DISCIPLINE COMMITTEE
OF THE COLLEGE OF CHIROPODISTS OF ONTARIO

PANEL:	Jamie Maczko, Chairperson Agnes Potts, Member Khalid Daud, Member Millicent Vorkapich-Hill, Member
BETWEEN:	
COLLEGE OF CHIROPODISTS OF ONTARIO	JILL DOUGHERTY for College of Chiropodists of Ontario
- and -	GAETANA CAMPISI for Michael Acosta
MICHAEL ACOSTA	
	Heard: December 1, 2015

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee on December 1, 2015 at the College of Chiropodists of Ontario ("the College") at Toronto.

The Allegations

The allegations against Mr. Acosta (the "Member") as stated in the Notice of Hearing dated April 7, 2015, are as follows.

IT IS ALLEGED THAT:

1. Michael Acosta is a chiropodist registered to practise chiropody in the Province of Ontario. At all material times, Mr. Acosta operated and practised at the Richview Foot Care Clinic in Etobicoke, Ontario.

2. From in or about July of 2011 until in or about July of 2012, Mr. Acosta treated his patient, J.J., for toenail fungus and warts (verrucae) on the toes of the right foot.

3. Initially, Mr. Acosta treated J.J.'s warts by debriding the lesion sites and applying caustic medications. In May of 2012, Mr. Acosta began treating the warts by using laser therapy.

4. Mr. Acosta failed to obtain and/or appropriately document J.J.'s prior informed consent to the use of laser therapy to treat the warts, in that Mr. Acosta:

    (i) relied upon a consent to the commencement of treatment which was provided by the patient on or about July 29, 2011, without any discussion of the expected benefits, material risks and material side effects of laser wart therapy, the alternative courses of action and/or the likely consequences of not having laser wart therapy;

    (ii) failed to discuss with J.J., prior to commencing laser wart therapy in or about May 2012, the specific risks and/or potential complications of that treatment, other than the formation of blisters; and/or

    (iii) failed to appropriately document in J.J.'s patient records a summary of the information provided regarding laser wart therapy and to obtain and document J.J.'s informed consent to that specific method of treatment.

5. By reason of the conduct alleged in paragraph 4, the Member engaged m professional misconduct within the meaning of the following subsections of Ontario Regulation 750/93 under the *Chiropody Act*, 1991:

    (i) 1.2 (Failing to meet or contravening a standard of practice of the profession),

    (ii) 1.3 (Doing anything to a patient for a therapeutic, preventative, diagnostic, cosmetic or other health-related purpose where consent is required by law, without such consent),

    (iii) 1.17 (Failing to keep records as required by the regulations),

    (iv) 1.30 (Contravening the *Chiropody Act*, 1991, the *Regulated Health Professions Act*, 1991, or the regulations under either of those Acts, including (but not limited to) section 17 of Ontario Regulation 203/94); and/or

    (v) 1.33 (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).

6. Mr. Acosta provided laser wart therapy to J.J. on or about May 27, 2012 and then provided J.J. with post-treatment care from on or about May 27, 2012 to in or about July of 2012.

7. The pre and post-treatment care provided by Mr. Acosta was insufficient, inappropriate and/or inadequately documented in that Mr. Acosta:

(i) failed to appropriately assess J.J.'s pre-treatment warts and post-treatment wounds and to note and record with sufficient particularity any relevant characteristics of the warts and wounds, including (but not limited to):

(a) the location(s), dimensions, depth and appearance of the warts and/or wounds;

(b) any possible symptoms and aggravating factors associated with the warts and/or wounds; and

(c) the condition of the wound sites, the surrounding tissue and the affected toes and foot.

(ii) failed to properly document, by means of contemporaneous notes and with sufficient particularity, signs of post-treatment infection that were present at the time of the first post-treatment visit (on or about June 2, 2012) and/or during subsequent appointments; and/or

(iii) failed to schedule follow-up visits with sufficient frequency after May 27, 2012 to properly assess and monitor the effectiveness of the post-treatment care (including, but not limited to, any antibiotics prescribed to J.J.) and to evaluate J.J.'s wounds for changes that might indicate progression of infection.

8. While J.J. was under Mr. Acosta's care from in or about May of 2012 to in or about July of 2012, he failed to obtain and record the relevant and pertinent information necessary to implement and evaluate the success of the treatment being provided.

9. By reason of the conduct described in paragraphs 6, 7 and 8 of this statement of allegations, Mr. Acosta engaged in professional misconduct within the meaning of paragraphs 2 (Failing to meet or contravening a standard of practice of the profession), 17 (Failing to keep records as required by the regulations); 30 (Contravening the *Chiropody Act*, 1991, the *Regulated Health Professions Act*, 1991, or the regulations under either of those Acts, including (but not limited to) section 17 of Ontario Regulation 203194) and 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. From in or about June of 2012 to in or about July of 2012, Mr. Acosta provided treatment to J.J. which he knew or ought to have known was ineffective or inappropriate to meet J.J.'s needs in that he treated the wounds primarily by means of debridement and antibiotics and continued to follow the same treatment plan, without making any, or any appropriate, changes to it, despite the fact that the wounds appeared not to be responding to the antibiotics prescribed and there appeared to be no significant improvement in J.J.'s condition after several weeks of treatment.

11. By reason of the conduct described in paragraph 10 of this statement of allegations, Mr. Acosta engaged in professional misconduct within the meaning of paragraphs 2 (Failing to meet or contravening a standard of practice of the profession), 14 (Providing treatment to a patient where the member knows or ought to know that the provision of the treatment is ineffective, unnecessary or deleterious to the patient or is inappropriate to meet the needs of the patient), 30 (Contravening the *Chiropody Act*, 1991, the *Regulated Health Professions Act*, 1991, or the regulations under either of those Acts, including (but not limited to) section 17 of Ontario Regulation 203/94) and 33 (Engaging in conduct or performing an act, in the course of practicing 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.

12. On two occasions after the May, 2012 laser treatment, Mr. Acosta prescribed Tylenol 3 to J.J., as J.J. was experiencing pain in the right foot and toes, but failed to retain copies of those prescriptions in J.J.'s medical record. While J.J. was able to have the first prescription filled by a pharmacist, that pharmacist refused to fill the second prescription, on the basis that Mr. Acosta, as a chiropodist, lacked authority to prescribe that type of medication (namely, a narcotic).

13. By reason of the conduct described in paragraph 12 of this statement of allegations, Mr. Acosta engaged in professional misconduct within the meaning of paragraphs 2 (Failing to meet or contravening a standard of practice of the profession), 30 (Contravening the *Chiropody Act*, 1991, the *Regulated Health Professions Act*, 1991, or the regulations under either of those Acts, including (but not limited to) section 5(1) of the *Chiropody Act*, 1991 and section 1 of Ontario Regulation 203194) and 33 (Engaging in conduct or performing an act, in the course of practicing 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. From in or about June, 2012 to in or about July, 2012, Mr. Acosta failed to advise J.J. to consult with a physician or other regulated health professional concerning the wounds on the right foot and toes and/or to attend at a hospital emergency room. The Member failed to advise J.J. to consult with a physician or other regulated health professional, or to go to the hospital, notwithstanding that:

    (i) there were signs that the wounds were infected and that the infection was progressing despite treatment with antibiotics; and/or

    (ii) given the condition of the wounds and progress of the infection, Mr. Acosta recognized, or ought to have recognized, that J.J.'s condition or status fell outside of his scope of practice, competence or experience.

15. On or about July 6, 2012, J.J. attended the Wound Clinic at the Etobicoke General Hospital and was immediately admitted to hospital. J.J. was placed on intravenous antibiotics and seen by a wound specialist and an orthopaedic surgeon, both of whom suggested that J.J. would need to have at least some of the toes amputated.

16. J.J. was subsequently diagnosed with osteomyelitis involving the right forefoot, requiring the amputation of all toes on the right foot and a portion of all of the metatarsals of the right foot on or about July 12, 2012.

17. By reason of the conduct described in paragraphs 10 and 14, 15 and 16 of this statement of allegations, Mr. Acosta engaged in professional misconduct within the meaning of paragraphs 2 (Failing to meet or contravening a standard of practice of the profession), 15 (failing to advise the patient to consult with a physician or other regulated health professional where the member recognizes or ought to recognize a condition that is beyond the competence or experience of the chiropodist or that requires such consultation to ensure the proper care of the patient), and 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 under the *Chiropody Act*, 1991.

Member's Plea

Mr. Acosta admitted the allegations set out in the Notice of Hearing, as modified by the Agreement Statement of Facts, described below. The panel conducted an oral plea inquiry and was satisfied that the Member's admission was voluntary, informed and unequivocal.

Agreed Statement of Facts

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

1. Mr. Michael Acosta D. Ch. ("Member") is a member of the College of Chiropodists of Ontario ("College"). At all material times, he practised chiropody at the Richview Foot Care Clinic in Etobicoke, Ontario ("Clinic").

ALLEGATIONS

2. The allegations of professional misconduct referred to the Discipline Committee in respect of the Member are set out in the Notice of Hearing dated April 7, 2015. These allegations relate to the Member's assessment and treatment of warts (verrucae) on the toes of patient J.J.'s right foot from July 2011 to July 2012.

FACTS

Background

3. From in or about July of 2011 until in or about July of 2012, Mr. Acosta treated J.J. for toenail fungus and warts on the toes of his right foot.

4. Initially, Mr. Acosta treated J.J.'s warts by debriding the lesion sites and applying caustic medications. In May of 2012, Mr. Acosta began treating both J.J.'s toenails and warts using laser therapy.

The May 27, 2012 Laser Wart Therapy and Related Consent

5. In performing the laser therapy, Mr. Acosta relied on a written patient consent that J.J. had provided on or about July 29, 2011. That consent did not specifically address the possibility of treatment using laser wart therapy.

6. On May 27, 2012, Mr. Acosta performed laser wart treatment on J.J.'s warts using a Cutera Genesis Pinpoint Laser. Apart from the risk of blister formation, Mr. Acosta's clinical notes do not mention any other specific risks or potential complications of laser wart therapy, or contain a summary of the information provided to J.J. about this method of treatment. At no point did Mr. Acosta obtain a signed informed consent from J.J. with respect to laser wart therapy.

7. The July 29, 2011 consent did not address the following subjects:

    (i) the expected benefits, material risks and material side effects of laser wart therapy, the alternative courses of action and/or the likely consequences of not having laser wart therapy; and/or

    (ii) the specific risks and/or potential complications of laser wart therapy, other than the formation of blisters.

8. The College's record-keeping standards require Members to obtain and keep written copies of informed consents in patient files, which Mr. Acosta failed to do.

The Post-Treatment Care and Records

9. Mr. Acosta provided J.J. with post-treatment care from on our about May 27, 2012 to in or about July of 2012. Throughout this period, he failed record, the relevant and pertinent information necessary to implement and evaluate the success of the treatment being provided. In addition, Mr. Acosta failed to note with sufficient particularity the characteristics of the warts and wounds and the details of the post-treatment infection.

10. After performing the laser wart treatment on May 27, 2012, Mr. Acosta cleaned the treated areas, applied an ointment and bandaged the open wounds on J.J.'s toes. Mr. Acosta also instructed J.J. on the proper method for cleaning and caring for the wounds at home. Mr. Acosta's clinical notes of this treatment do not record significant elements associated with the treatment and outcome of the verrucae, including the size and location of each of the 17 warts, or the number of laser pulses delivered to each wart.

11. There is a factual dispute as to whether Mr. Acosta scheduled follow-up appointments with J.J. on a timely basis after the May 27, 2012 treatment and J.J.'s subsequent June 2, 2012 attendance at Mr. Acosta's office. If he testified, Mr. Acosta would state that such follow-up appointments were arranged and are recorded in his clinical notes, whereas J.J. would state that those follow-up appointments were not arranged and that he attended of his own accord. Professor Merendino would testify that it is common practice to evaluate wounds on a weekly basis (even in the absence of infection) and that if there was a failure to schedule a follow-up appointment to monitor post-operative wounds, it would fall below the minimum standard of medical care.

12. After the May 27, 2012 laser wart treatment, Mr. Acosta's next interaction with J.J. occurred on or about June 2, 2012. Mr. Acosta's clinical notes indicate that there was erythema, calor, and sero-sanguenous discharge. His notes do not mention which lesion or lesions this was occurring on, nor do they identify the extent of the calor and/or erythema. Mr. Acosta cleaned the infected areas and reviewed the procedure for cleaning and caring for the wounds at home. He also provided a prescription for antibiotics.

13. J.J. next saw Mr. Acosta on June 23, 2012. Mr. Acosta's notes from the June 23, 2012 appointment indicate that the signs of infection had worsened in some of the wounds. However, his notes do not indicate the site of those wounds, and there is no noted description of the size and depth of the wounds or if the wounds were probed.

14. During the June 23, 2012 appointment, Mr. Acosta cleaned and bandaged the wounds and prescribed a stronger antibiotic. He also scheduled a follow-up appointment for two weeks later.

15. If this matter were to proceed to a contested hearing and Mr. Acosta testified, he would state that he advised J.J.to go to the hospital if the pain or symptoms worsened. However, if J.J. were to testify, he would state that no such advice was provided by Mr. Acosta. In any event, it is agreed that Mr. Acosta did not refer J.J. to a physician for further evaluation and testing.

16. Throughout the post-treatment period from in or about June of 2012 to in or about July of 2012, there were signs that the infection of J.J.'s wounds was worsening. However, Mr. Acosta continued to treat the wounds primarily by means of debridement and antibiotics and continued to follow the same treatment plan. Mr. Acosta persisted in this course of treatment despite the fact that the wounds appeared not to be responding to the different antibiotics prescribed and there appeared to be no significant improvement in J.J.'s condition after several weeks of treatment.

17. On two occasions after the May 27, 2012 laser treatment, when J.J. was experiencing pain in his right foot and toes, Mr. Acosta provided a prescription to him, on which were written the words "Tylenol 3". Mr. Acosta failed to retain copies of those prescriptions in J.J.'s medical record. While a pharmacist dispensed Tylenol 3 to J.J. on the first occasion, that pharmacist refused to fill the second prescription, on the basis that Mr. Acosta, as a chiropodist, lacked authority to prescribe that type of medication (namely, a narcotic).

18. On or about July 6, 2012, J.J. attended the Wound Clinic at the Etobicoke General Hospital and was immediately admitted to hospital. He was placed on intravenous antibiotics and seen by a wound specialist and an orthopaedic surgeon, both of whom suggested that J.J. would need to have at least some of his toes amputated.

19. J.J. was subsequently diagnosed with osteomyelitis involving his right forefoot, requiring the amputation of all toes on his right foot and a portion of all of the metatarsals of his right foot on or about July 12, 2012.

The Relevance of J.J.'s HIV+ Status

20. On the medical history form that J.J. completed in July 2011, he failed to indicate that he had been diagnosed with HIV. If called to testify, J.J. would state that he was not intentionally hiding his HIV+ status. Rather, the question pertaining to HIV is difficult to see on the form, and J.J. inadvertently overlooked it.

21. If called to testify, the Member would state that he would have followed a different course of treatment if he had known of J.J.'s HIV+ status. There is some disagreement among the experts as to whether J.J.'s HIV+ status would have affected his ability to combat infection. Kerri-Lynn Vallentin, D.Ch., provided an opinion for the College in which she stated that J.J.'s HIV+ status may have affected the type of antibiotic Mr. Acosta prescribed. She opined that "[i]mmunocompromised patients are more susceptible to polymicrobial contamination so broad spectrum antibiotics are often used for such patients...."

22. However, J.J.'s hospital records of July 2012 show that his CD4 count was normal. In Professor Merendino's opinion, this meant that J.J. was not immunocompromised and that J.J.'s ability to fight off infection was therefore not diminished at the relevant time.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

23. The Member admits that, while J.J. was under his care from in or about July 2011 to in or about July 2012, he failed to meet or he contravened a standard of practice of the profession, as alleged in the Notice of Hearing, by:

    a) failing to obtain and/or appropriately document J.J.'s prior informed consent to the use of laser therapy to treat the warts, in that he:

(i) relied upon a consent to the commencement of treatment that was provided by the patient on or about July 29, 2011 which did not reflect any appropriate discussion of the expected benefits, material risks and material side effects of laser wart therapy;

(ii) failed to discuss with J.J., prior to commencing laser wart therapy in or about May 2012, the specific risks and/or potential complications of that treatment, other than the formation of blisters; and/or

(iii) failed to appropriately document in J.J.'s patient records a summary of the information provided regarding laser wart therapy and to obtain and document J.J.'s informed consent to that specific method of treatment.

b) providing pre- and post-treatment care that was insufficient, inappropriate and/or inadequately documented in that he:

(i) failed to appropriately assess J.J.'s post-treatment wounds and to note and record with sufficient particularity any relevant characteristics of the wounds, including (but not limited to):

A. the location(s), dimensions, depth and appearance of the wounds;

B. any possible symptoms and aggravating factors associated with the wounds; and

C. the condition of the wound site, the surrounding tissue and the affected toes and foot.

(ii) failed to properly document with sufficient particularity, signs of post-treatment infection that were present at the time of the first post-treatment visit (on or about June 2, 2012) and/or during subsequent appointments; and/or

(iii) failed to schedule follow-up visits with sufficient frequency to properly assess and monitor the effectiveness of the post-treatment care (including, but not limited to, any antibiotics prescribed to J.J.) and to evaluate J.J.'s wounds for changes that might indicate progression of infection.

c) failing to obtain and record the relevant and pertinent information necessary to implement and evaluate the success of the treatment being provided;

d) providing treatment to J.J. which he knew or ought to have known was ineffective or inappropriate to meet J.J.'s needs in that he treated the wounds primarily by means of debridement and antibiotics and continued to follow the same treatment plan, without making appropriate, changes to it, despite the fact that the wounds appeared not to be responding to the different antibiotics prescribed and there appeared to be no significant improvement in J.J.'s condition after several weeks of treatment;

e) prescribing Tylenol 3 to J.J. on two occasions, despite the fact that he was not authorized to do so, and failing to retain copies of those prescriptions in J.J.'s medical record;

f) failing to clearly advise J.J. to consult with a physician or other regulated health professional concerning the wounds on the right foot and toes and/or to attend at a hospital emergency room, notwithstanding that:

(i) there were signs that the wounds were infected and that the infection was progressing despite treatment with antibiotics; and/or

(ii) given the condition of the wounds and progress of the infection, Mr. Acosta recognized, or ought to have recognized, that J.J.'s condition or status fell outside of his scope of practice, competence or experience.

24. The Member admits that while J.J. was under his care from in or about July 2011 to in or about July 2012, he failed to keep records, as required by the regulations, and as alleged in the Notice of Hearing by failing to do what is set out at paragraphs 23(a), (b) and (c) above.

25. The Member admits that while J.J. was under his care from in or about July 2011 to in or about July 2012, he engaged in conduct or performed an act, in the course of practicing chiropody, that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, as alleged in the Notice of Hearing by failing to do what is set out at paragraphs 23(a) to (f) above.

26. The Member admits that while J.J. was under his care from in or about July 2011 to in or about July 2012, he provided treatment to the patient where he knew or ought to have known that the provision of the treatment was ineffective, unnecessary or deleterious to the patient or was inappropriate to meet the needs of a patient, as alleged in the Notice of Hearing by doing what is set out at paragraph 23(d) above.

27. The Member admits that while J.J. was under his care from in or about July 2011 to in or about July 2012, he failed to advise the patient to consult with a physician or other regulated health professional where he recognized or ought to have recognized a condition that was beyond his competence or experience as a chiropodist or required such consultation to ensure the proper care of the patient, as alleged in the Notice of Hearing given what is set out at paragraph 23(f) above.

Decision

The panel considered the Agreed Statement of Facts and finds that the facts contained therein support findings of professional misconduct and, in particular, finds that the Member committed acts of professional misconduct as set out in the Notice of Hearing and as modified by the Agreed Statement of Facts.

Reasons for Decision.

The Panel evaluated the facts as presented December 1, 2015 and agreed that:

- The Member freely admitted that his treatment of J.J. fell below the College Standards of Practice and thereby committed professional misconduct as set out in the Agreed Statement of Facts, Exhibit 2.

- The Member did not complete a proper consent form signed by J.J. regarding the laser treatment.

- The Member prescribed Tylenol #3, a narcotic, twice to J.J. The Panel agreed that he should have known that a chiropodist he is not allowed to prescribe narcotics as it is not within the scope of practice.

- The Member's record keeping in regards to J.J. was inadequate and as such does not meet the Standards of Practice of the College.

- The Member failed to recognize the deterioration of J.J.'s foot ulcerations and also failed to advise the patient to seek out advice and treatment elsewhere, or to go an emergency room at his local hospital.

- The Member through his inadequate treatment plan, created harm to his patient, J.J.

The Panel, after deliberating and consideration of the Agreed Statement of Facts was convinced that the Member engaged in professional misconduct as agreed and admitted.

Penalty

Counsel advised the panel that the parties had agreed to present a Joint Submission as to Penalty and costs. The Joint Submissions provided as follows:

1. The College of Chiropodists of Ontario ("College") and Mr. Michael Acosta D. Ch. ("Member") agree and jointly submit that this Panel of the Discipline Committee ("Panel") make the following order:

    a) an Order requiring the Member to appear before the Panel to be reprimanded. This reprimand is to be made available on the College's website and/or Public Register;

    b) an Order directing the Registrar to suspend the Member's certificate of registration for a period of six 6 consecutive months commencing on January 1, 2016 ; three (3) months of which shall be remitted !.... the Member complies with subparagraphs 1(c)(i) and (ii) of this Order within twelve (12) months from the date the Penalty Order is signed by the Discipline Committee. The first three (3) months of the suspension shall commence on January 1, 2016 and any further period of suspension which is not remitted shall be served beginning twelve (12) months after the Penalty Order is signed.

        (i) For greater certainty, the Member is required to comply with subparagraphs 1(c)(i) and (ii) of this Order, regardless of whether the final three (3) months of his suspension are remitted.

    c) an Order directing the Registrar to impose the following terms, conditions and limitations on the Member's certificate of registration:

        (i) the Member is to successfully complete the ProBe course in ethics, to the satisfaction of the Registrar, and at the Member's own expense, within the six (6) month period commencing on the date of the Order.

        (ii) (ii) the Member is to successfully complete the University of Toronto's International lnterprofessional Wound Care Course (llWCC-CAN), to the satisfaction of the Registrar, and at the Member's own expense, within the twelve (12) month period commencing on the date of the Order.

        (iii) the Member shall not assess or treat ulcerations beyond the level of the dermis, or ulcerations breaching the subcutaneous tissues of the foot, including fat, muscle, tendon, fascia, joint capsule, and beyond, until he submits proof of successful completion of the two courses noted above and until an Expert Report is submitted to the satisfaction of the Registrar as described in subparagraphs (v) and (vii)(B) below.

        (iv) the Member shall, at his own expense and within the twelve (12) month period commencing on the date of the Order, attend six (6) mentoring sessions with a Chiropody I Podiatry expert approved by the Registrar who has expertise in the College's standards of practice ("Expert"). Such sessions may take place at the Member's Clinic or at the Expert's Clinic or Office. The sessions with the Expert shall address the following:

A. the College's standards of practice relating to:

1. Competence;

2. Infection Control;

3. Patient Relations; and,

4. Records.

B. the Member's understanding of the College's standards of practice as set forth in paragraph 1(c)(iv)(A) above;

C. the Member's conduct as described in the Agreed Statement of Facts;

D. the consequences of that conduct to clients, patients, colleagues, the profession, and to himself;

E. strategies for preventing the aforementioned conduct from occurring again; and,

F. the Member's responsibilities as a member of a self regulated profession.

(v) the Member shall provide a written direction to the Expert to forward his or her report to the Registrar within forty-five (45) days from the date of the last mentoring session. The Expert's report ("Report") shall:

A. confirm the dates of all sessions attended by the Member;

B. confirm that the standards of practice referred to above were covered with the Member; and,

C. include an assessment of the Member's insight into his conduct as described in the Agreed Statement of Facts.

(vi) All documents sent by the Member to the Registrar shall be made by verifiable method of delivery, the proof of which the Member shall retain.

(vii) the terms, conditions and limitations referred to in paragraphs (i) to (vi) above shall be removed when the Registrar receives:

A. satisfactory confirmation of successful completion of the two courses noted above; and,

B. satisfactory report from the Expert confirming that the Expert is satisfied that the member has appropriate insight into his conduct as described in the Agreed Statement of Facts, such that it is likely that he will practice chiropody in the future in accordance with the College's standards of practice.

d) Order requiring the Member to pay the College's costs fixed in the amount of $12,000.

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 had the chance to receive, and in fact has received, independent legal advice.

Penalty Decision

The panel accepts the Joint Submission as to Penalty and Costs and accordingly orders:

1. This Panel of the Discipline Committee ("Panel") makes the following order:

a) the Member is to appear before the Panel to be reprimanded. This reprimand is to be made available on the College's website and/or Public Register;

b) the Registrar is directed to suspend the Member's certificate of registration for a period of six 6 consecutive months commencing on January 1, 2016; three (3) months of which shall be remitted the Member complies with subparagraphs 1(c)(i) and (ii) of this Order within twelve (12) months from the date the Penalty Order is signed by the Discipline Committee. The first three (3) months of the suspension shall commence on January 1, 2016 and any further period of suspension which is not remitted shall be served beginning twelve (12) months after the Penalty Order is signed.

(i) For greater certainty, the Member is required to comply with subparagraphs 1(c)(i) and (ii) of this Order, regardless of whether the final three (3) months of his suspension are remitted.

c) the Registrar is directed to impose the following terms, conditions and limitations on the Member's certificate of registration:

(i) the Member is to successfully complete the ProBe course in ethics, to the satisfaction of the Registrar, and at the Member's own expense, within the six (6) month period commencing on the date of the Order.

(ii) the Member is to successfully complete the University of Toronto's International lnterprofessional Wound Care Course (llWCC-CAN), to the satisfaction of the Registrar, and at the Member's own expense, within the twelve (12) month period commencing on the date of the Order.

(iii) the Member shall not assess or treat ulcerations beyond the level of the dermis, or ulcerations breaching the subcutaneous tissues of the foot, including fat, muscle, tendon, fascia, joint capsule, and beyond, until he submits proof of successful completion of the two courses noted above and until an Expert Report is submitted to the satisfaction of the Registrar as described in subparagraphs (v) and (vii)(B) below.

(iv) the Member shall, at his own expense and within the twelve (12) month period commencing on the date of the Order, attend six (6) mentoring sessions with a Chiropody I Podiatry expert approved by the Registrar who has expertise in the College's standards of practice ("Expert"). Such sessions may take place at the Member's Clinic or at the Expert's Clinic or Office. The sessions with the Expert shall address the following:

A. the College's standards of practice relating to:

1. Competence;

2. Infection Control;

3. Patient Relations; and,

4. Records.

B. the Member's understanding of the College's standards of practice as set forth in paragraph 1(c)(iv)(A) above;

C. the Member's conduct as described in the Agreed Statement of Facts;

D. the consequences of that conduct to clients, patients, colleagues, the profession, and to himself;

E. strategies for preventing the aforementioned conduct from occurring again; and,

F. the Member's responsibilities as a member of a self regulated profession.

(v) the Member shall provide a written direction to the Expert to forward his or her report to the Registrar within forty-five (45) days from the date of the last mentoring session. The Expert's report ("Report") shall:

A. confirm the dates of all sessions attended by the Member;

B. confirm that the standards of practice referred to above were covered with the Member; and,

C. include an assessment of the Member's insight into his conduct as described in the Agreed Statement of Facts.

(vi) All documents sent by the Member to the Registrar shall be made by verifiable method of delivery, the proof of which the Member shall retain.

(vii) the terms, conditions and limitations referred to in paragraphs (i) to (vi) above shall be removed when the Registrar receives:

C. satisfactory confirmation of successful completion of the two courses noted above; and,

D. a satisfactory report from the Expert confirming that the Expert is satisfied that the member has appropriate insight into his conduct as described in the Agreed Statement of Facts, such that it is likely that he will practice chiropody in the future in accordance with the College's standards of practice.

d) the Member is required to pay the College's costs fixed in the amount of $12,000.

Reasons for Penalty Decision

The Panel concluded after deliberation and consideration that the penalty is reasonable and in the public interest. The Member has co-operated with the College and, by agreeing to the facts and a proposed penalty, has accepted responsibility for his actions.

The Panel believes that this penalty will serve as a deterrent for other members of the profession who engage in such acts, and will offer rehabilitation, remediation, and specific deterrence to this member in areas where he was shown to be practicing below acceptable standards.

This order will serve to further the mandate of the College of Chiropodists, which is in part to protect the public.

I, Jamie Maczko, 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:

Jamie Maczko, Chairperson

December 22, 2015
Date

Agnes Potts
Khalid Daud
Millicent Vorkapich-Hill