service should be available to those at most risk, patients with complex medical needs, and those who have no private insurance. I have no doubt in my mind that the government had that intention when it funded such services in hospital, FHT and CHC

models of care. The focus should be the most at risk and those who cannot afford care. There should be education and prevention but there needs to be more accountability of patient demographics using OHIP funded services. As well, CCAC should be working hand in hand with funded sites to provided funded service to CCAC clients. If these sites can better focus on high needs patients then there would be less burden on hospital and even emergency room admissions. Finally, I believe hospitals should offer some form of foot care, at least for high risk patients such as diabetics and dialysis patients. I have treated numerous patients that attend dialysis weekly but have never had their feet checked by the hospital. Hospitals get global funding for foot-care but it's not being directed to the right programs. The hospitals that get this funding should be held accountable to provide foot-care services. As for hospitals that offer foot-care, The Hospital Act needs to be amended to allow Chiropodists/Podiatrist to become better collaborators in health care. If I could function more like the podiatric physician I am, I could take wait times down for patients waiting to see a dermatologist or plastic surgeon for wound care on the foot and ankle, provide bone surgery and help lessen the wait times for orthopedic surgeons, or work in emergency departments to help treat wounds like they do at St Michaels's Hospital and Women's College Hospital. If you look at statistics of emergency departments related to diabetes, you will uncover that about 40-60% are related to foot infections such as cellulitis and ulcer care. A lot can be achieved by prevention i.e. being seen at a CHC or FHT when there are proper channels for communication and continuity of care. By mandating who can be seen at these funded programs wait times can be lessened by making sure the programs are running as they were intended. Summary The current foot care model needs adjustment so that the province of Ontario may handle the aging population and increased diabetic demands by using "Podiatrist" Chiropodists to their full scope. By making changes to the title, clarifying and making changes to the Ontario lab specimens act, and Healing Arts Radiation Protection act, the health minister will be able to decrease wait times in emergency departments, alleviate pressure of family and orthopedic physicians, and provide better health care and access to already funded programs. Making these changes makes economic sense, but it also provides better outcomes for patients and a better more efficient health system for Ontarians. It will also bring Ontario into line with other Canadian provinces. Thank you for the opportunity to express my thoughts to your question.

Submitter 165

The current foot care model in Ontario is inadequate to say the least.

Patient issues: Limited access to quality care because of 1)out of pocket cost/no OHIP funding 2)government regulations limiting superiorly trained DPMs from practicing to their full potential 3)No DPM programs in Canada (English speaking) 4)The limited number of foot and ankle orthopedists 5)The limited scope of a 'Chiropodist'

Practitioner issues: 1)No one knows what a Chiropodist is, or even how to pronounce their title! 2) DPMs that have graduated in the last two decades have 1, 2 or 3 years residency training and are the equivalent to (if not better trained than) Foot & Ankle Orthopedists, yet are treated as diploma graduates in Ontario and cannot call themselves a doctor?? This is a joke, except its not funny. 3)The lack of knowledge on the part of family physicians as to when to refer to a foot specialist and what they can do.

The sad reality is that in the world today every 20 seconds someone is having a lower limb

amputation as a result of diabetes and currently Canada has a population of 2 million diabetics yet, when it comes to foot care, Ontario has dropped the ball. We are so far from what needs to take place that this is surely an uphill battle. I suggest starting with acknowledging DPMs for what they are- DOCTORS of PODIATRIC MEDICINE. Patients, family physicians, etc should also become aware. Then I would motivate U of A (or McMaster) to go ahead with their plan of opening a DPM program. Certainly there is a place for Chiropodists in Ontario foot care but I do not think the answer is to call everyone a Chiropodist or call everyone a Podiatrist. Confusing! Why don't we call foot care nurses Chiropodists as well, or Chiropractors Orthopedists. I mean, we have to be realistic. If we want better care for Ontarians, there is no easy answer. We address the specialists available, define their role, assist patients with funding and access, develop a Canadian training program (at least in the near future) and address the incompetency of the current Chiropody Regulatory College.

Table 2: Responses from organizations

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

Canadian Podiatric Medical Association

The Canadian Podiatric Medical Association (CPMA) is pleased to provide a response to the request for commentary from the Health Professions Regulatory Advisory Council (HPRAC) regarding Ontario's current foot care model.

Established in 1926, the CPMA is the national professional association that represents Canada's premier foot practitioners – podiatric physicians and surgeons. The majority of our members hold the degree of Doctor of Podiatric Medicine (D.P.M.), while a few hold the degree of Bachelor of Honours in Podiatry or Podiatric Medicine (B.Sc. Hons. in Podiatry).

The CPMA applauds the Government of Ontario for initiating the HPRAC process regarding the current situation of foot practitioners in Ontario. We are very supportive of the College of Chiropodists of Ontario's initiative to convert to a podiatry model of foot care delivery in Ontario and to use the podiatry models operating in British Columbia and Alberta as the standards that should be implemented in Ontario. Full scope podiatry models (defined as a four year Doctor of Podiatric Medicine Degree from an accredited institution, completion of national board exams and at least two years of residency) exist in Alberta and British Columbia. It is our understanding through our members in Manitoba that this province has also initiated a process to adopt a full-scope podiatry model. The CPMA believes that full scope podiatry models have served patients and provincial healthcare systems well and are also complementary to and supportive of modern healthcare delivery priorities, objectives and paradigms.

It is our understanding that the Government of Ontario adopted the chiropody model of the United Kingdom in the late 1970s as a way to deal with its current health care program. Although a podiatry model was already underway in Ontario, the provincial government at that time initiated a cap to disallow any future Doctors of Podiatric Medicine being able to practice to their full scope. This decision has created many detrimental impacts for the province and for podiatric medicine across Canada. For example, the limited chiropody scope of practice significantly limits foot practitioners to provide a reasonable continuum of care to their patients. It also keeps Doctors of Podiatric Medicine from using their full competencies, which significantly wastes health resources and creates significant added costs to Ontario's health system through circular referrals, duplication of effort and delayed diagnosis and treatment.

The peculiar situation of foot care in Ontario also causes unnecessary complications and delays at the national level. One key example was the drafting and eventual proclamation of the New Classes of Practitioners Regulations. These regulations were delayed for several years to accommodate the situation in Ontario. That delay not only held up access to clinically important drugs for podiatrists, but also for midwives and nurse practitioners.

Another prime example of the confusion across Canada resulting from the Ontario situation is

the meetings that the CPMA has with insurance companies. So often we have to explain the differences between Doctors of Podiatric Medicine and chiropodists, including the education and scope of practice. When the CPMA first started meeting with insurance companies, we were surprised by how surprised the insurance companies were that DPMs outside of Ontario could perform the full scope of practice on patients. This was also the same reaction when the CPMA met with the Royal Canadian Mounted Police and other personnel-heavy companies and organizations.

The decision to prohibit the registration of Doctors of Podiatric Medicine after July 31, 1993, was both frustrating and disturbing, as this decision had a profound impact on the future of podiatric medicine in Canada. In addition to cutting growth of the DPM profession in Ontario, it forced graduates to locate to provinces outside of their home province and away from their families.

The current Ontario model has also impacted the ability to create a university-level English-speaking podiatry education program at an accredited institution. Although Quebec has been able to develop a podiatric medicine program, attempts by other provinces (e.g. Alberta) have been hindered by the situation in Ontario as graduates of the program would not be allowed to practice full scope podiatry in Ontario. The federal government's Agreement on Internal Trade was also obstructed by the Ontario situation.

As this letter points out, the current chiropody/podiatry model is ineffective, costly and neglectful of providing Ontario residents the full continuum of podiatric medicine. Especially with the rapid growth of diabetes, the CPMA strongly encourages HPRAC and Ontario Health Care to move to a full-scope podiatry model, such as that in place in Alberta and British Columbia.

Feet for Life Medical Foot Care Ltd. & Feet for Life School of Podiatric Nursing Inc.

There is a strong need for our aging population to have easy access to Regulated Health Professionals specialized in Podiatry. It is also important for the health professional to understand the existing health related history of a patients to perform competent assessments and formulate a plan of care. Nurses have the knowledge skill and judgment to properly assess the needs of their patients and provided optimal care including patient education. Nurses have been the forefront of health care for decades. They have the ability and strong educational background to specialize in the field of Foot Care and Podiatry. Providing this care is also having the insight into lower limb issues and possible systemic issues that can effect the lower limbs. Wound care is also a specialty of Nursing that is of assistance and benefit to any Nurse practicing in the field of Foot and lower limb care. From what I understand 'Podiatrist' specialize in mostly bone surgery's and more complicated bio-mechanical issues. It appears Chiropodists have a bone to pick with Nurses and are trying to discount our years of education and long standing history in Canadian Health Care. This is not acceptable.

First Choice Foot Care

I am a nurse who works in the community doing both foot care clinics and home visits. Here are the issues as I see them:

- 1) Infection Control issues: are tools being properly cleaned, disinfected, sterilized with the testing of autoclaves happening regularly
- 2) Cost: most of my clients are seniors or have severe disabilities and pay for the service out of

pocket- it's a difficult balance to make the service worthwhile for the client and profitable for myself/employer

3) Regulation of foot care training- nurses who practice foot care are practicing with all kinds of training , from as short as a weekend to as long as 150 hours. That needs to be addressed and presented to clients.

4) Chiropody/Podiatry/Nursing- can all of these (and perhaps others) practice foot care?

Giselle's Foot Care

I am an independent foot care nurse providing care to Residents in my area and I provide in home care meaning that I do foot care in the person's home. I also go to long term care homes, retirement homes, group homes and the local hospital.

I have researched 'The current model of foot care in Ontario' and could not find it online. I am not aware there was a current model of foot care in Ontario and if there isn't one, my view is that there should be a model developed that is accessible and easy to find for all of us. I have my own views on how foot care should be provided which I developed through my nursing education, existing laws concerning nursing foot care, my patients' request and my own experience doing foot care. I think a model would help new foot care nurses to develop their skills and understand better what is required in foot care. The model will help patients and their loved ones understand what we do and what they can expect from foot care. The model (if followed) would also help to regulate the profession and ultimately, foot care nurses would be recognized as professionals rather than just toe nail clippers.

When it comes to providing foot care, I believe that people have a choice, everyone's concerns should be heard and people's preferences should be respected. Proper sterilization and safety of the patient is very important to me which is why I take my time when I provide care. I think foot care should be accessible and patients should not have to wait for care which is why I provide flexible scheduling. I approach each patient individually as everyone is unique and these are the core values of my practice.

My main issue regarding foot care is in the context of long term care homes and retirement homes. Policies and laws need to be developed about how such facilities are required to act when a Resident needs foot care. According to Resident Bill of Rights, people have a right to choose who they want as a foot care nurse. Furthermore, when a Resident requires a foot nurse to come in to their own room to provide care, the facility should not have a right to charge the nurse for coming in to provide care. I find that facilities hires one-two nurses, have a business contract with them where the facility makes a cut. Some people say, 'Oh it's just business' and 'It's for liability reasons we have our foot care nurse' or 'We have to charge for the towels'.

Unfortunately, this is very unethical in many ways. First of all, the facility is trying to make a profit out older adults who can't provide their own foot care due to physical limitations. Portion of the money paid to the nurse for foot care is taken away by the establishment for reasons that really don't seam logical to me because I am doing all the work and it's the Resident's money which is intended for foot care only. I know two nurses who were asked to pay for parking when parking is free for others. This sounds very discriminatory, disrespectful and just shows how facilities try to take money away from foot nurses. Foot nurses are visitors of the Residents as Residents have a right to have their visitors parking for free as they are paying for rent already which includes access to visitors parking. I had one retirement home trying to force me to rent

their space, pay for their towels and asked me to do over 13 clients a day. From my point of view, you can't always do this high number of clients unless you rush and don't do a thorough job. Some older adults are cognitively impaired which means that you need to take your time meaning that it can take an hour for me to do a proper job. Unfortunately, some foot nurses have no problem with this picture which is also part of the problem. They are not only trying to squeeze money out of the elderly, they sign up people for foot care telling them when they are scheduled and who will provide care for them. This does not give people the right to choose and does not provide people much options. My main reason for telling you the challenges I am facing is because I believe that if you implement laws how these facilities are required act, I would not have issues with facilities trying to take the money that I rightfully earn and the money belonging to the Residents. Another major problem is that facilities prevent Residents access to other foot care nurses' contact by not informing them that there are other foot nurses available because they want to fill their 'contracted' nurse so they can make their cut. This is ethically wrong and I believe this is elder abuse which must be stopped. The only way this can be stopped is if you develop laws that they are not allowed to charge foot care nurses to provide care.

Independent Business Specialty Interest Group of the RPNAO

Any nurses whether RNs or RPNs with advanced foot care training need to be able to continue to provide foot care to the public including any initial consultation through to provision of patient care plans and implementation. There are overlaps in scope of practice between chiropody, podiatry and nursing and the demand for foot care services provided by nurses must continue as does their referral to chiropody or podiatry when and if foot care should fall beyond their scope of practice. This is the current model of care that should continue. This allows for the public to have access to providers regulated under RHPA and their health colleges.

The Michener Institute of Applied Health Sciences

The Michener Institute has been graduating Chiropodists since 2003. The program's curriculum is fully cross referenced to the College of Chiropodists of Ontario's (COCOO) published Standards. The program routinely incorporates continuous quality improvement measures to ensure graduates meet expectations of the public and COCOO. In 2006 the education program changed its admission requirements and all entrants now require a Bachelor of Science degree. A Program Advisory Council informs the program and includes representation from diverse professionals such as Family Physicians, Podiatrists, and Chiropodists.

The general public is more aware of the title Podiatrist as being a foot care specialist than the title Chiropodist. A unified title may be more meaningful to the public.

Michener supports the Chiropody and Podiatry community working together to establish an agreed Canadian National Competency Profile (NCP). This document would support the members in their expectations and standardize care across the country to an understood Canadian level and standard. An NCP would also facilitate an accreditation process to help educational facilities prepare students for the future of the profession. Development of these expectations would help provide a solid educational base upon which curriculum could be cross-referenced and further certification and continuing education offered. Michener continues to welcome opportunities to support the profession in preparing new practitioners and existing regulated healthcare professionals to continue to meet their continuous education expectations.

North East Local Health Integration Network

Ontario does not have a foot care model. There are issues with:

Equitable Access: There are 26 Chiropodists/Podiatrists in Northeastern Ontario covering 500,000 square km of land and the highest incidence of soft tissue foot infections and leg ulcers across the Province. The 26 professionals are located in only 7 of the communities in the region requiring patients to travel significant distances to access foot care and management. Foot care nurses are also at a premium so the assessments and early/basic interventions aren't being provided. When patients get to a Chiropodist it is often too late. When patients are fortunate to have care from a Chiropodist, the capacity for ongoing follow up in the community is also missing.

Cost: If patients have the opportunity to access foot care, only 2 of Chiropodists are compensated on an alternate payment plan through a hospital program and are able to provide the services without cost to the patient. Patients are required to pay out of pocket and the sociodemographic of patients in this region are such that they can not afford foot care and therefore opt not to receive it. An amputation is a lower cost to the patient than Chiropodist intervention.

First Nations: With a high presence of First Nations people (on and off reserve), the incidence and prevalence of diabetes and related foot care ulcers is double. When Health Canada withdrew funding for foot care in August 2013, this further compounded the issues described above.

North Shore Family Health Team

Access to foot care and cost is a barrier in my community. I would like to be able to have the budget or have training subsidized to offer free foot care for those at high risk in my role as RPN at a family health team and also as my role as certified diabetes educator and coordinator with the North Shore Diabetes Program. We are lacking in both trained advanced foot care providers in my small town and also in funding to assist people without health insurance that covers foot care. We do have 2 nurses trained in foot care but they are extremely busy and it is becoming hard to keep up with the demand.

Ontario Community Health Centre (unspecified)

Demand for footcare is very high.

One of the most requested services at our centre
internal and external requests daily as our services are provided at no charge vis CHC model of care

We have a waiting list for new patients

Chiropodists are doctors who provide excellent care to a wide number of patient populations

We wish the government to allow them to practice to their full scope

The current footcare system is missing links to allow Chiropodists and Podiatrists to practice to their full scope.

Our team does wonderful work for in teaching, not only chiropody students, but nursing, social work and family medicine.

Our chiropodists manage complex patients and are able to practice better under delegated acts which allow them to practice to their full scope. When doing so they are able to help take the burden off our Family doctors and Nurse practitioners. If they did not have delegated acts from our physicians ie the ability to order x-ray's blood work, make OHIP referrals, ultrasound and vascular testing all these clients would have to be seen by physicians or our NP's. I can tell you

that would slow down our ability to see patients. I think it a sad that we have canadian trained doctors that can not practice fully in our health care system.

Ontario Medical Association, Sport & Exercise Medicine Section

There is a major problem in this province with wait times for Foot and Ankle Surgery in Orthopaedics. In the Ottawa area it ranges from 3-5 years. Many of the surgeons have agreed to only see hind foot pathology.

I often involve allied health care professionals in the development of custom made orthotics and custom foot wear.

I occasionally refer to Podiatry for minor procedures such as resection of Morton's Neuroma or bunion correction.

As chair of the Sport and Exercise Medicine Section of the OMA we have discussed these issues and feel that a Foot & Ankle Intake clinic would be a valuable asset, similar to the Joint assessment clinics for Joint replacements.

The intake clinic should be made up of a multidisciplinary team including a Sport Medicine Physician, Physiotherapist and chiropodist or podiatrist working in collaboration with a local orthopaedic surgeon to assist with quicker access to care and reasonable referrals to surgery and to assist with wait lists.

Ontario Physiotherapy Association

Introduction:

The Ontario Physiotherapy Association (OPA) is the professional association representing over 5500 members across Ontario including physiotherapists, physiotherapy students and physiotherapist assistants. The OPA is pleased to participate and to present our thoughts regarding this initial consultation on the current model of foot care in Ontario.

Though it is unclear what the Health Professional Regulatory Advisory Council (HPRAC) means by an "Ontario foot care model", the OPA appreciates this opportunity to discuss the current state of foot care and elements that should be considered as these consultations continue.

Our views on the current state of foot care in Ontario; the major issues facing patients, practitioners and others:

Ontario's 'current foot care model' is multidisciplinary and multifaceted along a continuum of care. This foot care 'model' is not defined by legislation or policy, cannot be said to be integrated or comprehensive and has evolved over time and continues to evolve in response to health care system demands and the needs and choices of patients. The OPA suggests that there is no current, organized or easily identifiable model for foot care in Ontario. Having said that, the growth of the senior population coupled with the increased incidence of chronic diseases such as diabetes, arthritis, cancer and peripheral vascular disease that often manifest themselves in the foot or ankle can be expected to put increased pressure on the available practitioner resources. Ontario needs to ready itself for that eventuality.

Elements of foot and ankle care in Ontario have also, in recent years, been an area of growth for non-regulated providers, especially in the case of orthotics and specialized footwear. In many cases the “storefront” approach can be confusing, or even misleading, and difficult to navigate for patients seeking valid and appropriate health care in this area. With the cost of orthotics on the rise, more emphasis on the importance of relying on regulated health professionals for complex and involved cases would allow patients to make more informed choices in their own best interest. Better consumer protection (not RHPA regulation) also appears necessary to protect the public against unqualified or fraudulent orthotics dispensers.

Many regulated health professions have foot and ankle assessment and treatment as part of their scopes of practice and play important roles in the overall “model” of care in Ontario. The foot and ankle complex is not isolated from conditions, injuries and functional issues affecting the entire person and is also subject to specific impairments and issues that, in turn, impact overall function. Regulated professionals such as physiotherapists, who have specialized competencies and knowledge of the foot and ankle as well as a holistic approach to the musculoskeletal, neurological, cardiorespiratory and integumentary systems of the whole body, are well-positioned to provide needed care in this area, either as sole providers of care or as part of larger multidisciplinary teams.

As with any other condition or body part-specific program, any model related to foot and ankle care should place the patient at the centre and encourage interprofessional outcome-based care and communication in the best interest of the patient.

Ontario faces many challenges related to access to care including the shortage of health professionals in rural, remote, aboriginal, and other underserved areas. An interprofessional approach to foot and ankle care, recognizing the skills and competencies of all regulated professions who work in this area, is critical to ensuring that Ontarians have the care they need when they need it in the communities in which they live.

The Role of Physiotherapists in Foot and Ankle Care:

Physiotherapists receive extensive education at a Master’s degree level, as a condition of their entry to practice. The focus of physiotherapy education has always included anatomy, physiology, biomechanics and pathology and prepares physiotherapists to assess, diagnose and treat diseases, conditions, disorders and dysfunctions of the neurological, musculoskeletal, cardiorespiratory and integumentary systems of the whole body, including the foot and ankle. As professionals with specialized education in physical function, and in diseases, conditions, disorders and injuries affecting function, physiotherapists are important in the delivery of foot and ankle care, either in their own individual practices or as part of an interprofessional approach to care. Generally, physiotherapists approach foot and ankle care as an element of a multi-systemic approach including the musculoskeletal, neurological, cardiorespiratory and integumentary systems. Interventions by physiotherapists in foot care include, but are not limited to:

- Assessment and diagnosis of diseases, disorders and impairments resulting in loss of function or pain of the foot and ankle including assessment and diagnosis of conditions associated with the full kinetic chain including the spine that impact on foot and ankle

function.

- Assessment and diagnosis of diseases, disorders and impairments leading to interruption of the integumentary system of the foot and ankle including pressure ulcers, ulcers as a result of circulatory issues such as diabetes and other wounds whether as a result of injury or surgical intervention.
- Ordering of diagnostic imaging and lab tests within the scope of practice of physiotherapy was enabled through Bill 179 that was granted Royal Assent in 2010, though implementation has been delayed as regulations under associated legislation and including other professions are worked through. However, where these acts are now occurring under delegation they are part of the role the physiotherapist performs in this area.
- Gait analysis and interventions to address gait issues including balance retraining, mobility aid prescription, orthotic prescription and/or dispensing, splinting, gait training, strengthening, range of motion, exercise prescription, techniques to retrain after neurological events such as stroke, proprioception exercises.
- Debridement and wound care, pressure redistribution and offloading (including the prescription of orthotics, corrective footwear and mobility aides), patient and caregiver education on neuropathy (a cause of injury and wounds to feet) and proprioception and balance issues. Electrotherapy modalities may also be applied to assist with healing of ulcers/wounds.
- Mobilizations and other manual therapy techniques to increase the mobility of the foot and ankle complex
- Exercise prescription, home exercise programs and activity re-education and training to strengthen and improve function.
- Modalities to address pain including electrophysical, therapeutic heat/cold, acupuncture and acupressure

As direct access professionals with the competencies to assess and diagnose within scope, physiotherapists are able to identify when patients require referral to another regulated health professional for assessment and treatment. For example, physiotherapists do not perform surgical procedures (as per the Physiotherapy Act, the authorized act of performing procedures below the dermis is limited to the purpose of treating wounds). Should it be identified that a patient might need surgical intervention, the physiotherapist would refer to a physician or other appropriate professional such as a podiatrist. Direct referral to a specialist – such as an orthopedic surgeon – by non-physicians is not facilitated by funding policies in Ontario. The availability of podiatrists is noted to be insufficient to meet demand and so referring to the family physician is the most utilized route to access services. Any consideration of a model for foot care in Ontario should fully assess the impact of funding policies and other potential barriers such as availability of health human resources and inefficiencies in the system that impact access and seamless transitions of care.

Conclusion:

It is critical that in reviewing any model associated with foot care in Ontario it is fully recognized that no disease, condition, disorder or dysfunction of the foot and ankle occur in isolation to the function of the rest of the body in motion. We recognize the roles that regulated

health professions, including physiotherapists, have to play in any model of care being considered. In fact, many health professionals have a role that has made it possible to ensure that services are available to Ontarians where and when they need it. The OPA looks forward to working with HPRAC and other regulated health professions as this review of chiropody and podiatry in Ontario moves forward.

Prosthetics Orthotics Barrie

I am a prosthetist--provide prosthetic devices (partially funded by ADP) for partial foot amputees. No significant issues with current foot care model delivery system. I expect though that there are individuals who are eligible for funding for their device through ADP and they are not made aware of it.

Rexdale Community Health Centre

One of the major issues facing patients who are diagnosed with diabetes is that they have to live within the catchment area of the CHC to access Chiropody services. However, they do not have to live within the catchment area to access diabetes services.

As a health care provider it is difficult to refer to patient for foot care who have low income status and they live outside of the catchment area. The demand for Chiropody services is high and it would be great if more funding was allotted to having more than one Chiropodist.

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