DISCIPLINE COMMITTEE
OF THE COLLEGE OF CHIROPODISTS OF ONTARIO

PANEL:	Cesar Mendez – Chair Sohail Mall – Public Member Adrian Dobrowsky – Professional Member Neil Naftolin – Professional Member Agnes Potts – Public Member
BETWEEN:	
COLLEGE OF CHIROPODISTS OF ONTARIO (the "College")	JORDAN GLICK for the College
- and -	MEGAN SAVARD for the Member, PIERRE DUPONT
PIERRE DUPONT, D.Ch.	LUISA RITACCA, Independent Legal Counsel
	Heard: July 11, 2017

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee on July 11, 2017 at Victory Verbatim, in Toronto.

The Allegations

The allegations against Pierre Dupont (the "Member") as stated in the Notice of Hearing dated January 3, 2017, (Exhibit 1, Tab 1), are as follows.

IT IS ALLEGED THAT:

1. Pierre Dupont (the **"Member"**) is, and was at all materials times, a chiropodist registered to practise chiropody in the Province of Ontario.

2. At all material times, the Member practised chiropody at Ottawa Foot Practice ("**OFC**"), located in Ottawa, Ontario.

3. The Member advertised to prospective clients that he performed the subtalar arthroereisis procedure (**"Stent Implant Procedure"**), a procedure devised to address the ill- effects of excessive pronation (commonly referred to as "flat feet", "pes planus" or "fallen arches"). The Stent Implant Procedure involves the placement of an Extra-Osseous TaloTarsal Stabilization Device (the **"Stent"**) into the canalis portion of the sinus tarsi of the foot. Once inserted, the Stent is intended to re-align the foot and ankle bones thereby reducing pain while restoring normal function.

4. The Member advertised to prospective clients that the procedure would be performed using the HyProCure Stent which is a Stent that is produced by GraMedica. The HyProCure Stent has been approved for use by Health Canada.

5. In or about the years 2014 to 2016, the Member provided chiropody services to the clients listed in Appendix "A" (collectively the **"Clients"**), as well as client C.G., including initial chiropody assessment, performing the Stent Implant Procedure and providing post- operative care.

6. Before performing the Stent Implant Procedure, the Member advised some or all of the Clients that he would be implanting the HyProCure Stent and some or all of the Clients signed an informed consent which indicated that the HyProCure Stent would be inserted. Notwithstanding the signed informed consent, the Member implanted a Stent of his own design (the **"Member's Stent"**) into one or both of the Clients' feet.

7. The Member thereby engaged in professional misconduct within the meaning of paragraph 2 (failing to meet or contravening a standard of practice of the profession), paragraph 3 (doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent), paragraph 12 (breaching an agreement with a patient relating to professional services for the patient or fees for such services), paragraph 20 (signing or issuing, in the member's professional capacity, a document that contains a false or misleading statement), paragraph 31 (contravening a provincial law if the purpose of the law is to protect the public health or the contravention is relevant to the member's suitability to practice, and in particular, the *Health Care Consent Act, 1996*) and paragraph 33 (engaging in conduct or performing an act, in the course of practising the profession, that having regard to all the circumstances would reasonably be regarded by members as disgraceful, dishonourable or unprofessional) of section 1 of Ontario Regulation 750/93 under the *Chiropody Act*, 1991.

8. The Member's Stent was not approved by Health Canada prior to use, though it was required to be. The Member did not take steps to seek necessary Health Canada approvals before surgical implantation.

9. The Member thereby engaged in professional misconduct within the meaning of paragraph 31 (contravening a federal or provincial law if the purpose of the law is to protect the public health or the contravention is relevant to the member's suitability to practice, and in particular, the *Food and Drugs Act,* RSC 1985 and its Regulations) and paragraph 33 (engaging in conduct or performing an act, in the course of practising the profession, that having regard to all the circumstances would reasonably be regarded by members as disgraceful, dishonourable or unprofessional) of section 1 of Ontario Regulation 750/93 under the *Chiropody Act*, 1991.

10. The Member additionally fitted and dispensed to clients E.B., N.B., F.D., A.K. and C.G. custom orthotic devices prior to performing the Stent Implant Procedure, notwithstanding that:

(i) the HyProCure Stent is designed so as to avoid a need for orthotics;

(ii) the Stent Implant Procedure may change the anatomy and positioning of the foot as well as the patient's gait; and,

(iii) the Member did not account for the fact that post-operative adverse effects, such as significant and prolonged swelling of these clients' foot and leg, may occur which could render prescribed orthotics unusable and of little functional benefit.

11. *Allegations Withdrawn*.

12. While providing care to E.B., N.B., F.D., A.K., M.K., T.C., A.L.D., K.N. and C.G., the Member failed to:

(i) adequately record reasonable information about every examination he performed and reasonable information about every clinical finding, diagnosis and assessment he made;

(ii) adequately record reasonable information about all significant advice given by him;

(iii) adequately record the treatment plan; and,

(iv) adequately conduct operative and post-operative record keeping.

13. The Member thereby contravened Sections 13 and 17 of Ontario Regulation 203/94 under the *Chiropody Act,* 1991 and engaged in professional misconduct within the meaning of paragraph 2 (failing to meet or contravening a standard of practice of the profession), paragraph 17 (failing to keep records as required by the Regulations) and paragraph 33 (engaging in conduct or performing a! act, in the course of practising the profession, that having regard to all the circumstances would reasonably be regarded by members as disgraceful, dishonourable or unprofessional) of section 1 of Ontario Regulation 750/93 under the *Chiropody Act*, 1991.

14. The Member additionally engaged in acts of professional misconduct

as follows:

(i) With respect to client E.B., the Member:

(a) failed to conduct an adequate assessment and to consider whether E.B. was a good candidate for the Stent Implant Procedure;

(b) failed to consider, discuss and/or attempt more conservative means to manage E.B.'s principle complaint of pain;

(c) failed to provide to E.B. a realistic assessment for recovery post- operatively;

(d) failed to perform the Stent Implant Procedure in an appropriate manner;

(e) failed to adequately conduct post-operative care; and,

(f) injected E.B. in an anatomic location that is beyond the permissible scope of practice (calf).

(ii) With respect to client N.B., the Member:

(a) failed to conduct an adequate assessment and to consider whether N.B. was a good candidate for the Stent Implant Procedure;

(b) failed to recognize and adequately advise N.B. that as a result of significant posterior tibial tendon dysfunction in the patient, it was unlikely that the stent procedure would be successful;

(c) failed to perform the Stent Implant Procedure in an appropriate manner;

(d) failed to adequately place the Stent in the appropriate position;

(e) booked the Stent Implant Procedure for the contralateral limb when the post-operative outcome was not adequate after the first procedure; and,

(f) failed to adequately conduct post-operative care.

(iii) With respect to Client F.D., the Member:

(a) failed to conduct an adequate assessment and to consider whether F.D. was a good candidate for the Stent Implant Procedure;

(b) failed to consider less invasive options to the Stent Implant Procedure, including the option of continuing to treat via orthotics as F.D. was asymptomatic;

(c) failed to adequately advise F.D. and guardian to consult with another regulated health professional regarding treatment options;

(d) failed to perform the Stent Implant Procedure in an appropriate manner;

(e) failed to adequately place the Stent in the appropriate position but instead, implanting the Stent in a manner that created an "overcorrection";

(f) booked the Stent Implant Procedure for the contralateral limb when the post-operative outcome was not adequate after the first procedure;

(g) failed to identify post-operative complications including muscle contracture of the peroneal brevis and longus of the right foot, and to advise F.D. and guardian to consult with another regulated health professional regarding treatment options; and,

(h) failed to adequately conduct post-operative care.

(iv) With respect to client A.K., the Member:

(a) failed to conduct an adequate assessment of A.K.'s anatomy to determine whether A.K. was a good candidate for the Stent Implant Procedure;

(b) failed to adequately consider less invasive alternatives to the Stent Implant Procedure;

(c) failed to perform the Stent Implant Procedure in an appropriate manner; and,

(d) failed to adequately conduct post-operative care.

(v) With respect to client M.K., the Member:

(a) failed to conduct an adequate assessment of M.K.'s anatomy to determine whether M.K. was a good candidate for the Stent Implant Procedure;

(b) failed to adequately advise M.K. that as a result of M.K.'s foot anatomy, it was unlikely that the procedure would be successful, and recommend that M.K. consult with another regulated health professional;

(c) failed to use a guidewire to ensure proper placement of the Stent;

(d) failed to perform the Stent Implant Procedure in an appropriate manner;

(e) used a medical instrument to curette the bony structures adjacent to the sinus tarsi and the articular facets to widen the sinus tarsi;

(f) failed to adequately place the Stent in the appropriate position;

(g) failed to use intraoperative fluoroscopy to confirm Stent position and/or misidentified the Stent as being in the correct position;

(h) failed to adequately address complications throughout the procedure, including the excessive hemorrhage that had occurred;

(i) booked the Stent Implant Procedure for the contralateral limb when the post-operative outcome was not adequate after the first procedure; and,

(j) failed to adequately conduct post-operative care.

(vi) With respect to client A.L.D., the Member:

(a) failed to adequately consider less invasive alternatives to the Stent Implant Procedure;

(b) failed to perform the Stent Implant Procedure in an appropriate manner; and,

(c) failed to adequately conduct post-operative care.

(vii) With respect to client C.G., the Member:

(a) failed to conduct an adequate assessment of C.G.'s anatomy to determine whether C.G. was a good candidate for the Stent Implant Procedure;

(b) failed to adequately consider whether C.G.'s presenting issues, and potential complications from performing the Stent Implant Procedure, were beyond his competence and/or would require treatment beyond his scope of practice;

(c) failed to adequately advise C.G. that it was unlikely that the procedure would address C.G.'s issues, and recommend that C.G. consult with another regulated health professional;

(d) failed to perform the Stent Implant Procedure in an appropriate manner;

(e) made use of his own surgical instruments;

(f) booked the Stent Implant Procedure for the contralateral limb when the post-operative outcome was not adequate after the first procedure;

(g) failed to adequately conduct post-operative care, including permitting C.G. to ambulate right away; and,

(h) failed to communicate quickly and effectively with another regulated health professional when post-operative complications presented.

15. *Allegations Withdrawn*.

16. *Allegation Withdrawn.*

SCHEDULE “A”

PATIENT

1. E.B.
2. N.B.
3. F.D.
4. A.K.
5. M.K.
6. T.C.
7. A.L.D.
8. K.N.
9. M.M.
10. V.B.
11. G.S.
12. A.N.
13. T.N.
14. K.W.
15. D.H.
16. M.H.
17. D.O.
18. M.O.
19. M.L.F.
20. S.B.
21. P.Z.
22. A.H.
23. R.M.
24. F.L.
25. M.L.B.

Member's Plea

The Member admitted the allegations set out in the Notice of Hearing, save for those which the College sought to withdraw.

The panel conducted an oral plea inquiry and was satisfied that the Member's admissions were voluntary, informed and unequivocal.

Agreed Statement of Facts

Counsel for the College and Member advised the panel that agreement had been reached on the facts and introduced an Agreed Statement of Facts (Exhibit 2) which provided as follows.

> MEMBER
>
> l. Pierre Dupont (the "Member") is and was at all material times a chiropodist registered to practise chiropody in the Province of Ontario. At all material times, he practised chiropody at Ottawa Foot Practice ("OFC") located in Ottawa, Ontario.
>
> STENT IMPLANT PROCEDURE
>
> 2. The Member advertised to prospective clients that he performed the subtalar arthroereisis procedure ("Stent Implant Procedure"), a procedure devised to address the ill-effects of excessive pronation (commonly referred to as "flat feet", "pes planus" or "fallen arches"). The Stent Implant Procedure involves the placement of an Extra-Osseous TaloTarsal Stabilization Device (the "Stent") into the canalis portion of the sinus tarsi of the foot. Once inserted, the Stent is intended to re-align the foot and ankle bones thereby reducing pain while restoring normal function.
>
> 3. In or about the years 2014 to 2016, the Member advertised to prospective clients that he performed the Stent Implant Procedure using the HyProCure Stent which is a Stent that is produced by GraMedica. The HyProCure Stent has been approved for use by Health Canada. The Member used HyProCure Stents to perform Stent Implant Procedures between February 2014 and April 2016. In November 2014, in addition to performing the Stent Implant Procedure using HyProCure Stents, he began performing Stent Implant Procedures using Stents of his own design (the "Member's Stent").
>
> 4. In or about the years 2014 to 2016, the Member provided chiropody services to the clients listed in Appendix "A" (collectively the "Clients"), as well as client C.G., including initial chiropody assessment, performing the Stent Implant Procedure and providing post-operative care.
>
> 5. Before the Stent Implant Procedure, some of the Clients signed an informed consent which indicated that the HyProCure Stent would be inserted (the "HyProCure

Consent"). Notwithstanding the signed informed consent, the Member implanted the Member's Stent into one or both of the Clients' feet.

6. The Member's Stent was not approved by Health Canada, though it was required to be. The Member did not take steps to seek necessary Health Canada approvals before surgical implantation.

7. If the Member were to testify, he would state that he did not believe he needed Health Canada approval for the Member's Stent because the nature, composition and design was the same as or similar to the HyProCure Stent and because he was not planning to resell the Member's Stents to other health care professionals. He would state that he believed the Member's Stents were of similar quality to the HyProCure Stents. He would state that he developed a HyProCure Consent at a time when he exclusively used HyProCure Stents in the Stent Implant Procedures. When he began performing Stent Implant Procedures with the Member's Stent, he did not think to modify or replace the HyProCure Consent forms. He frequently used the term "HyProCure Procedure" as shorthand for the Stent Implant Procedure generally, and did not turn his mind to the misleading effect of referring to the Procedure by brand name.

8. If the Clients were to testify, they would state that they believed that the Stent Implant Procedure was going to be performed using the HyProCure Stent.

9. While providing care to E.B., N.B., F.D., A.K., M.K., T.C., A.L.D., K.N. and C.G., the Member failed to:

> (i) adequately record reasonable information about every examination he performed and reasonable information about every clinical finding, diagnosis and assessment he made;
>
> (ii) adequately record reasonable information about all significant advice given by him;
>
> (iii) adequately record the treatment plan; and,
>
> (iv) adequately conduct operative and post-operative record keeping.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

10. By virtue of the above conduct, the Member admits to contravening:

> (a) paragraph 2 (failing to meet or contravening a standard of practice of the profession), paragraph 3 (doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent),

paragraph 12 (breaching an agreement with a patient relating to professional services for the patient), paragraph 20 (signing or issuing, in the member's professional capacity, a document that contains a false or misleading statement), paragraph 31 (contravening a provincial law if the purpose of the law is to protect the public health or the contravention is relevant to the member's suitability to practice, and in particular, the Health Care Consent Act, 1996) and paragraph 33 (engaging in conduct or performing an act, in the course of practising the profession, that having regard to all the circumstances would reasonably be regarded by members as disgraceful, dishonourable or unprofessional) of section 1 of Ontario Regulation 750/93 under the Chiropody Act, 1991 by virtue of the conduct admitted to in paragraphs 3 to 5 above. For greater clarity, the admissions in this section correspond with the allegations at paragraph 7 of the Notice of Hearing;

(b) paragraph 31 (contravening a federal or provincial law if the purpose of the law is to protect the public health or the contravention is relevant to the member's suitability to practice, and in particular, the Food and Drugs Act, RSC 1985 and its Regulations) and paragraph 33 (engaging in conduct or performing an act, in the course of practising the profession, that having regard to all the circumstances would reasonably be regarded by members as disgraceful, dishonourable or unprofessional) of section 1 of Ontario Regulation 750/93 under the Chiropody Act, 1991 by virtue of the conduct admitted to in paragraph 6 above. For greater clarity, the admissions in this section correspond with the allegations at paragraph 9 of the Notice of Hearing ;

(c) sections 13 and 17 of Ontario Regulation 203/94 under the Chiropody Act, 1991 and paragraph 2 (failing to meet or contravening a standard of practice of the profession), paragraph 17 (failing to keep records as required by the Regulations) and paragraph 33 (engaging in conduct or performing an act, in the course of practising the profession, that having regard to all the circumstances would reasonably be regarded by members as disgraceful, dishonourable or unprofessional) of section l of Ontario Regulation 750/93 under the Chiropody Act, 1991 by virtue of the conduct admitted to in paragraph 9 above. For greater clarity, the admissions in this section correspond with the allegations at paragraph 13 of the Notice of Hearing.

MEMBER'S ACKNOWLEDGEMENTS

11. The Member understands the nature of the allegations that have been made against him and that by voluntarily admitting to these allegations, he waives his right to require the College to otherwise prove the case against him.

12. The Member understands that the Discipline Committee can accept that the facts herein constitute professional misconduct.

13. The Member irrevocably acknowledges that the facts and admissions at paragraphs 1-6 and 9-1O are correct and that these facts cannot be withdrawn under any circumstance.

14. The Member understands that depending on any penalty ordered by the Discipline Committee, the panel's decision and reasons may be published, including the facts contained herein and his name.

15. The Member understands that any agreement between him and the College does not bind the Discipline Committee.

Decision

The panel considered the Agreed Statement of Facts and the parties' submissions. It concluded that the facts support a finding of professional misconduct as admitted.

Further, the panel grants the College its request to withdraw the allegations set out at paragraphs 11, 15 and 16 of the Notice of Hearing.

Reasons for Decision

Informed consent is a fundamental patient right based on the moral and legal premise that patients have the right to make decisions about their own health. The panel finds that based on the conduct admitted in paragraphs 3 to 5 of the Agreed Statement of Facts, this right was not afforded to the Member's patients and by virtue of this conduct, the Member engaged in professional misconduct within the meaning of:

a) paragraph 2 of section 1 of Ontario Regulation 750/93 under the Chiropody Act, 1991 (failing to meet or contravening a standard of practice of the profession);

b) paragraph 3 of section 1 of Ontario Regulation 750/93 under the Chiropody Act, 1991 (doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent);

c) paragraph 12 of section 1 of Ontario Regulation 750/93 under the Chiropody Act, 1991 (breaching an agreement with a patient relating to professional services for the patient or fees for such services);

d) paragraph 20 of section 1 of Ontario Regulation 750/93 under the Chiropody Act, 1991 (signing or issuing, in the member's professional capacity, a document that contains a false or misleading statement);

e) paragraph 31 of section 1 of Ontario Regulation 750/93 under the Chiropody Act, 1991 (contravening a provincial law if the purpose of the law is to protect the public health or

the contravention is relevant to the member's suitability to practice, and in particular, the *Health Care Consent Act, 1996*);

f) paragraph 33 (engaging in conduct or performing an act, in the course of practising the profession, that having regard to all the circumstances would reasonably be regarded by members as disgraceful, dishonourable or unprofessional) of section 1 of Ontario Regulation 750/93 under the *Chiropody Act*, 1991.

In denying patients the right to informed consent, the panel specifically finds the Member's conduct to be disgraceful, dishonourable and unprofessional.

Further, the panel finds that based on the conduct admitted in paragraphs 5 and 6 of the Agreed Statement of Facts, , the Member engaged in professional misconduct within the meaning of:

a) paragraph 31 of section 1 of Ontario Regulation 750/93 under the Chiropody Act, 1991 (contravening a federal or provincial law if the purpose of the law is to protect the public health or the contravention is relevant to the member's suitability to practice, and in particular, the Food and Drugs Act, RSC 1985 and its Regulations);

b) paragraph 33 of section 1 of Ontario Regulation 750/93 under the Chiropody Act, 1991 (engaging in conduct or performing an act, in the course of practising the profession, that having regard to all the circumstances would reasonably be regarded by members as disgraceful, dishonourable or unprofessional).

The panel finds the Member's admission of disregard to laws designed to protect patients against potentially harmful medical devices as specifically disgraceful, dishonourable and unprofessional.

Finally, the panel finds that by virtue of the conduct admitted in paragraph 9 of the Agreed Statement of Facts, the Member engaged in professional misconduct within the meaning of:

a) sections 13 and 17 of Ontario Regulation 203/94 under the Chiropody Act, 1991;

b) paragraph 2 of section 1 of Ontario Regulation 750/93 under the Chiropody Act, 1991 (failing to meet or contravening a standard of practice of the profession);

c) paragraph 17 of section 1 of Ontario Regulation 750/93 under the Chiropody Act, 1991 (failing to keep records as required by the Regulations);

d) paragraph 33 of section 1 of Ontario Regulation 750/93 under the Chiropody Act, 1991 (engaging in conduct or performing an act, in the course of practising the profession, that having regard to all the circumstances would reasonably be regarded by members as disgraceful, dishonourable or unprofessional).

Documentation and record keeping are a critical component to the successful delivery of healthcare and a legislative requirement. The panel finds the Member's seeming indifference to these tasks as dishonourable and unprofessional.

Penalty

Counsel for the parties advised the panel that a Joint Submission as to Penalty and Costs had been agreed upon. The Joint Submission as to Penalty and Costs provides as follows:

> 1. The College of Chiropodists of Ontario (the "College") and Dr. Pierre Dupont (the "Member") agree and jointly submit that the Discipline Committee make the following order:
>
> (a) An Order directing the Registrar to revoke the Member's certificate of registration. The Member undertakes (pursuant to the Undertaking and Acknowledgment attached as Schedule "A"), never to re-apply to the Registrar or the College for a new certificate of registration or to seek reinstatement of his certificate of registration.
>
> (b) An Order requiring the Member to appear before the panel to be reprimanded and the fact of the reprimand to be recorded on the Register of the College.
>
> (c) An Order requiring the Member to pay the College's costs fixed in the amount of $30,000.00 of which $20,000.00 is to be provided in a certified cheque on the date that this matter is to be heard. The remaining $10,000.00 is to be paid no later than July 31st, 2017.
>
> 2. The Member acknowledges that pursuant to section 56 of the *Health Professions Procedural Code*, being Schedule 2 to the *Regulated Health Professions Act, 1991*, the decision and reasons, or a summary thereof, will be published in the College's annual report and may be published in any other publication of the College with the Member's name.
>
> 3. The Member acknowledges that this Joint Submission as to Penalty is not binding upon the Discipline Committee.
>
> 4. The Member acknowledges that he has obtained independent legal advice from Megan Savard of Addario law Group LLP.

Penalty Submissions

The parties filed a Joint Submission as to Penalty and Costs and indicated that the proposed penalty represents an appropriate result in the public interest.

The College also submitted a signed Undertaking and Acknowledgment document in which the Member consents to the permanent revocation of his certificate of registration and undertakes never to seek reinstatement to this College again. Further, the College filed impact statements from several patients affected by the misconduct of the Member germane to this hearing. Several of these impact statements were delivered to the panel orally by the patients themselves or their representatives.

Submissions by the Member included several letters in support of the Member's integrity and character.

Penalty Decision

The panel accepts the Joint Submission as to Penalty and accordingly makes an order accordingly.

(a) That the Registrar revoke the Member's certificate of registration. The Member undertakes (pursuant to the Undertaking and Acknowledgment attached as Schedule "A"), never to re-apply to the Registrar or the College for a new certificate of registration or to seek reinstatement of his certificate of registration.

(b) That the Member appear before the panel to be reprimanded and the fact of the reprimand to be recorded on the Register of the College.

(c) That the Member to pay the College's costs fixed in the amount of $30,000.00 of which $20,000.00 is to be provided in a certified cheque on the date that this matter is to be heard. The remaining $10,000.00 is to be paid no later than July 31st, 2017.

Reasons for Penalty Decision

The panel concluded that the proposed penalty is reasonable and in the public interest and therefore accepted the Joint Submission as to Penalty.

In coming to its decision to accept the joint submission, the panel considered the following mitigating factors:

1. By admitting the allegations of professional misconduct and entering into Agreed Statements of Facts and a joint submission as to penalty, the Member has saved the College considerable time and expense, which would have been incurred had the matter proceeded on a contested basis.

2. In admitting the allegations of professional misconduct, entering into Agreed Statements of Facts, a joint submission as to penalty, and apologizing to his patients and the panel, the Member revealed that he is accepting responsibility for his actions. He has shown regret and remorse for his conduct.

3. By agreeing to enter into the Undertaking, the Member provided the panel with the additional assurance that the Member would never again practice chiropody in this Province.

The panel considered the following aggravating factors as well:

1. The professional misconduct was not an isolated incident; rather it consisted of multiple incidents on multiple patients over an extended period of time.

2. The Member's conduct preyed upon patient vulnerability in their search for resolution to their specific health concerns and displayed an overall betrayal of the patient's trust in the Member.

3. The Member's conduct demonstrated minimal interest in existing healthcare standards and legislation designed, and in place, to protect patients from potential harm.

4. The panel is unconvinced in the potential for rehabilitation of this Member and considers the permanent revocation of the Member's certificate of registration essential in protecting the public.

5. The panel considers this penalty, and the publication and reporting of the case on the College website and in College newsletters, an effective general deterrence demonstrating to the profession as a whole that this type of conduct will not be tolerated.

6. The reporting of the case on the College website and in College newsletters is consistent with the College's mandate to protect the public and to do so in a fair and transparent manner.

Reprimand

At the conclusion of the hearing, having confirmed that the Member waived any right to appeal, the panel delivered its reprimand. A copy of the reprimand is attached at Schedule "B" of these reasons.

I, Cesar Mendez, sign this Decision and Reasons for the decision as Chairperson of this Discipline panel and on behalf of the members of the Discipline panel as listed below:

July 20, 2017

Cesar Mendez, Chairperson — Date

Sohail Mall	Public Member
Adrian Dobrowsky	Professional Member
Neil Naftolin	Professional Member
Agnes Potts	Public Member

Schedule “A”

DISCIPLINE COMMITTEE OF

THE COLLEGE OF CHIROPODISTS OF ONTARIO

BETWEEN

COLLEGE OF CHIROPODISTS OF ONTARIO

-and-

PIERRE DUPONT

UNDERTAKING AND ACKNOWLEDGEMENT

WHEREAS I am currently a member of the College of Chiropodists of Ontario (“the **College**”);

AND WHEREAS the Inquiries, Complaints and Reports Committee of the College referred allegations of professional misconduct against me to the Discipline Committee;

AND WHEREAS the College and I are prepared to resolve the allegations of professional misconduct against me based on admissions of professional misconduct and a joint submission as to order, which includes my consent to the permanent revocation of my certificate of registration;

AND WHEREAS I wish to provide additional assurances by means of this Undertaking and Acknowledgement;

Schedule “A”

NOW THEREFORE, I, **Pierre Dupont**, undertake that:

1. I will hereafter refrain from engaging in the practice of chiropody and podiatry, as described under heading “Scope of practice” in section 4 of the *Chiropody Act, 1991,* S.O. 1991, c. 20, or using any of the titles set out in section 10 of the *Act*.

2. I will hereafter refrain from reapplying for a certificate of registration with the College, or in any way seeking the reinstatement of my certificate of registration with the College.

3. I acknowledge that the Registrar will record on the College Register the fact of my voluntary Undertaking and Acknowledgement to permanently refrain from reapplying for a certificate of registration, seeking reinstatement of my certificate of registration, engaging in the practice of chiropody and podiatry, as described in section 4 of the Act, or using any of the titles set out in section 10 of the Act.

4. I am signing this Undertaking and Acknowledgement voluntarily and without compulsion or duress.

5. I have had the opportunity to obtain independent legal advice prior to signing this Undertaking and Acknowledgement and have done.

Dated _____ ___, 2017

_____

Pierre Dupont

_____

Witness:

Schedule “B”

Oral Reprimand

As you know, Mr. Dupont, as part of its penalty, this Discipline Panel has ordered and you have agreed to receive an oral reprimand.

The fact that you have received this reprimand will be part of the public portion of the Register and, as such, part of your record with the College.

The panel has found that you have engaged in professional misconduct in:

1. failing to meet or contravening the standards of practice;

2. contravening a federal law that is in place to protect public health;

3. engaging in conduct that would reasonably be regarded by members of the profession as disgraceful, dishonourable, and unprofessional

The fact that you engaged in professional misconduct is a matter of profound concern. You have brought discredit to the entire profession and to yourself. Public confidence in this profession has been put in jeopardy. The result of your misconduct is that you have let down the public, the profession, and yourself.

While we do not know why you chose to use your own stents on your patients, doing so, you broke your obligations to your patients, essentially choosing to experiment on them with no concern for the potential for harm. Your conduct is totally unacceptable to your fellow chiropodists and to the public. Of special concern to us is the fact that the professional misconduct in which you engaged has involved misuse of medical devices and failure to obtain informed consent. It also concerns us that the misconduct took place over an extended period of time.

Consequently, it is necessary for us to take steps to impress upon you the seriousness of the misconduct in which you have engaged.

While we acknowledge your apology, your undertaking, and willingness to work with the College to resolve this matter, we nonetheless want to make clear that revocation is the only reasonable response to your conduct. The only way we can adequately ensure that the public is safe is to make sure you do not practice chiropody in Ontario ever again. Your undertaking provides this panel with additional reassurance that your chiropody practice is at an end.

July 11, 2017

Cesar Mendez, Chairperson — Date

Sohail Mall	Public Member
Adrian Dobrowsky	Professional Member
Neil Naftolin	Professional Member
Agnes Potts	Public Member