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WORKPLACE MEDICAL

At DATAC, we're proud to work alongside organizations that share our commitment to safer, healthier workplaces through education, compliance, and evidence-based workplace health programs.

This month, we're pleased to shine the spotlight on one of our long-standing members, Workplace Medical, who offer a full spectrum of occupational health services designed to support employers at every stage of employment.

Workplace Medical was started in 1951 by Dr. Frank Shapiro, a Hamilton native. Dr. Shapiro grew his practice from his family home and through serving the community of industrial workers around him.

Through this practice Dr. Shapiro recognized the lack of occupational health expertise for the smaller companies around him. Dr. Shapiro was an early champion of the return-to-work program, understanding that employers need their workers back, but workers must be ready and able to work before returning to work. Dr. Shapiro's programs pioneered such things as the Time Loss Review which included getting information from the employer's family physician to work together to develop a plan for returning to work. That same house in which Dr. Shapiro started his practice, with additions and upgrades, remains the headquarters of this Hamilton fixture, headed now by William Shapiro.

Workplace Medical added drug testing to their services about 30 years ago and have been a valued member of the DATAC community since 2019.

As workplace substance testing continues to evolve, Workplace Medical has built flexible programs that meet the needs of organizations of every size—from single-site employers to complex national operations. Their testing services include providing breath tests, oral fluid and urine screening and lab testing; in person, mobile or virtually.

One of the strengths of Workplace Medical's drug and alcohol testing programs is their commitment to education. For more than 10 years, Workplace Medical has partnered with DATAC to provide Designated Employer Representative (DER) and Supervisor Awareness Training (SAT) to their clients. This partnership allows Workplace Medical to offer employers more than testing services—it provides the education needed to build effective, compliant workplace drug and alcohol testing programs.

At DATAC, we believe that quality training is the foundation of a successful testing program. Through our DER and SAT courses, employers gain the knowledge and confidence to understand their responsibilities, recognize signs of impairment, manage testing programs appropriately, and support safe, respectful workplaces. We're proud that Workplace Medical continues to recommend DATAC's training as part of the comprehensive solutions they provide to clients across Canada.

As the Workplace Medical team shared:

> **"DATAC has been an important part of our business for our clients. We partner with DATAC for DER and SAT training, offering these programs to help fill an important need within our clients' drug and alcohol testing programs. We have been working with DATAC for over 10 years. Working with DATAC is amazing. The team has been accommodating and flexible over these years."**

The relationships we build with organizations like Workplace Medical are an important part of DATAC's mission to advance education and best practices within Canada's drug and alcohol testing industry. We thank Workplace Medical for their continued support, collaboration, and commitment to helping employers create safer, healthier, and more compliant workplaces. We look forward to many more years of working together to strengthen workplace drug and alcohol testing across Canada.

Product Spotlight

CANADIANMRO
Setting the standard

DATAC is pleased to spotlight Canadian MRO, a service provider supporting employers and organizations with professional Medical Review Officer services and expertise in workplace drug and alcohol testing. Medical Review Officer (MRO) review provides an important layer of medical expertise, quality assurance, and confidentiality between the laboratory, the employer, and the employee.

What Is an MRO?

A Medical Review Officer is a licensed physician who provides an independent medical review of drug testing results. The MRO's role is to review laboratory results, interview the donor when needed, evaluate relevant medical information, and determine the appropriate final status of a test. This independent review helps protect both sides of the testing process—giving employers confidence that results have been appropriately reviewed while giving employees an opportunity to provide legitimate medical information that may explain a laboratory finding.

For employers, TPAs, collection providers, occupational health organizations, and other testing professionals, having access to an experienced MRO can make the administration of a drug testing program considerably easier.

A strong MRO service can help provide:

- Independent Medical Review
- Professional Comunication
- Confidentiality
- Regulatory Knowledge
- Support for Complex Result

If your organization is looking for professional MRO services or would like to learn more about incorporating MRO review into your workplace drug and alcohol testing program, Canadian MRO is available to help.

DATAC is proud to highlight the organizations and service providers that contribute to Canada's growing drug and alcohol testing community. Through education, collaboration, and access to qualified industry professionals, we can continue to strengthen workplace testing practices across Canada.

TO LEARN MORE, CALL CANADIAN MRO 403-744-5213

Industry News Article

Let's Talk DOT Random Testing

Random drug testing is one of the cornerstones of the U.S. Department of Transportation's (DOT) drug and alcohol testing program. While the concept seems straightforward—select employees at random and conduct testing—the compliance requirements are often misunderstood.

Questions frequently arise about what happens if a test is cancelled, whether a recollection is required, and what the DOT means when it says an employee must "require" a negative test before returning to safety-sensitive duties. Understanding these distinctions is essential for maintaining a compliant random testing program.

When the DOT Requires a Negative Drug Test

Most random drug tests do not require a negative result before an employee can continue performing safety-sensitive duties. The employee is selected, tested, and continues working unless another circumstance requires removal from duty.

However, there are several situations under Part 40 where the DOT specifically requires an employee to have a verified negative drug test before they are authorized to perform safety-sensitive functions. These include:

Pre-employment testing: before an individual first performs a DOT safety-sensitive function, 49 CFR §40.25 and applicable modal regulations:

FMCSA - §382.301
FTA - §655.41
FAA - §120.109(a)
PHMSA - §199.105(a)
USCG - §16.210

Return-to-duty testing: following a DOT drug or alcohol regulation violation. Before resuming safety-sensitive duties, the employee must successfully complete the return-to-duty process and have a negative drug test (or an alcohol result of less than 0.02). (49 CFR §§40.305–40.307.)

Follow-up testing: After returning to duty, follow-up tests required by the Substance Abuse Professional (SAP) also require a negative drug test (or alcohol result below 0.02) before the employee continues safety-sensitive work. (49 CFR §40.307.)

These are often referred to as situations that "require a negative test."

Cancelled Tests Are Different

A cancelled drug test is frequently misunderstood. Under **49 CFR §40.207**, a cancelled drug test is **neither positive nor negative.** It is simply invalid for compliance purposes.
The regulation is very clear:

- A cancelled test cannot be treated as a positive result.
- A cancelled test cannot be treated as a negative result.
- In situations where the DOT requires a negative test before an employee may perform safety-sensitive duties, a cancelled test does not satisfy that requirement.

For example, if a return-to-duty test is cancelled because of a laboratory or collection issue, the employee cannot resume safety-sensitive work until another test is completed and a verified negative result is obtained.

One of the most important compliance points for employers and consortium administrators is remembering that the 49 CFR §40.207(b) states that a cancelled test **does not count toward compliance with DOT requirements** - this INCLUDES meeting the employer's minimum annual random testing rate.
A possible example could look like this:

- An employee is randomly selected.
- The specimen is cancelled by the Medical Review Officer because of an invalid laboratory result, but donor not required to retest.
- A cancelled test cannot be counted so the employer must choose a new employee

Depending on the reason for the cancellation, another collection may or may not be required from the employee under Part 40.

When Is Another Collection Required?

Not every cancelled test results in an automatic recollection.
Under **49 CFR §40.207(a)(3)**, employers generally must not order another collection simply because a test was cancelled.

A recollection is permitted only when another section of Part 40 specifically requires it.
Examples include:

- Certain invalid laboratory results, which may require an immediate recollection and, in some circumstances, collection under direct observation (49 CFR §40.159).
- Specimens reported as Rejected for Testing, where recollection may be required (49 CFR §40.161).
- Other situations identified in 49 CFR §40.201, where the Medical Review Officer must cancel the test and direct the Designated Employer Representative (DER) regarding any required additional collection.

The reason for the cancellation—not simply the fact that it was cancelled—determines whether another test is required.
For employers, consortiums, collectors, and DERs, understanding these distinctions helps ensure that random testing programs remain compliant while avoiding unnecessary recollections or compliance deficiencies.

Key Takeaways

Understanding what counts—and what doesn't—is critical for maintaining DOT compliance.

Remember:

- Random selections must be scientifically valid and truly random.
- Most random tests do not require a negative result before the employee continues working.
- The DOT specifically requires a verified negative drug test before employees may perform safety-sensitive duties following **pre-employment, return-to-duty, and follow-up** testing.
- A cancelled test is **neither positive nor negative.**
- A cancelled test **does not count** toward an employer's required annual random testing rate.
- Whether another collection is required depends on the specific reason for the cancellation and the applicable provisions of Part 40.

Industry News Article

Overview of risk and prevention in rural communities

A recent systematic review published in the peer-reviewed journal Cureus examined the burden of mental health and substance use harms in British Columbia by reviewing the available evidence. Specifically, the researchers assessed the scale of the problem and its implications for public health policy in the province.

The review found that Northern British Columbia experiences disproportionately high rates of mental health and substance use disorders, including depression, anxiety, psychological distress, substance-related harms, and suicide. The authors also noted that residents of rural and remote communities face significant barriers to accessing mental health and addiction services. The review highlighted the disproportionate impact of B.C.'s toxic drug crisis on the region, citing limited access to harm reduction and addiction treatment services, geographic isolation, and other social challenges as contributors to elevated overdose-related harms.

Substance use and access to treatment emerged as major concerns across rural and Northern B.C. Geographic distance, housing instability, stigma, transportation challenges, and clinic policies were repeatedly identified as barriers to opioid agonist treatment and other harm reduction services. Rural and smaller communities were also less likely than urban areas to have access to safer supply prescriptions, while the availability and implementation of services such as drug checking varied considerably between communities.

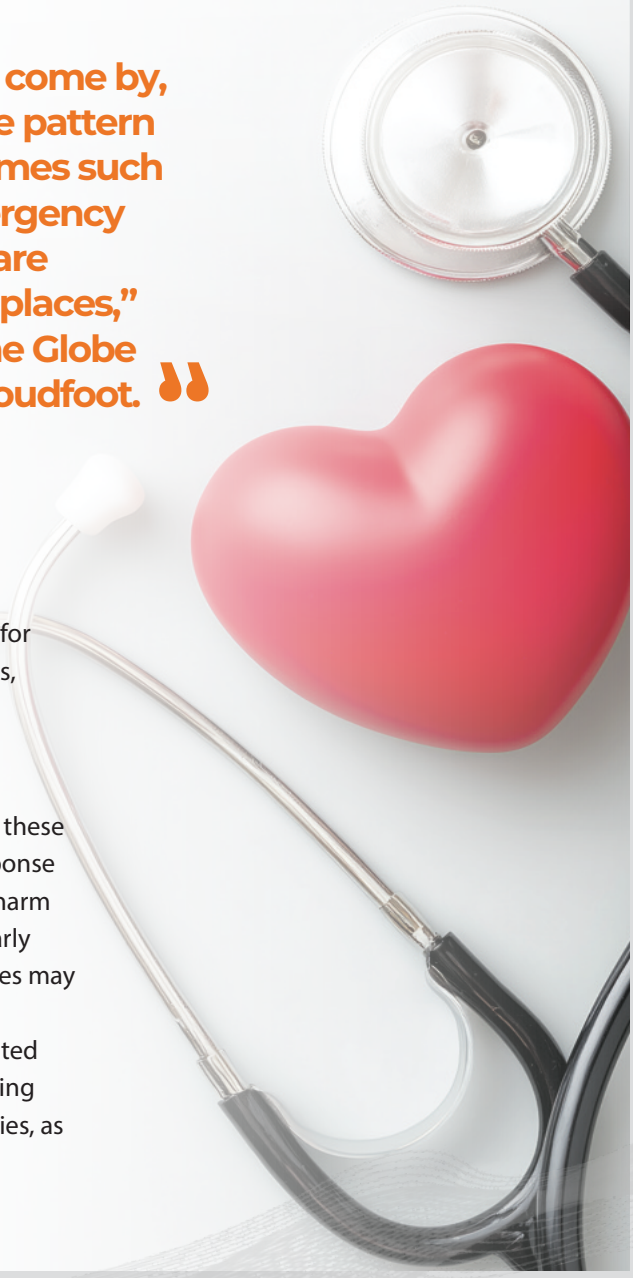
The review also identified important mental health challenges, including depression, psychological distress, anxiety, and social isolation. At the same time, social support and community-based programs emerged as important protective factors, with some initiatives associated with reduced apathy and social isolation. However, only two of the 14 studies evaluated interventions using measurable outcomes, highlighting a major lack of evidence on which interventions are most effective for improving mental health and substance use outcomes in rural and Northern B.C.

> **"The results show that depression, anxiety disorders, trauma-related disorders, alcohol misuse, opioid use disorder, and polysubstance use are still disproportionate in underserved and remote populations," wrote the authors. "These results are also determined by individual-level vulnerabilities and systemic injustices, such as poor healthcare access, socioeconomic instability, stigma, and historical marginalization."**

The study authors called for a multilevel approach to addressing mental health and substance use disparities in rural and Northern B.C., combining prevention and early intervention with more equitable access to services and broader structural changes. They also recommended investments in workforce development, culturally appropriate care, regional surveillance, and further research to determine which interventions can be effectively sustained and expanded.

Evidence from elsewhere in Canada suggests that these disparities extend beyond British Columbia. Previous research has shown that smaller Canadian communities experience substantially higher rates of opioid poisoning hospitalizations than the country's largest cities. An analysis published by the Canadian Institute for Health Information (CIHI) found that, although hospitalization rates varied across provinces and territories, communities with populations between 50,000 and 99,999 experienced some of the highest rates of opioid poisoning. This pattern remained evident over the period spanning 2018 to 2024.

> **"Other national statistics are difficult to come by, but provincial numbers show the same pattern – on a per-capita basis, negative outcomes such as opioid deaths, hospitalizations, emergency room visits or ambulance attendance are consistently more common in smaller places," concluded an analysis published by The Globe and Mail and authored by Shannon Proudfoot.**



More recent research from Ontario provides further evidence of this geographic disparity. A 2025 study found that sparsely populated regions had an opioid-related death rate 3.5 times higher than urban regions, while rural regions also experienced substantially higher mortality. Similar disparities were observed for opioid-related emergency department visits and hospitalizations, with both rural and sparsely populated regions consistently experiencing greater per-capita harms than urban areas.

The researchers identified several factors that may contribute to these disparities, including geographic isolation, long emergency response times, limited transportation options, and difficulties accessing harm reduction and addiction services. These barriers can be particularly consequential in smaller and remote communities, where services may be centralized in regional hubs and residents may have to travel considerable distances to receive care. The authors also highlighted socioeconomic instability, housing insecurity and stigma, including concerns about privacy and confidentiality in smaller communities, as additional barriers that may discourage people from seeking treatment or accessing harm reduction services.

Industry News Article

Oral fluid testing: Use vs. Impairment

Earlier this month, a labour arbitrator struck down the Toronto Transit Commission's (TTC) random drug and alcohol testing program, finding that it violated employees' Charter rights and their collective agreement. The TTC's largest union, ATU Local 113, welcomed the ruling, which followed a legal challenge to the policy dating back to 2011. The decision concluded that oral fluid tests for cannabis and cocaine cannot reliably determine workplace impairment.

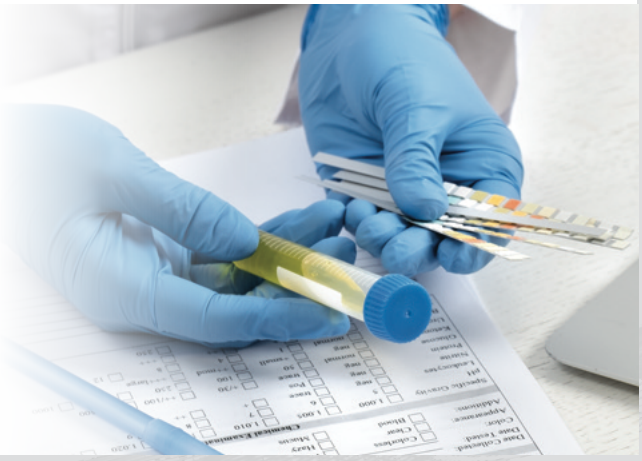
The decision has generated considerable discussion within Canada's drug and alcohol testing community, not only about random testing, but about the science and purpose of oral fluid drug testing. The decision deserves careful consideration and raises an immediate question: what is an oral fluid drug test actually designed to determine?

No claim they measure impairment

The central criticism of oral fluid cannabis testing in the TTC arbitration was that a positive tetrahydrocannabinol (THC) oral fluid test result cannot reliably establish that an individual is impaired at the time of testing. On that point, the drug testing industry should be completely clear: Correct. It does not, nor is it intended to be or marketed that way.

The arbitrator, Laura Trachuk, said the test "is not as reliable as a breathalyzer, which determines if someone has consumed alcohol, and has not been accepted as evidence of impairment in criminal matters." This is, however, not a failure of the test; it is a misunderstanding of the intended purpose of the test. While oral fluid testing may detect recent cannabis use, it does not establish whether an employee is impaired. A test designed to identify recent cannabis use should not be expected to function like a breath alcohol testing instrument designed for a completely different purpose: determining impairment based on an approximation of the person's blood alcohol content. Yet much of the discussion surrounding the TTC decision appears to make precisely that comparison.

Comparing an oral fluid THC test to a breathalyzer, as Ms. Trachuk did in her arbitration, is an argument based on a false equivalency. Breathalyzers measure alcohol concentration in breath, which has decades of research showing its measurable relationship, in a fixed ratio to blood alcohol concentration, using an approximated ratio called the partition ratio, of 2100:1. There are innumerable studies showing the relationship between impairment and the levels of blood alcohol content. Whereas for oral fluid, research repeatedly shows that it should not be used as a test for impairment, but as a test to indicate recent use.



In 2022, Robertson et al.[1] did a systematic review of THC in oral fluid that concluded that results should not be treated as a surrogate for the level of THC in blood or as a measurement of impairment based on the amount of THC present in the oral fluid specimen. That doesn't mean oral fluid is an inherently inaccurate drug testing matrix; it means that the concentration in oral fluid should not be interpreted as though it were related to blood THC concentration and, as such, a measurement of impairment.

Scientific literature solidly supports oral fluid as a very useful and accurate matrix for detecting recent cannabis use. A 2024 individual participant meta analysis by Macdonald & Zhao[2] examined THC concentrations in oral fluid after cannabis administration and found that oral fluid testing can identify prior cannabis use. The researchers also explicitly stated that oral fluid tests are not a valid way to detect cannabis impairment and that detection times vary according to factors such as dose, frequency of use, and route of administration.

The detection of THC in oral fluid is fundamentally different from alcohol. Cannabis does not behave like alcohol in the human body, and THC concentrations related to the effects of impairment, through metabolization and eventually elimination, vary considerably between individuals. A person's THC oral fluid concentration cannot simply be translated into a predictable level of impairment in the same way that a breath alcohol concentration can be interpreted. This is precisely why oral fluid THC testing should never be used as an impairment test. What the results of oral fluid testing do indicate, very reliably and accurately, is recent cannabis use.

Tests have defined purposes: The reliability of a test must be assessed against what the test is designed and validated to measure. Oral fluid THC testing is designed, and scientifically shown, to detect THC in oral fluid following cannabis use much the same as urine tests do. The difference is that THC is detectable in oral fluid for a much shorter period of time than in urine, but the point and purpose of testing these two specimens is the same.

DOT approved oral fluid testing

In 2023, the U.S. Department of Transportation (DOT) amended its regulated drug testing program to authorize oral fluid testing alongside urine testing. The rulemaking process involved extensive scientific, regulatory, and public comment consideration, including alignment with the Department of Health and Human Services' (HHS) Federal Workplace Drug Testing guidelines. The DOT specifically described oral fluid as an alternative testing methodology to that of urine testing that would provide employers with another means of achieving the safety objectives of the program. The DOT did not authorize oral fluid as an "impairment test"; it authorized it as an alternative sample to urine for the purpose of determining recent drug use.

The DOT's framework recognizes that urine and oral fluid provide different windows of detection, with oral fluid looking at a more recent window of use than urine. Rather than declaring one matrix "reliable" and the other "unreliable," the regulatory framework recognizes both as legitimate specimen types for federal workplace drug screening programs.

Oral fluid drug testing should be evaluated according to its stated purpose, its cutoff levels, its collection methodology, its confirmation process, and the scientific evidence supporting its use. It should not be evaluated based on its accuracy, or viability, as an impairment test, as it would be unfair and ill-informed to do so.

References

1. Robertson, M. B., Li, A., Yuan, Y., Jiang, A., Gjerde, H., Staples, J. A., & Brubacher, J. R. (2022). Correlation between oral fluid and blood THC concentration: A systematic review and discussion of policy implications. Accident Analysis & Prevention, 173, 106694. https://doi.org/10.1016/j.aap.2022.106694
2. Macdonald, S., & Zhao, J. (2024). Concentrations of Delta 9 tetrahydrocannabinol (THC) in oral fluid at different time points after use: An individual participant meta analysis. Heliyon, 10(22), e39873. https://doi.org/10.1016/j.heliyon.2024.e39873

Industry News Article

U.S. federal cannabis rescheduling: status and considerations

Federal efforts to reschedule cannabis began in 2022, when President Joe Biden directed HHS and the DEA to review its classification under the Controlled Substances Act. Following HHS's recommendation to move cannabis from Schedule I to Schedule III, the DEA proposed a rule in 2024, prompting more than 42,000 public comments and administrative hearings that were subsequently delayed. In late 2025, President Trump directed the attorney general to expedite the rescheduling process, and in April 2026 Acting Attorney General Todd Blanche placed certain medical cannabis products in Schedule III while initiating expedited proceedings on broader rescheduling.

Under the Controlled Substances Act, Congress authorizes the Attorney General to schedule, reschedule, or deschedule controlled substances, with this authority delegated to the DEA.. The DEA determines a substance's scheduling status based on factors including its medical use, abuse potential, and safety profile. The HHS also plays a central role by conducting a scientific and medical evaluation and recommending an appropriate schedule. In addition, the DEA must consider HHS's findings when proposing and finalizing scheduling decisions.

NDASA has concerns

NDASA has formally opposed the broader rescheduling of cannabis from Schedule I to Schedule III under the Controlled Substances Act. The organization argues that rescheduling could create unintended consequences for federally mandated drug testing programs, including potential challenges to the authority of SAMHSA-certified laboratories to test for cannabis. NDASA presented these concerns during the DEA's 2026 administrative proceedings, emphasizing the potential impact on workplace and transportation safety.

What Could This Mean for the DOT Drug Panel?

One of the biggest questions for the drug testing industry is whether cannabis would remain part of the DOT-regulated drug testing panel if cannabis is ultimately moved to Schedule III.

At present, there has been no change to DOT's canabis testing requirements. However, NDASA is concerned about what could happen after rescheduling. The concern centres on the relationship between DOT's testing requirements and the federal laboratory standards established through HHS/SAMHSA. If cannabis were moved to Schedule III, questions could arise about whether federally certified laboratories would continue to have the necessary authority to test for it under the existing federal framework.

If those regulatory issues are not resolved, one potential outcome could be the removal of THC from federally mandated testing panels, including the DOT panel. This is not a current DOT decision, nor is THC removal guaranteed—but it is one of the possible consequences being raised by NDASA in its opposition to rescheduling.

Why Is This Important?

For transportation employers, collectors, laboratories, MROs, SAPs, TPAs, and other service agents, cannabis testing is a fundamental component of the DOT program. A change to the panel could have significant implications for testing procedures, policies, training, laboratory operations, and workplace safety programs.

There is also a broader concern: rescheduling cannabis would not necessarily mean that cannabis use is acceptable for safety-sensitive employees. The DOT has made clear that its safety requirements are separate from the drug's classification under the Controlled Substances Act. For now, the message to the industry is simple: nothing has changed in the DOT testing program. Employers should continue following the existing DOT regulations and testing for cannabis as required.

However, this is an issue worth watching closely. Any future changes involving cannabis' federal classification, HHS/SAMHSA laboratory authority, or DOT regulations could have significant consequences for the workplace drug testing industry.

DATAC will continue to monitor developments in the United States and share information that may affect Canadian professionals who work with U.S. DOT programs or serve organizations operating on both sides of the border.

MEDICAL REVIEW OFFICER

AND ASSISTANT'S ROLES **IN DRUG TESTING**

TEST PROCEDURE

Specimen Collected

→ Collector sends the specimen to the laboratory

→ Collector sends a copy of the CCF to the MRO

→ The MRO completes the QA (Quality Assurance) of the CCF.

If an error is found the MRO issues an MFR (Memorandum For the Record).

OBTAINING RESULTS

After the lab tests the specimen, the results are sent digitally to the MRO.

→ When the MRO receives the test results they must match the correct CCF with the results.

NEGATIVE RESULT

If a result is Negative the MRO matches the results to the CCF. QA is completed before releasing the report to the employer.

NON-NEGATIVE RESULT

If a result is Non-Negative, the interview process begins. The MRO calls the donor to obtain any medical information or prescriptions.

If the donor has a Rx and can provide proof, the MRO may overturn the positive test result.

INTERVIEW PROCESS

The interview process requires that the donor be called at least three times within the first 24 hours after receipt of the results.

→ MROA ····· DER

If the donor has not been reached within 24 hours, the MRO will contact the DER asking for their help to reach them.

The DER notifies the MRO that they were able to contact the donor. The report will be released 72 hours later, or immediately after the interview is completed.

The MRO will continue to call the donor and if they not interviewed, the MRO will then release the report 10 days from when the lab results were received.

When a POS result is released, the DER will be notified by the MRO so they may remove the donor from safety-sensitive jobs.

Why is it important to have a Medical Review Officer?

To comply with regulations – DOT, Federal and Provincial Laws

To reduce exposure to liability in your drug testing program

Effective Date: 06DEC22 | Version: 1.4

Canadian MRO provides DOT drug test medical review, and excellent customer service.

Please contact us for more information to learn how we can help your drug testing business succeed.

(403) 744-5213 | CanadianMRO.ca

DATAC

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Thanks for reading!

If you would like more content like this, head over to DATAC.ca where we post frequent articles on the latest drug & alcohol testing news.

DATAC.CA

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