DISCIPLINE COMMITTEE OF THE COLLEGE OF CHIROPODISTS OF ONTARIO

THE DISCIPLINE COMMITTEE OF THE COLLEGE OF CHIROPODISTS OF ONTARIO

IN THE MATTER OF a Hearing directed by the Inquiries, Complaints and Reports Committee of the College of Chiropodists of Ontario pursuant to Section 26(1) of the ***Health Professions Procedural Code*** being Schedule 2 of the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

BETWEEN:

COLLEGE OF CHIROPODISTS OF ONTARIO

- and –

DAVID ALLISON

PANEL MEMBERS:

Eliot To	Chair, Professional Member
Millicent Vorkapich-Hill	Professional Member
Donna Shewfelt	Professional Member
Winnifred Linker	Public Member

COUNSEL FOR THE COLLEGE: Debra McKenna

REPRESENTATIVE FOR THE MEMBER: Jacinthe Boudreau

INDEPENDENT LEGAL COUNSEL: Ted Marrocco

Hearing Date: July 5, 2022
Decision Date: July 5, 2022
Release of Written Reasons: August 8, 2022

DECISION AND REASONS

1. This matter came on for hearing before a panel of the Discipline Committee on July 5, 2022. With the consent of the parties, this matter was heard electronically.

The Allegations

2. The allegations made against the Member were set out in a Notice of Hearing, dated July 28, 2020. The Notice of Hearing can be found at Tab 1 of Exhibit 1 and the allegations are as follows:

    1. At all material times, David W.G. Allison ("**Mr. Allison**" or the "**Member**") was a registered member of the College.
    2. During the period of time from approximately January 2020 to February 2020 (the "**Relevant Period**"), Mr. Allison engaged in professional misconduct within the meaning of the following paragraphs of section 1 of the *Professional Misconduct Regulation*, O. Reg. 750/93 under the *Chiropody Act, 1991*:

        (i) paragraph 2 (failing to meet or contravening a standard of practice of the profession), and, in particular, the College's standards pertaining to:

        i. Assessment and Management;

        ii. Competence;

        iii. Patient Relations; and/or

        iv. Records;

        (ii) paragraph 11 (giving information about a patient to a person other than the patient or his or her authorized representative except with the consent of the patient or his or her authorized representative or as required or allowed by law);

        (iii) ***allegation withdrawn***;

        (iv) paragraph 17 (failing to keep records as required by the regulations);

        (v) paragraph 30 (contravening the Act, the Regulated Health Professions Act, 1991 or the regulations under either of those Acts), specifically:

        i. Ontario Regulation 750/93 (Professional Misconduct) under the *Chiropody Act, 1991*, as specified in this Notice of Hearing;

        ii. Ontario Regulation 203/94 (General) under the *Chiropody Act, 1991*, and, in particular, Records (Part III); and/or

        iii. section 51(1)(c) of the *Health Professions Procedural Code*, beingSchedule 2 to the *Regulated Health Professions Act, 1991*; and/or

        (vi) 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).

Particulars of the Allegations

1. At all material times, Mr. Allison was a chiropodist registered with the College to practise chiropody in the Province of Ontario.
2. During the Relevant Period, the Member engaged in the practice of chiropody at The Foot Guy located in Toronto, Ontario (the "Clinic").
3. On or about February 29, 2020, the College received a complaint from P.H. about the Member (the "**Complaint**"). As set out in the Complaint, P.H. is the brother of M.H., a patient of the Member.
4. On or about January 23, 2020, the Member had an appointment to assess M.H. It was the Member's first visit with M.H.
5. M.H. had made the appointment because he had developed a blister on his right foot following ice-fishing on or about January 19, 2020. At the material time, M.H. was 58 years old.
6. Upon arrival at the Clinic, M.H. was provided with a patient intake form to complete and then brought into the examination room to see the Member.
7. The Member did not take and/or record any patient history in his clinical notes.
8. On examination, M.H. presented with a large lesion on the right lateral edge of the right foot. The area around the lesion was swollen. The lesion and/or swelling extended up the leg.
9. The Member queried and charted in his clinical notes whether the lesion was cellulitis.
10. The Member then applied a 10% povidone iodine solution to the right foot and covered the lesion with a sterile dressing. He provided M.H. with directions for changing the dressing and prescribed him with a 7-day course of amoxicillin, with two repeats.
11. According to the Member, M.H. then left the Clinic with directions to follow-up with a family doctor.
12. Approximately a week or so later, M.H. contacted the Member and inquired about refilling his prescription. The Member spoke to M.H., but did not see M.H or make any follow-up appointment. The Member did not record any discussion with M.H. in his clinical notes.
13. That was the last contact the Member had with M.H.
14. On or about February 26, 2020, M.H. attended at the emergency department at Michael Garron Hospital in Toronto. On presentation, M.H. complained of sweats and chills, increased swelling, and a discoloured wound on his right foot.
15. Upon admission to the hospital, it was noted that M.H.'s blood glucose level was 27.2.
16. M.H. was ultimately diagnosed on February 26, 2020, with a gangrenous foot and taken to the operating room later that day for an above-the-knee amputation.
17. On or about February 29, 2020, P.H. attended at the Clinic and spoke with the Member. At that time, P.H. requested his brother's patient records. The Member provided the records to him.

18. No consent from M.H. was obtained by the Member prior to providing P.H. with his brother's patient records.
19. M.H. was discharged from Michael Garron Hospital to the Providence Healthcare for rehabilitation on or about March 5, 2020.

Member's Plea

3. At the outset of the hearing, College counsel sought and obtained leave to withdraw the allegation contained at paragraph 2(iii) of the Notice of Hearing. The Notice of Hearing was amended accordingly.

4. The Member subsequently admitted that he engaged in professional misconduct as described in the Notice of Hearing, as amended. The Panel conducted an oral plea inquiry and was satisfied that the Member's admissions were voluntary, informed, and unequivocal.

Agreed Statement of Facts

5. The evidence at the hearing proceeded by way of agreement. The parties tendered an Agreed Statement of Facts which can be found at Tab 2 of Exhibit 1. The material portions of the Agreed Statement of facts provide as follows:

   1. David W.G. Allison (**"Mr. Allison"** or the **"Member"**) was at all material times a chiropodist registered with the College to practise chiropody in the Province of Ontario. He was first registered with the College on June 22, 1993.
   2. On August 30, 2004, Mr. Allison appeared before the Discipline Committee and, based on an Agreed Statement of Facts, he was found to have committed professional misconduct. Attached as **Exhibit "A"** is a summary of the decision of the Discipline Committee dated August 30, 2004.
   3. From February 2000 to March 2020, the Member engaged in the practice of chiropody at The Foot Guy located at 2494 Danforth Avenue in Toronto, Ontario (the **"Clinic").**
   4. On or about January 23, 2020, the Member had an appointment to assess M.H. It was the Member's first visit with M.H. at the Clinic.
   5. M.H. made the appointment because he developed a blister on his right foot after ice-fishing on or about January 19, 2020. At the material time, M.H. was 58 years old. Attached as **Exhibit "B"** are the Member's records in relation to M.H.
   6. Upon arrival at the Clinic, M.H. was provided with a patient intake form to completeand then brought into the examination room to see the Member.
   7. During his assessment, the Member did not take or record the patient's medical history in his clinical notes. He documented that the lesion presented after M.H. went ice fishing on January 19, 2020.
   8. On examination, M.H. presented with a large lesion on the right lateral edge of the right foot. The area around the lesion was swollen. The lesion and/or swelling extended up the leg.

9. The Member applied a 10% povidone iodine solution to the right foot and covered the lesion with a sterile dressing. He provided M.H. with directions for changing the dressing and prescribed him with a 7-day course of amoxicillin, with two repeats.

10. As noted in Exhibit "B", the Member charted "cellulitis" in his clinical notes. Other than obtaining information from the Patient that the lesion started after ice-fishing, the Member did not query the source of the cellulitis. In addition, other than visually examining and dressing the lesion, the Member undertook no further assessment of the patient. The Member admits that there were further steps that he should have taken, in the circumstances, to assess M.H.'s risk with this infection and query the source of the infection. In particular, because M.H. presented with little or no pain in the foot, it was appropriate for the Member to assess M.H.'s vascular and neuropathic functioning using pedal pulses, by checking M.H.'s blood refilling capabilities in the toes or foot, and by conducting monofilament or vibration testing, among other things.

11. The Member charted, "PT to follow up on wound [with] physician before RTC". The Member did not make an appointment for a follow-up visit.

12. If the Member were to testify, he would say that he prescribed amoxicillin to allow M.H. time to see a physician. In addition, he would testify that he told M.H. what cellulitis was and that "it could be serious", and that_ M.H. left the Clinic with directions to follow-up with a physician. The Member acknowledges that he did not document any of that information in his patient chart. The Member was aware at that time that M.H. did not have a family doctor.

13. Approximately a week or so later, M.H. contacted the Member and inquired about refilling his prescription. The Member spoke to M.H. over the telephone and advised M.H. that there was a repeat available on his prescription. The Member did not see M.H at that time or make any follow-up appointment with him at that time or at any time. The Member did not record in his clinical notes his discussion with the patient.

14. If the Member were to testify, he would say that M.H. told him during the telephone call that he was feeling better. However, on this call with M.H., the Member was also made aware that M.H. had not yet been seen by a doctor. The Member would further testify that he reiterated to M.H. the importance of seeing a physician and that his condition could be serious. However, the Member acknowledges that, upon learning that M.H. had not seen a doctor, he ought to have taken steps to assist M.H. in obtaining an assessment with a doctor.

15. This telephone call was the last contact the Member had with M.H.

16. On or about February 26, 2020, M.H. attended at the emergency department at Michael Garron Hospital in Toronto. Between January 23, 2020 and February 26, 2020, M.H. had not seen a doctor.

17. On presentation to the emergency room, M.H. complained of sweats and chills, increased swelling, and a discoloured wound on his right foot. A crack was apparent between M.H.'s first and second toes on the dorsum of the right foot. Upon

admission to the hospital, it was noted that M.H.'s blood glucose level was 27.2 and he had undiagnosed diabetes. Attached as **Exhibit "C"** is the emergency record from Michael Garron Hospital.

18. M.H. was ultimately diagnosed, on February 26, 2020, with a gangrenous foot and was taken to the operating room later that day for an above-the-knee amputation.

19. If the Member were to testify, he would say that it was his understanding that M.H.understood the seriousness and the importance for him to see a physician. Given later events and the fact that M.H. did not attend to be assessed by a physician, the Member acknowledges that he failed to ensure that M.H fully understood the seriousness of the condition or the potential consequences of not following though on obtaining assessment and treatment.

20. The Member also acknowledges that he did not provide M.H. with a referral to a physician, assist M.H. in identifying a walk-in clinic, or direct him to attend the emergency department for assessment.

21. On February 29, 2020, P.H., the brother of M.H., attended at the Clinic and spoke with the Member. At that time, P.H. requested his brother's patient records. The Member provided the records to him. No consent from M.H. was obtained by the Member prior to providing P.H. with his brother's patient records. The records were not requested by P.H. for any clinical purpose related to M.H.'s treatment.

22. The following written standards of the College were standards of practice of the profession at the relevant time and are appended as **Exhibits "D" to "G"** to the Agreed Statement of Facts:

    a. Assessment and Management;

    b. Competence;

    c. Patient Relations; and

    d. Records.

23. Based on the facts set out above, the Member admits that he committed acts of professional misconduct within the meaning of the following paragraphs of section 1 of the *Professional Misconduct Regulation,* 0. Reg. 750/93 under the *ChiropodyAct, 1991:*

    (ii) paragraph 2 - failing to meet or contravening a standard of practice of the profession and, in particular, the College's written standards pertaining to:

    i. Assessment and Management;

    ii. Competence;

    iii. Patient Relations; and/or

    iv. Records;

    (iii) paragraph 11 - giving information about a patient to a person other than the

patient or his or her authorized representative except with the consent of the patient or his or her authorized representative or as required or allowed by law;

(iv) paragraph 17 - failing to keep records as required by the regulations;

(v) paragraph 30 - contravening the Act, the *Regulated Health Professions Act*, 1991 or the regulations under either of those Acts, specifically:

i. Ontario Regulation 750/93 (Professional Misconduct) under the *Chiropody Act, 1991,* as specified in this Notice of Hearing;

ii. Ontario Regulation 203/94 (General) under the *Chiropody Act* 1991, and, in particular, Records (Part Ill); and

iii. section 51(1)(c) of the Health Professions Procedural Code, being Schedule 2 to the *Regulated Health Professions Act, 1991;* and/or

(vi) 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.

Joint Submission on Penalty and Costs

6. The Panel received and considered a Joint Submission on Penalty and Costs from the parties (the "**Joint Submission**") which sought the following:

1. An oral reprimand;

2. An order, effective the date of the hearing, suspending the Member's certification of registration for a period of seven (7) months,[1] two (2) months of which will be remitted upon the Member successfully completing the University of Toronto Medical Record-Keeping course as outlined in paragraph 3(a) below;

[1] During the period of suspension, the Member is not permitted to practise chiropody. For the sake of clarity, this includes, among other things, the Member is not permitted to use the restricted title of chiropodist, or hold himself out as being able to practise, or hold himself out as a member of the College. The Member is not permitted to invoice or earn any income from the practice of chiropody (directly or through a health profession corporation) or be present at the Member's primary practice location or any secondary practice location or attend at a practice setting where chiropody patients are *in* attendance.

3. An order directing the Registrar to impose terms, conditions, and limitations on the Member's certificate of registration requiring the following:

   (a) Prior to returning to practice, the Member shall successfully complete the University of Toronto Medical Record-Keeping course at his own expense;

   (b) For greater certainty, the Member is required to successfully complete the Medical Record-Keeping course, regardless of whether the two months of his suspension are remitted, and the Member will not be permitted to return to practice until he does so;

   (c) Upon returning to practice after completion of the suspension, an order prohibiting the Member from assessing or treating 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 the Member submits proof to the Registrar that he has successfully completed the University of Toronto International lnterprofessional Wound Care Course (IIWCC-CAN) and until a mentor report is submitted to the satisfaction of the Registrar as described below;

   (d) Upon returning to practice after completion of the suspension, an order requiring the Member to attend, at his own expense, six (6) mentoring sessions over a period of twelve (12) months with a mentor approved by the Registrar, who has expertise in the College's standards of practice. The terms of the mentoring session are as follows:

      - The mentor shall visit with the Member in person on at least six (6) occasions - three times in the first six months and three times in the last six months;
      - The visits with the mentor will be unannounced, save for a call to the Member two hours before the mentor's attendance at the Clinic;
      - The mentor shall determine the length of each visit;
      - In conducting the mentorship, the mentor shall discuss wound care, record-keeping, and compliance with the College's standards with the Member;
      - The supervisor shall prepare a report to the Registrar after the third (3rd) visit and after the sixth (6th) visit;
      - The Member shall seek consent from his patients to share personal health information with his mentor in order to allow the mentor to review patient files and engage in review of the Member's practice;
      - The Member shall provide the mentor with the discipline panel's decision and then provide written confirmation to the Registrar, signed by the mentor, that the mentor has received and reviewed the decision;

(e) In the event that the Member obtains employment to provide chiropody services during the twelve (12) months following the date on which he is able to return to practise after his suspension, the Member shall:

- notify any current or new employers of the Discipline Committee's decision;
- ensure the Registrar is notified of the name, address, and telephone number of all employer(s) within fifteen (15) days of commencing employment;
- provide his employer(s) with a copy of:
  - o the Discipline Committee's Decision;
  - o the Notice of Hearing;
  - o the Agreed Statement of Facts;
  - o the Joint Submission on Penalty; and
  - o have his employer forward a report to the Registrar within fifteen (15) days of commencing employment confirming that the employer has received the documents noted above and agrees to notify the Registrar immediately upon receipt of any information that the Member is not complying with the College's standards;

(f) An order that the Discipline Committee's decision be published, in detail with the Member's name, in the College's official publication, on the College's website, and/or on the College's public register;

(g) An order directing the Member to pay costs to the College in the amount of $15,000.00 to be paid on the following schedule:

- $7,500.00 - July 5, 2022
- $1,250.00 - August 1, 2022
- $1,250.00 - September 1, 2022
- $1,250.00 - October 1, 2022
- $1,250.00 - November 1, 2022
- $1,250.00 - December 1, 2022
- $1,250.00 - January 1, 2023

(h) The College and the Member agree that if the Discipline Committee accepts this Joint Submission as to Penalty and Costs, there will be no appeal or judicial review of the decision to any forum.

Decision and Reasons for Penalty

7. The Panel reviewed the Joint Submission and received submissions from counsel. The Panel accepted the Joint Submission and made an order consistent with its terms before the conclusion of the hearing.

8. The Panel is satisfied that the terms contained in the Joint Submission are reasonable, proportionate, and will maintain public confidence in the Tribunal.

9. This is a case with a catastrophic patient outcome. There were significant gaps in the Member's patient assessment, management planning and documentation. The Member also demonstrated deficiency in the understanding of informed consent by improperly sharing confidential information with the patient's family member without first obtaining the requisite consent.

10. Despite the seriousness of the misconduct, the Panel is satisfied that the proposed penalty in this case is sufficient to both serve as a deterrent while also affording an appropriate path for rehabilitation and remediation.

11. The Member accepted responsibility for his actions and cooperated with the College. Public protection is being appropriately balanced with rehabilitation and remediation by way of the Member being required to complete the University of Toronto Medical Record-Keeping course, the International Interprofessional Wound Care Course (IIWCC-CAN) and additional mentorship to ensure that he will be practicing according to the College's standards moving forward.

12. As part of the Joint Submission, the Member has agreed to pay the College a portion of its costs incurred to investigate and prosecute this matter. While these costs are not part of the penalty, the Member's agreement to make this payment is noted.

13. At the conclusion of the hearing, having confirmed that the Member waived any right to appeal, the Panel delivered an oral reprimand on the record.

I, Eliot To, sign this decision and reasons as Chairperson of this Discipline panel and on behalf

of the members of the Discipline panel as listed below:

Eliot To, Chairperson
Millicent Vorkapich-Hill
Donna Shewfelt
Winnifred Linker

August 8, 2022
Date

COLLEGE OF CHIROPODISTS OF ONTARIO v. DAVID ALLISON

As you know, Mr. David Allison, as part of its penalty, this Discipline panel has ordered you be given an oral reprimand. This is the purpose of your attendance today.

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.

Although you will be given an opportunity to make a statement at the end of the reprimand, this is not an opportunity for you to review the decision made by the Discipline panel, nor a time for you to debate the merits of our decision.

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

1. Failing to meet or contravening a standard of practice and profession and, in particular, the College's written standards pertaining to: Assessment and Management; Competence; Patient Relations; and/or Records

2. Giving information about a patient to a person other than the patient or his or her authorized representative except with the consent of the patient or his or her authorized representative or as required or allowed by law

3. Failing to keep records as required by the regulations

4. Contravening the Act, the *Regulated Health Professions Act*, 1991 or the regulations under either of those Acts, specifically:

- Ontario Regulation 750/93 (Professional Misconduct) under the *Chiropody Act, 1991*, as specified in this Notice of Hearing;
- Ontario Regulation 203/94 (General) under the *Chiropody Act, 1991*, in particular, Records (Part III); and
- Section 51(1)(c) of the Health Professions Procedural Code, being Schedule 2 to the *Regulated Health Professions Act, 1991*, and/or

5. 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 dishonourable and unprofessional

The fact that you engaged in professional misconduct is a matter of concern. You have brought discredit on yourself. The result of your misconduct is that you have let down the public and yourself.

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 inadequate assessment and record keeping, ultimately putting a patient at risk

Your willingness to work with the College reassures this panel that you have recognized the seriousness of your conduct.

We also want to make it clear to you that while the penalty that this panel has imposed upon you is a fair penalty, a more significant penalty will likely be imposed by another Discipline panel in the event that you are ever found to have engaged in professional misconduct again.