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During the process of consolidating the Standards of Practice, some SP numbers will be missing.

Introduction and Terms

December 15, 2011

Standards of Practice Introduction

As set out in the *Health Professions Act* (HPA) in Alberta, all self-regulating health professions are required to have Standards of Practice (Standards). Each profession's regulatory body must establish, maintain and enforce a set of Standards for the regulated members who practice in Alberta.

The ACAC Standards of Practice are standards of professional behaviour and conduct required of all chiropractors in Alberta that ensures the safe and appropriate interaction between a regulated member and their patients, as well as the public.

Standards are a part of the structure within which the ACAC governs members in a manner that protects and serves the public by providing direction to regulated members and regulating the practice of chiropractic. Each regulated member, in their professional capacity, is required to understand and comply with these Standards, which are enforceable under the HPA and which will be referenced in complaints investigations and disciplinary proceedings where applicable.

The ACAC Standards of Practice continue to evolve with the profession of chiropractic in Alberta and may change from time-to-time. New Standards and adopted revisions will come into force after a period of consultation with regulated members and others as set out in the HPA.

Enforceability

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

Common Terms

ACAC: Alberta College and Association of Chiropractors

Regulated member: a chiropractor who is registered with the ACAC and holds an active practice permit

Patient: the patient or patient's legal guardian/substitute decision maker, where applicable

HPA: *Health Professions Act*

SP 1.0 Advertising, Promotions and Presentations

December 15, 2011

Purpose and Objective

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

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

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

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

1.1 Advertising, Marketing and Practice Promotion

December 15, 2011

Definition: All materials, information and presentations designed to reflect or promote a regulated member's practice to both current and potential patients.

Materials, information and presentations used or provided by a regulated member are required to be:

- a) Truthful and factual in all respects
- b) Professional in description, content and presentation
- c) Respectful in every manner of other health professions and chiropractic colleagues
- d) Clearly identifiable as being provided by a Doctor of Chiropractic
- e) Inclusive of only matters within the training and scope of practice of chiropractic
- f) Of a nature that does not inappropriately evoke concern or fear
- g) Exclusive of any claims of guaranteed results, or clinically predictive or specific outcomes
- h) Compliant with patient confidentiality requirements
- i) Compliant with all ACAC Standards, policies and position statements
- j) Free from reference to esoteric or limited research based information
- k) Exclusive of any claims or allusion to professional superiority

Examples of Advertising, Promotions and Presentations

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

May include:	May not include:
<ul style="list-style-type: none"> • Practitioner and clinic name • Address, including directional wording • Phone and fax numbers • Website and email addresses • Hours of operation • Professional Corporation information • Photos/images • Methods of payment accepted • Languages spoken • Services/techniques available • CCA, ACAC member and clinic logos • ACAC recognized chiropractic specialties as specified in SP 1.3 • WCB authorization • Handicapped (facility) access availability • Other current province/state licenses • Academic credentials from post-secondary degree granting institutions and/or accredited chiropractic colleges 	<ul style="list-style-type: none"> • Information that violates the requirements of any other Alberta legislation (e.g., <i>Veterinary Medicine Act</i>) • Information restricted by copyright law • Information or statements in conflict with any ACAC Standards, Code of Ethics, policies or position statements

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

May include:	May not include:
<ul style="list-style-type: none"> • All information permitted in example one • General chiropractic health information • Testimonials (with written patient permission) • Practitioner or clinic photographs/graphics 	<ul style="list-style-type: none"> • Same restrictions as example one

Examples 3) regulated member's personal or clinic website

May include:	May not include:
<ul style="list-style-type: none"> • All information permitted in examples one and two • Link to the ACAC website • Link to other chiropractic information sites that do not provide information that is contradictory to ACAC standards or policies • Clinic fees and current promotions with eligibility clearly defined 	<ul style="list-style-type: none"> • Same restrictions as example one

Example 4) internal practice promotion materials

May Include:	May not include:
<ul style="list-style-type: none"> All information permitted in examples one and two Patient photos (with written patient permission) Practitioner/staff (with written permission) photos and information about activities Specific fee and promotional information with eligibility clearly specified Personal patient acknowledgement (with written permission) 	<ul style="list-style-type: none"> Same restrictions as example one Sign-in sheets (in accordance with privacy legislation)

Example 5) internal materials related to promotional fees

May include:	May not include:
<ul style="list-style-type: none"> Promotional discounts with specific fees and eligibility clearly specified <p>Please note: An internal fee schedule for current patients must clearly identify the parameters of promotional services.</p>	<ul style="list-style-type: none"> Same restrictions as example one

Example 6) external materials related to promotional fees

May include:	May not include:
<ul style="list-style-type: none"> Reference to promotional activities with specific fees and eligibility clearly specified 	<ul style="list-style-type: none"> Same restrictions as example one

Example 7) television and radio

May include:	May not include:
<ul style="list-style-type: none"> All information permitted in categories listed above 	<ul style="list-style-type: none"> Same restrictions as examples one

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

1.2 Professional Communication

December 15, 2011

Definition: All communication with patients, members of the public, other health professions, chiropractic colleagues and any other party that a regulated member interacts with in the context of their professional capacity.

All professional communication provided or delivered by a regulated member shall be:

- a) Truthful and factual in all respects
- b) Professional in its content and presentation
- c) Clearly identifiable as being provided by a Doctor of Chiropractic
- d) Inclusive of only those matters within the training and scope of practice of chiropractic
- e) Respectful in every manner of other health professions and chiropractic colleagues
- f) Of a nature that does not inappropriately evoke concern or fear
- g) Exclusive of any claims of guaranteed results, or clinically predictive or specific outcomes
- h) Compliant with patient confidentiality requirements
- i) Compliant with all ACAC Standards, policies and position statements
- j) Free from reference to esoteric or limited research based information
- k) Exclusive of any claims or allusion to professional superiority

1.3 Use of the Term Specialist

March 1, 2012

Definition: The term *specialist* shall only be used when the regulated member holds an ACAC recognized Canadian chiropractic specialty designation.

A regulated member on the General or Courtesy Register may use the title of *specialist* as well as the appropriate abbreviations and initials, providing he or she has successfully completed and is certified by one or more of the following specialty programs approved by the Council:

- a) Chiropractic College of Radiologists (FCCR)
- b) College of Chiropractic Sciences (FCCS)
- c) College of Chiropractic Orthopedists (Canada) (FCCO(C))
- d) Canadian Chiropractic Specialty College of Physical and Occupational Rehabilitation (FCCPOR(C))
- e) Royal College of Chiropractic Sports Sciences (FRCCSS(C))

A regulated member on the General or Courtesy Register may continue to use the title of *specialist* as well as the appropriate abbreviations and initials, providing he or she continues to meet the requirements for maintenance of the specialty certification.

SP 2.0 Financial Accountability

April 11, 2012

Purpose and Objective

To ensure that regulated members demonstrate financial accountability by:

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

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

2.1 Fee Schedule

April 11, 2012

Definition: A fee schedule is the usual and customary fees established by the regulated member that is published and available to patients and payers.

With respect to fees charged by a regulated member:

- a) Fees for a proposed course of treatment shall be congruent with the clinic fee schedule and will be reviewed in detail with the patient prior to the commencement of treatment.
- b) Regulated members shall have and apply a consistent fee schedule regardless of insurance coverage.
- c) Fee schedules may contain fee stratification with regard to specific patient groups such as children, students, and/or seniors provided that such stratification is equally applied to all patient billing circumstances.
- d) Individual financial consideration for reduced fees based on a patient's personal circumstances may be applied at the discretion of the regulated member.
- e) Where legislation or contractual agreement governs fees specific to the delivery of chiropractic services, i.e., WCB, Minor Injury MVA Protocols; the specified fee schedule is appropriate.

2.2 Provider Contractual Agreements

April 11, 2012

Definition: A written agreement between a regulated member and a specific organization representing a defined patient group, and specified fees and services.

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

- a) be appropriately documented
- b) clearly define the specific services to be provided
- c) identify the patient group and fee schedule that will be charged to all patients in the group (or third-party payers on behalf of the patient group)
- d) have a defined timeline (sunset clause) for review and renewal
- e) be agreed to in writing by both parties (authorized and signed by regulated member and the Corporate Officer representing the patient group who is authorized to enter into such an agreement)
- f) be available for review by the ACAC upon request or as part of the ACAC Practice Review process

2.3 Prepayment of Fees

April 11, 2012

Definition: A financial option, as defined by this Standard, available to a patient that allows them, at their discretion, to prepay for chiropractic care not yet received.

The financial option of prepayment shall:

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

2.4 Patient Financial Agreement for Care

April 11, 2012

Definition: A financial agreement between a regulated member and an individual patient for specified chiropractic care.

Financial agreements for care shall:

- a) be consistent with fees charged on an individual *per session* fee
- b) be offered only as an option to the individual *per session* fee
- c) be presented as a financial agreement for care and not a binding contract for a specified treatment regime, period of time or suggested outcome
- d) be offered as a payment option only after the patient has been given the recommendations for care as presented in the Report of Findings
- e) only pertain to fees incurred after the initial consultation and examination
- f) be based on a unique patient treatment plan and shall not create or reflect a *case fee* or *unlimited care at fixed fee* agreement
- g) contain a clause indicating the plan may be terminated by the patient at their sole discretion
- h) contain a clause indicating "Upon termination of the agreement, treatments-to-date used under the terms of the financial agreement will be assessed at the lowest fee-per-treatment rate specified in the agreement and not adjusted to a higher rate due to withdrawal from the proposed treatment plan"
- i) be free from financial penalty to the patient for terminating the agreement
- j) contain a clause indicating "The balance of funds remaining in the patient account will be refunded within seven days of the termination of the agreement"
- k) be consistent with section 2.1 Fee Schedules
- l) adhere to the maximum financial incentive/discount of 10% as described in section 2.2 Prepayment of Fees and not contain any addition financial incentives or discounts
- m) adhere to the maximum prepayment limit as outlined in section 2.3 Prepayment of Fees regardless of the number of treatments as agreed to in the agreement
- n) be consistent with the ACAC Standards related to Patient Files and Records
- o) be free from requirements or suggestions that the patient refer others to care
- p) be free from any reference to *free* or *discounted* services

2.5 Fraudulent Billing

April 11, 2012

Definition: Fraudulent billing is any action involving billing anomalies that result in a regulated member's receipt of funds under false pretences.

Regulated members' billing practices shall:

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

SP 3.0 Provision of Information

April 11, 2012

Purpose and Objective

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

3.1 Informed Consent

May 9, 2012

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

As part of the informed consent process, regulated members are responsible for disclosing to each patient, or the guardian of each minor patient:

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

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

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

Informed consent must:

1. be signed by the patient
2. indicate the patient's consent to treatment
3. indicate that it is the doctor's obligation to keep patients informed by advising them of any changes to the treatment or the risk of treatment
4. be present on all existing patient files (if verbal informed consent is noted from previous treatment, this must be replaced by written consent on the next patient visit)

3.2 Treatment Recommendations

April 11, 2012

Definition: any treatment recommendation or plan the regulated member has deemed appropriate for the specific patient based on case history, examination and any other diagnostic measures

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

Patient treatment recommendations must be consistent with the recorded individual treatment plan and cannot be contingent upon any other factors.

3.3 Disclosure of Harm

April 11, 2012

Definition: the acknowledgement and discussion of a negative outcome as the result of a harm, (the unexpected or normally avoidable outcome that negatively affects the patient's health and/or quality of life) that occurred in the course of chiropractic treatment.

If a regulated member becomes aware that the patient has suffered harm in the course of receiving care and that harm does or can be reasonably expected to negatively affect the patient's health and/or quality of life, the regulated member is obligated to inform the patient.

The disclosure of harm:

1. may be made to the patient directly or through his or her authorized substitute decision maker
2. should take place as soon as possible, taking into account the clinical and emotional condition of the patient
3. where the patient requires treatment for the harm that was sustained, should include identification of remedial care proposed by the chiropractor or referrals to other health care providers or health care facilities, if appropriate

SP 4.0 Provision of Professional Services

May 9, 2012

Purpose and Objective

To provide direction and clarity on the provision of professional services, specifically the provision of services that:

- are within the scope of practice of chiropractic in Alberta
- may have additional requirements of regulated members in order to provide certain services
- may engage clinical support staff
- ensure an appropriate clinical perspective within a public health and safety context

In the delivery of professional services, a regulated member shall at all times be current in their knowledge and skills to provide safe and effective care and treatment of the patient and only ever perform a restricted activity to the level they are competent and that is appropriate to the area of practice and procedure being performed.

4.1 Scope of Practice for Regulated Members

May 9, 2012

The scope of practice for regulated members will include:

1. all activities outlined in the *Health Professions Act*, Schedule 2.3
 - a) examine, diagnose and treat, through chiropractic adjustment and other natural means, to maintain and promote health and wellness, and
 - b) provide restricted activities authorized by the Regulation.
2. all restricted activities as listed in the *Regulation* to the HPA, Section 13 and Section 14
 - s13. a) to use a deliberate, brief, fast thrust to move the joints of the spine beyond the normal range but within the anatomical range of motion, which generally results in an audible click or pop;
 - b) to insert or remove instruments, devices or fingers
 - (i) beyond the cartilaginous portion of the ear canal,
 - (ii) beyond the point in the nasal passages where they normally narrow, and
 - (iii) beyond the anal verge;
 - c) to reduce a dislocation of a joint;
 - d) to order any form of ionizing radiation in
 - (i) medical radiography, and
 - (ii) nuclear medicine;
 - e) to apply any form of ionizing radiation in medical radiography;
 - f) to order non-ionizing radiation in
 - (i) magnetic resonance imaging, and
 - (ii) ultrasound imaging.
 - s14. Advanced restricted activities include acupuncture and setting or resetting a fracture of a bone.
3. therapeutic and diagnostic procedures taught in the core curriculum, postgraduate curriculum or continuing education division of a program accredited by the Council on Chiropractic Education.
4. other therapeutic and diagnostic procedures as approved by the Council of the ACAC.

4.2 Assignment of Clinical Duties

May 9, 2012

Definition: The parameters within which the assignment of basic clinic and therapeutic activities to appropriately trained and properly supervised clinical support staff may occur.

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

Responsibilities of the regulated member:

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

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

Activities that may be assigned

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

Activities that may not be assigned

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

Other activities that regulated members may not assign to clinical support staff:

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

4.3 Infection Prevention and Control

May 9, 2012

Definition: The requirements of regulated members related to appropriate infection prevention and control procedures in their clinical practice.

Regulated members will incorporate current, appropriate and generally accepted infection control measures as established by and updated from time-to-time by Health Canada¹ and Alberta Health and Wellness, and must:

- Remain current in generally accepted routine practices² and infection control protocols
- Ensure that their clinic facility is equipped, operated and maintained to meet generally accepted infection control guidelines including requirements for:
 - hand hygiene, which should include the use of an alcohol based cleaner or hand washing before and after each patient contact
 - use of protective barriers³ as standard practice whenever contact with blood and body fluids is likely to occur during patient contact. (Barriers should also be used when a patient's personal care equipment is likely to have been contaminated with potentially infected fluids (e.g., wheel chairs, walkers))
 - cleaning and disinfecting/sterilizing equipment and facilities, and managing wastes and materials contaminated by blood or body fluids (see Appendix A)
- Adopt appropriate infection control measures including contact management protocols (and continually monitor their use and effectiveness to identify problems, outcomes and trends)
- Be aware of, or if not otherwise available develop, incorporate and keep up-to-date, infection control policies to promote the use of infection control measures, which may be unique to personal professional practice style

- Apply sufficient knowledge, skills and judgment to conduct ongoing assessments of current risks of infection and transmission to patients, staff, colleagues and other health professionals, and take appropriate remedial action in a timely manner consistent with professional requirements and the applicable law based on consideration of the following:
 - the assessments or treatment interventions planned or conducted
 - the health conditions of patients being assessed or treated
 - the degree of infection risk currently present in the internal practice environment
 - the degree of infection risk currently present in the external practice environment
 - current best practice in infection control protocols relevant to his or her professional practice style
 - the health and immunization status of the regulated member, the staff and all other individuals in the practice environment
- Consider the necessity of self-immunization for common and/or preventable illness as appropriate, and based on the outcome of this consideration ensure that appropriate action is taken in a timely manner to ensure patients are properly protected from diseases while being treated

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

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

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

4.4 Acupuncture

May 9, 2012

Definition: To provide guidance on the delivery and restrictions of the provision of the advanced restricted activity of needle acupuncture.

To provide needle acupuncture, regulated members must:

1. be certified in the area of needle acupuncture, and make demonstration of training to the satisfaction of the Registrar
2. provide evidence of professional liability insurance for needle acupuncture treatments to the ACAC
3. not list or promote acupuncture as a specialty anywhere, as it is not a fellowship recognized by the Canadian Federation of Chiropractic Regulatory and Education Accreditation Boards (CFCREAB)
4. observe the principles and health care industry standards for aseptic technique and the Alberta Infection Prevention and Control (IPC) Standards (<http://www.health.alberta.ca/newsroom/pub-infection-prevention.html>)
5. not reuse a single-use medical device (any acupuncture device associated with the puncture of the dermis or mucosa, and any device that comes into contact with the patient at any puncture site) unless the single-use device has been reprocessed by a third party re-processor in a manner that ensures the device is safe and will function as intended by the manufacturer

4.5 Chiropractic Treatment of Animals

May 9, 2012

Definition: The parameters within which a regulated member may provide chiropractic treatment to animals.

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

In all circumstances, regulated members may only treat animals in consultation with (or) with a written directive from a member of the Alberta Veterinarian Medical Association.

4.6 Setting a Fracture

May 9, 2012

Definition: Provides direction on the advanced restricted activity of setting a fracture (for regulated members who maintain credentials of a Fellowship in chiropractic orthopedics).

Regulated members may set or reset simple, non-displaced fractures as part of their therapeutics, subject to the following requirements:

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

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

4.7 Sacro-coccygeal Adjustments

May 9, 2012

Definition: To outline a minimum standard of care that must be met prior to performing sacro-coccygeal adjustment.

To perform manipulative procedures of the sacro-coccygeal joint, a regulated member shall be thoroughly familiar with the procedure and consider contraindications.

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

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

Consideration of Patient Understanding and Consent

A regulated member shall fully explain the diagnosis, options, proposed treatment procedure and prognosis to the patient before proceeding with the manipulation of the tailbone. Specific consent must be fully informed, voluntarily given and evidenced in written form.

4.8 Gynecological and Urological Examinations

May 9, 2012

Definition: Regulated members are disallowed from performing gynecological and urological examinations

A regulated member may not conduct gynecological or urological examinations as these are restricted activities that do not fall within the chiropractic scope of practice in Alberta.

Regulated members will refer patients that are in need of a gynecological or urological examination to a medical facility.

SP 5.0 Patient Health Records

May 9, 2012

Purpose and Objective

To make clear the responsibilities of a regulated member in the creation, maintenance and retention of patient health records to ensure appropriate care and control of all patient information.

In particular, regulated members must be certain that all Electronic Medical Records (EMR) systems are compliant with the requirements for the protection, privacy, and security of the electronic records as set out in the Alberta Electronic Health Record Regulation (to the *Health Information Act*)

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

5.1 Record Keeping Requirements

May 9, 2012

Definition: The information a regulated member is required to obtain, collect and maintain on all patient health records.

Patient health records must be dated, accurate, legible and comprehensive, and must include the following documentation:

History

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

Physical exam findings

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

Written diagnosis

- Working diagnosis and/or index of suspicion
- VSC that identifies the segmental level(s) and components of the “complex”
- ICD codes with two digit, post-decimal point descriptor code

Written treatment plan

- All proposed treatment methods (adjustments, ultrasound, electrical stimulation, controlled exercise plan and lifestyle counseling, as appropriate)

Appropriate progress notes

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

5.2 Clinical Relevance of Treatment Recommendations

May 9, 2012

Definition: The direct and rational connection between the presenting complaint, the diagnosis and the recommended treatment.

The patient health record will clearly and completely demonstrate that the regulated member has:

- elicited and recorded an appropriate case history
- performed and recorded an appropriate physical examination and other relevant investigations congruent with the presenting complaint
- derived and recorded a diagnosis congruent with the presenting complaint
- derived and recorded an appropriate treatment plan, consistent with the diagnosis and congruent with a treatment protocol taught at a CCE accredited chiropractic institution (or technique systems approved by Council)
- identified clear progress markers or milestones in association with the treatment plan

5.3 Custodianship of Health Records

May 9, 2012

Definition: The responsibilities of the regulated member for the care and control of the health records in their practices in various circumstances as required by the *Health Information Act* of Alberta. The term care provider is defined the same as regulated member, that is an active member of the ACAC.

The custodian is the individual who is the current and active care provider as defined by the patient, unless there is a written agreement naming another qualified custodian (such as may occur in the context of group practice where the practice principal is named as the custodian of all patient health records).

Examples of custodianship situations:

- Custodianship may be defined via contract agreement that specifies the custodian of the health records. A contract agreement must identify a qualified individual (a corporate entity is not permitted) to be the custodian.
- In the absence of a contract agreement, the custodian is the individual who is the current and active care provider as defined by the patient.
- Interim care provided by another regulated member does not shift the custodianship of the health record unless agreed to by both patient and regulated member.
- In the absence of a contract agreement, a custodian who is departing a clinic has the obligation to continue the custodianship of their health records and to take these records with them unless there exists a written agreement with another qualified custodian to transfer the custodianship of these health records to that qualified custodian.
- Professional Corporations are not eligible custodians

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

5.4 Health Records Retention

May 9, 2012

Definition: The requirements of the regulated member related to the availability, retention and disposition of patient health records.

As custodians, regulated members have a responsibility to ensure that access to patient health records is available to patients (current and former) and other appropriate parties.

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

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

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

SP 14.0 Substance Abuse

August 2005

Purpose and Objective

As a regulated and primary care provider, it is imperative that all chiropractors follow a formal set of standards governing misuse and abuse of alcohol, illicit drugs, over-the-counter medication and prescription drugs. The purpose and objective of implementing a substance abuse standard is to ensure our members fulfill their professional obligations by maintaining a safe working environment, including protecting the well-being of themselves as well as their patients. This standard will assist in ensuring that registered members shall not act or continue to act in any manner in which they may be reasonably seen as being unable to provide safe and competent services.

Definition(s)

Substance Abuse refers to patterns of use of alcohol and/or drugs (street, over the counter or prescribed drugs) which interfere with an individual's social, occupational, legal, financial, emotional and physical function.

Current literature defines addiction as a primary, progressive, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease can be progressive and fatal. It is characterized by impaired control over use of the substance, preoccupation with the substance, use of the substance despite adverse consequences, and distortions in thinking.

Enforceability

A member identified to the Complaints Director as non-compliant in the Standard of Practice related to substance abuse is subject to sanction through the complaint process under Part 4 of the *Health Professions Act* by the Hearing Tribunal. These sanctions may include, but are not limited to:

- conditions on practice;
- practice supervision;
- psychological evaluations;
- suspension of license;
- revocation of license;
- voluntary entrance into a treatment facility of the Complaint Director's choice;
- referral to a mandated treatment facility of the Complaint Director's choice, or;
- any combination of the above.

In situations where public safety is identified as a clear and present concern, the member may, be directed to cease providing professional services by the Complaints Director (per Section 118(4) of the *Health Professions Act*)

Identification of concern may occur as a result of information provided by the affected member, a colleague, a patient obtaining services at a member's practice, a member of the ACAC staff or a member of the public at large.

The Hearing Tribunal, upon finding a member to be identified as having a substance abuse issue may:

- a) mandate that the member engage in the substance abuse treatment program, abide by the decisions of the evaluation process of the program, and demonstrate successful evaluations as scheduled by the program. Such engagement to be a matter of a contractual agreement between the member and the ACAC.
- b) suspend the member from practice until the treatment program is engaged.
- c) cancel the registration of the member as unfit to practice chiropractic as a matter of unskilled practice and/or professional misconduct.
- d) place any other conditions on the practice of the member that it sees as appropriate.

Penalty

	Member agrees to	Follow-up treatment
Voluntary entrance into treatment	<ul style="list-style-type: none"> • participate in an initial assessment (at the expense of the member) • enter into a treatment program of the Complaint Director's choice, if it is deemed necessary after the initial assessment, for a minimum of <u>two</u> years (at the expense of the member) which includes: <ul style="list-style-type: none"> - admission of circumstances - consent to obtain or share information with relevant parties - contractual arrangements regarding other program expectations - specified expectations and consequences in the event of relapse • suspension <u>if it is deemed</u> that the member may jeopardize the safety of patients, peers or his/her self. Such determination to be made by the treatment program in consultation with the Complaints Director • attend any weekly/monthly recovery meetings as deemed necessary by the treatment program and/or the Complaints Director 	<ul style="list-style-type: none"> • agree to any follow-up treatment as deemed necessary by the treatment program and/or the Complaints Director.

	Enforceable penalty	Follow-up treatment
Mandated entrance into treatment	<ul style="list-style-type: none"> • participate in an initial assessment (at the expense of the member) • enter into a treatment program of the Complaint Director's choice for a minimum of <u>five</u> years (at the total expense of the member) which includes: <ul style="list-style-type: none"> - admission of circumstances - consent to obtain or share information with relevant parties - contractual arrangements regarding other program expectations - specified expectations and consequences in the event of relapse • suspension <u>until it is deemed</u> that the member is able to return to practice with no threat to patients or him or her self. Such determination to be made by the treatment program in consultation with the Complaints Director • attend any weekly/monthly recovery meetings as deemed necessary by the treatment program and/or the Complaints Director 	<ul style="list-style-type: none"> • agree to any follow-up treatment as deemed necessary by the treatment program and/or the Complaints Director.

SP 15.0 Sexual Misconduct

September 2009

Purpose and Objective

1. To ensure that ACAC members are aware that the ACAC has a definition of, and specific policy regarding behaviour or activity that is defined as sexual misconduct.
2. To ensure that both ACAC members and the public are aware that the ACAC is committed to protecting the public from such behaviour, activity and misconduct.

Definitions and Context within this Standard of Practice

The authority vested in any health care provider may, at times, exert undue emotional influence over a patient. Behaviour or activity that takes advantage of that authority is unethical and unprofessional. Doctors of chiropractic must be particularly sensitive to this issue since they treat patients with very “hands on” procedures. Additionally, it is not acceptable to use a clinic as a place to initiate personal relationships or dating opportunities.

Sexual misconduct is any behaviour or activity that exploits the chiropractor/patient relationship in a sexual way. This behaviour or activity may be verbal or physical, including:

- verbal comments or expressions of thoughts and feelings that are sexual in nature or that may be reasonably interpreted to be sexual in nature
- gestures or actions that are sexual in nature or that may be reasonably interpreted to be sexual in nature

Nothing in this Standard of Practice precludes a chiropractor from providing treatment to his or her spouse. For the purpose of this provision, “spouse” is interpreted to include a common-law spouse as defined by provincial legislation.

This Standard specifically identifies two levels of sexual misconduct as listed below. Behaviours or activities listed in either level may be the basis for disciplinary action if found that the behaviour or activity was in the context of the chiropractor/patient relationship.

LEVEL I – Sexual Violation

Sexual violation may include chiropractor/patient sex, whether initiated by the chiropractor or the patient, and/or engaging in any conduct with a patient that is sexual in nature or may be reasonably interpreted to be sexual in nature. Behaviours or activities, generally of a non-consensual nature are considered to be a sexual violation when occurring between the chiropractor and a patient, and may include but are not limited to:

- sexual intercourse
- genital to genital contact
- oral to genital contact
- kissing in a romantic or sexual manner
- encouraging the patient to masturbate in the presence of the chiropractor or masturbation by the chiropractor while the patient is present
- touching the patient’s breasts, genitals, or any sexualized body part for any purpose other than appropriate examination or treatment for which specific written consent has been obtained prior to proceeding

- touching the patient’s breasts, genitals, or any sexualized body part where the patient has refused or has withdrawn consent for such examination or treatment
- offering to provide practice-related services in exchange for sexual favours
- other physical contact that may be reasonably interpreted as sexual in nature

LEVEL II – Sexual Impropriety

Sexual Impropriety may comprise behaviours, activities, gestures or expressions that are, or may be reasonably interpreted as, seductive in nature, sexually suggestive, or sexually demeaning to a patient. Behaviours or activities considered to be a sexual impropriety when occurring between the chiropractor and a patient may include but are not limited to:

- gowning or disrobing practices that reflect a lack of respect for a patient’s privacy and dignity
- inappropriate comments about the patient, including but not limited to:
 - making sexual comments about a patient’s body or underclothing
 - making sexual or sexually demeaning comments to a patient criticizing the patient’s sexual orientation
 - requesting clinically irrelevant information such as sexual likes or dislikes
- using the chiropractor/patient relationship to solicit a date
- initiation, by the chiropractor, of clinically irrelevant conversation regarding the sexual problems, preferences, or fantasies of the chiropractor
- involvement, by the chiropractor, in a clinically irrelevant conversation regarding the sexual problems, preferences, or fantasies of the patient
- inquiries into a patient’s sexual history that are not related to the diagnosis and treatment of the patient’s current complaints and would be considered clinically irrelevant
- dating a patient involved in active treatment:
 - including personal relationships pre-existing the onset of treatment, but excluding legally recognized spousal relationships
 - active treatment can be terminated by agreement between the doctor and patient. This agreement should be noted on the patient chart and signed by both parties. The patient should be referred to another chiropractor.

Sexual Impropriety may also include activities and commentary of a nature that would commonly be considered “sexual harassment”. This behaviour does not need to be specifically directed at the patient to constitute sexual harassment. Examples may include but are not limited to:

- idle chatter of a sexual nature and graphic sexual descriptions
- offensive and risqué jokes or jesting and kidding about sex or gender-specific traits
- suggestive or insulting sounds such as whistling, wolf-calls or kissing sounds
- comments of sexual nature about weight, body shape, size or figure
- pseudo-medical advice with sexual overtones
- staged whispers or mimicking of a sexual nature about things such as the way a person walks, talks or sits
- innuendos or taunting
- rough and vulgar humour or language
- gender-based insults or sexist remarks
- comments about a person’s looks, dress, appearance or sexual habits
- comments about an individual’s sex life or relationship with a sex partner
- telephone calls with sexual overtones

Enforceability

Any member identified to the Complaints Director as non-compliant in the Standard of Practice related to Sexual Misconduct is subject to the investigations and complaints process under Part 4 of the *Health Professions Act*. Identification may occur as a result of Practice Visit process, patient complaint or any other means by which the information may be brought to the attention of the Complaints Director.

Proposed Penalties and Sanctions

The ACAC recognizes that the chiropractor/patient relationship, like all relationships where there is an imbalance of power, carries with it the potential for abuse. Sexual misconduct with patients is considered an extremely serious matter by the ACAC. In recognition of the mandate for protection of the public, the sanctions proposed by the ACAC against members who are found guilty of sexual misconduct are intended to be severe. Penalty options are provided to ensure that individual context and circumstances are considered in the determination of appropriate sanctions.

Level I - Sexual Violation: Proposed Penalties and Sanctions

- Suspension of registration for a minimum of 180 days and/or up to permanent revocation of registration
- Conditional Practice Permit (practice under supervision)
- Payment of a fine as set out by the Hearing Tribunal
- Payment of costs associated with the investigation, hearing and discharge of any sanctions
- Formal written reprimand presented, in person, by Council
- Mandated entry into a treatment facility or program for sexual addiction and/or behaviour modification
- Provision of a written apology to the victim
- Provision of the offer of restitution to the victim by payment of costs for a set number of counseling sessions as set out by the Hearing Tribunal to aid the victim in recovery
- Any other penalty as determined appropriate by the Hearing Tribunal
- Any combination of the above

Level II - Sexual Impropriety: Proposed Penalties and Sanctions

- Suspension of registration:
 1. First Offence: minimum 60 days suspension
 2. Second Offence: minimum 120 days suspension
 3. Third Offence: permanent revocation of registration, or suspension of registration with treatment period, pending report of eligibility for practice (for a minimum of 180 days)
- Payment of a fine as set out by the Hearing Tribunal
- Payment of costs associated with the investigation, hearing and sanctions
- Conditional Practice Permit (practice under supervision)
- Formal written reprimand presented, in person, by Council
- A combination of any of the following:
 1. Mandated entry into a treatment facility or program for sexual addiction and/or behaviour modification – regular and timely reports will be provided from the therapist on progress related to appropriateness for practice in the chiropractic profession, and/or
 2. Mandated psychological assessment and adherence to any recommendations provided as a result of the assessment, and/or
 3. Attend boundary/gender sensitivity courses as set out by the Complaints Director or Hearing Tribunal
- Provision of a written apology to the victim
- Provision of the offer of restitution to the victim by payment of costs for a set number of counseling sessions as set out by the Hearing Tribunal to aid the victim in recovery
- Any other penalty as determined appropriate by the Hearing Tribunal
- Any combination of the above

SP 27.0 Ordering Advanced Diagnostic Imaging Studies

March 2007

Purpose and Objective

To identify when ordering advanced imaging procedures is appropriate and facilitate in making an accurate and timely diagnosis. This will enable the chiropractor to acquire information for the appropriate management of the investigated complaint.

Description of Standard

Overview

Advanced imaging procedures such as computed tomography (CT), computed tomography with myelography (CT-myelo.), magnetic resonance (MR) imaging, and radionuclide bone scans are occasionally required in chiropractic patients in addition to conventional radiographs.

Advanced imaging should be obtained in patients with a history, examination, or prior tests that strongly suggest a serious condition such as persistent neurologic deficit (e.g. cauda equine) syndrome, infection, cancer or tumor. In addition, these tests should be reserved for patients that fail to respond to a trial of conservative care.

Degree of Skill

Familiarity with the following areas is essential:

- the science, principles and objectives of advanced imaging studies
- the indications of advanced imaging studies,
- contraindications,
- biological effects,
- limitations and hazard, and
- an introduction to interpretation

Obtaining advanced imaging in patients with sciatica arising from disc herniation or spinal stenosis is generally unnecessary unless the patient fails to respond to a trial of four weeks of conservative care. Lack of correlation between symptoms and imaging findings (poor specificity) reduces the value of imaging, especially in low back pain patients.

The following table outlines some indications for advanced imaging procedures. It should be emphasized however, that some clinical scenarios may not be included in this table, and that imaging decisions may need to be determined on a case-by-case basis.

TABLE: Clinical and radiographic indications for advanced imaging in chiropractic patients

Clinical or Radiographic Indication	Imaging Modality			
	MR	CT	CT- myelo	Bone Scan
A. Spine				
Evaluation of neoplasms detected on radiographs	++	+	+	
Determining skeletal distribution of neoplasms or other multifocal skeletal diseases				++
Clinical or laboratory tests suggesting plasma cell myeloma	++			
Myelopathy	++			
Cauda equina syndrome	++		+	
Lumbar radiculopathy with positive straight leg raise test, abnormal reflex, dermatome, or myotome not responding to 4 weeks of conservative care	++			
Cervical radiculopathy with positive neurologic signs not responding to 4 weeks of conservative care	++			
Myelopathy or radiculopathy (as above) when MR is contraindicated		+	++	
Infectious spondylodiscitis	++	+		+
Neural tumors and multiple sclerosis	++			
Post-operative evaluation of arthrodesis		+		
Post-operative evaluation of recurrent disc herniation vs. fibrosis	++ GAD			
Burst fracture or other unstable fractures	+	++		
Suspected occult fracture	+	+		++
Complicated disease processes or findings unexplained by more conservative tests	+	+		
B. Extremities	MR	CT	Bone Scan	
Evaluation of neoplasms detected on radiographs	++	+		
Determining skeletal distribution of neoplasms or other multifocal skeletal diseases			++	
Internal joint derangements	++			
Osteomyelitis	++	+	+	
Osteonecrosis	++		+	
Complicated fractures		++		
Suspected occult fracture	+	+	++	
Complicated disease processes or findings unexplained by more conservative tests	+	+		

++ first choice; + second choice (must be determined on a case-by-case basis)

GAD, MR imaging obtained with and without gadolinium injection

Enforceability

Any member identified to the Complaints Director as non-compliant in the Standard of Practice related to ordering advanced diagnostic imaging studies will be subject to the investigations and complaints process under Part 4 of the *Health Professions Act*. Identification of noncompliance may occur as a result of Practice Visit process, patient complaint or any other means by which this information may be brought to the attention of the Complaints Director.

SP 39.0 Radiography of Children

June 2004

Purpose and Objective

As a regulated and primary care provider, it is appropriate to demonstrate professional competency in the area of radiography of children. The chiropractic profession recognizes that diagnostic x-ray examinations, while offering inestimable benefits, have risk which must be weighed against those benefits. Diagnostic imaging, including plain film radiography, is not unique to chiropractic. Because of the potentially harmful biologic effects of ionizing radiation, this area of practice has long been a subject of well developed and universally accepted guidelines. In Canada, there are federal and provincial government guidelines and regulations addressing every aspect of radiography to all user groups.

The fundamental objective of performing an x-ray examination is to obtain optimum diagnostic information with minimal patient exposure.

Definition(s)

There should always be clinical evidence of the need for a diagnostic x-ray examination before such is performed. A chiropractor's responsibility to diagnose is broader than a scope of treatments, therefore they must have the ability to perform or prescribe all imaging procedures needed to formulate a diagnosis.

Of significant importance in the event of radiological examination, is the mandatory use of proper protective shielding.

Radiography in children from birth to 10 years of age:

- **Indications** - the overall justification for radiography is considered low due to the high radiosensitivity and the juvenile appearance of ossification of the spine. However, in the presence of developing or idiopathic scoliosis, developmental or congenital defects producing aberrant spinal curvatures, marked locomotor disturbances of the spine and pelvis, suspicion of pathology and significant trauma including suspected fracture or child abuse, justification may be high. The clinical examination and history is of the utmost importance in determining the clinical judgment for the use of diagnostic imaging in this age group.
- **Contraindications** - prior exposure to high radiation dosage and/or positioning difficulty which can be challenging in infants because of the physical and/or mental state that prevents proper immobilization of positioning for good radiographic detail. Routine screening examinations or re-examinations would be contraindicated unless clinically justified.

Radiography in children 10 to 18 years of age:

- **Indications** - justification for radiography would be decreased in the absence of marked spinal pelvic locomotor defects, idiopathic or developmental scoliosis, marked inter-related spinal lesions or development defects, congenital abnormalities, suspicion of pathology including the epiphyseal or growth centre diseases, significant trauma including suspected fracture. Multiple symptom complexes, altered spinal curvatures, suspicion of pathology would result in increased justifications.

Due consideration must be given to females with reproductive capacity and appropriate shielding must be utilized.

- **Contraindications** - prior exposure to high radiation dosage. Routine screening examinations or re-examinations would be contraindicated unless clinically justified.

Enforceability

Any member identified to the Complaints Director as non-compliant in the Standard of Practice related to radiography of children is subject to the investigations and complaints process under Part 4 of the *Health Professions Act*. Identification of non-compliance may occur as a result of the Practice Visit process, patient complaint or any other means by which this information may be brought to the attention of the Complaints Director.