DISCIPLINE COMMITTEE OF
THE COLLEGE OF CHIROPODISTS OF ONTARIO

B E T W E E N:

COLLEGE OF CHIROPODISTS OF ONTARIO

- and -

PIERRE DUPONT

NOTICE OF HEARING

The Inquiries, Complaints and Reports Committee of the College of Chiropodists of Ontario has referred specified allegations against **PIERRE DUPONT** to the Discipline Committee of the College. The allegations were referred in accordance with paragraph 26(1)1 of the *Health Professions Procedural Code*, being Schedule 2 to the *Regulated Health Professions Act, 1991*. Further information about the allegations is contained in a Schedule of Allegations which is attached to this notice of hearing. A discipline panel will hold a hearing under the authority of sections 38 to 56 of the *Health Professions Procedural Code* for the purposes of deciding whether the allegations are true.

IF YOU DO NOT ATTEND AT THE HEARING IN ACCORDANCE WITH THE PRECEDING PARAGRAPH, THE DISCIPLINE PANEL MAY PROCEED IN YOUR ABSENCE AND YOU WILL NOT BE ENTITLED TO ANY FURTHER NOTICE IN THE PROCEEDINGS.

If the discipline panel finds that you have engaged in professional misconduct, it may make one or more of the following orders:

1. Direct the Registrar to revoke your certificate of registration.

2. Direct the Registrar to suspend your certificate of registration for a specified period of time.

3. Direct the Registrar to impose specified terms, conditions and limitations on your certificate of registration for a specified or indefinite period of time.

4. Require you to appear before the panel to be reprimanded.

5. Require of you to pay a fine of not more than $35,000 to the Minister of Finance.

If the discipline panel finds that you are incompetent, it may make one or more of the following orders:

1. Direct the Registrar to revoke your certificate of registration.

2. Direct the Registrar to suspend your certificate of registration and to specify criteria to be satisfied for the removal of the suspension.

3. Direct the Registrar to impose specified terms, conditions and limitations on your certificate of registration for a specified or indefinite period of time, and to specify criteria to be satisfied for the removal of the terms, conditions and limitations.

The discipline panel may, in an appropriate case, make an order requiring you to pay all or part of the College's costs and expenses pursuant to section 53.1 of the *Health Professions Procedural Code*.

You are entitled to disclosure of the evidence against you in accordance with section 42(1) of the *Health Professions Procedural Code*, as amended. You, or your representative, may contact the solicitor for the College in this matter:

Jordan Glick
WEIRFOULDS LLP
Barristers & Solicitors
4100-66 Wellington Street West
PO Box 35, TD Bank Tower
Toronto, ON M5K 1B7

Telephone: (416) 947-5082
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Email: jglick@weirfoulds.com

You must also make disclosure in accordance with section 42.1 of the *Health Professions Procedural Code*, which states as follows:

> Evidence of an expert led by a person other than the College is not admissible unless the person gives the College, at least ten days before the hearing, the identity of the expert and a copy of the expert's written report or, if there is no written report, a written summary of the evidence.

Date: January 3, 2017

Felecia Smith, LL.B.
Registrar
College of Chiropodists of Ontario
180 Dundas Street West, Suite 2102
Toronto, ON M5G 1Z8

TO: Pierre Dupont
suite 101, 28 Deakin Street
Ottawa, ON
K2E 8B7

Statement of Allegations

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. 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 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) 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.

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 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.

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. 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 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), paragraph 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 a consultation to ensure the proper care of the patient), paragraph 30 (contravening the *Chiropody Act, 1991*, the *Regulated Health Professions Act, 1991* or the Regulations under either of those Acts) 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 Ontario Regulation 750/93 under the *Chiropody Act*, 1991.

16. Having regard to all of the circumstances, the Member is incompetent as defined in subsection 52(1) of the Health Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professions Act, 1991*.

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.

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DISCIPLINE COMMITTEE OF THE COLLEGE OF CHIROPODISTS OF ONTARIO

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