**DISCIPLINE COMMITTEE OF**
**THE COLLEGE OF CHIROPODISTS OF ONTARIO**

**PANEL:** Millicent Vorkapich-Hill, Chairperson
Grace King, Member
Khalid Daud, Member

BETWEEN:

| | | |
|---|---|---|
| COLLEGE OF CHIROPODISTS OF ONTARIO | ) | *Jill Dougherty* |
| | ) | College of Chiropodists of Ontario |
| - and - | ) | |
| | ) | *Josh Liswood* |
| | ) | Member |
| MICHAEL TURCOTTE | ) | |
| | ) | *Luisa Ritacca* |
| | ) | Independent Legal Counsel |
| | ) | |
| | ) | Heard: March 27 & April 1, 2015 |

**DECISION AND REASONS**

Introduction

A hearing before a Panel of the Discipline Committee ("Panel") of the College of Chiropodists of Ontario ("College") was held on March 27 and April 1, 2015. The hearing concerned allegations of professional misconduct against a member of the College, Mr. Michael Turcotte (the "Member"). The College has a mandate to regulate the practice of the chiropody profession and to govern its members and, in so doing, serve and protect the public interest.

The Allegations

The allegations against the Member were set out in the Notice of Hearing, dated September 3, 2014. The Notice of Hearing was entered as Exhibit 1 at the hearing.

The allegations in respect of the Member's conduct were as follows:

1. Michael Turcotte is a chiropodist registered to practice chiropody in the Province of Ontario. At all material times, Mr. Turcotte operated and practiced at the "Foot and Ankle Clinic" in Cornwall, Ontario.

2. From in or about October, 2012 to in or about December, 2012, Mr. Turcotte provided treatment to [redacted], a 92-year-old diabetic patient, with respect to an ulcer on her left heel.

3. When [redacted] first attended at the clinic on or about October 15, 2012, Mr. Turcotte failed to perform and record an adequate assessment of her condition and failed to establish a proper management plan for [redacted], in that he:

   i. failed to appropriately assess the ulceration and to note and record relevant specific physical characteristics of the lesion, including but not limited to findings such as: the dimensions, depth and appearance of the lesion; the presence or absence of drainage; the characteristics of the wound bed; the presence or absence of odour; the quality of the wound margins; and the condition of the peri-ulcer skin;

   ii. failed to appropriately assess and to note and record any possible symptoms and aggravating factors associated with the ulcer;

   iii. failed to obtain and record pertinent information about the onset, duration and progression of the ulcer;

   iv. failed to obtain and record information regarding the potential cause or causes of the ulcer;

   v. failed to gather and record the pertinent information from the patient's medical history and relevant clinical findings required to perform an appropriate assessment; and

   vi. failed to state and record a differential diagnosis with a treatment plan and anticipated prognosis.

4. While [redacted] was under Mr. Turcotte's care from in or about October of 2012 to in or about December 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;

5. By reason of the conduct described in paragraphs 3 and 4 of this statement of allegations, Mr. Turcotte 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) 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.

6. From in or about October, 2012 to in or about December, 2012, Mr. Turcotte provided treatment to [redacted] which he knew or ought to have known was ineffective, unnecessary, deleterious or inappropriate to meet her needs in that:

   i. he prescribed and provided compression stockings in circumstances where he understood the patient to be suffering from conditions for which they may be contra-indicated, including Chronic Obstructive Pulmonary Disease ("COPD") and Peripheral Vascular Disease ("PVD");

   ii. he prescribed antibiotics (namely Cephalexin 250mg qid x 10 days) prophylactically, on or about October 15, 2012 and again, without seeing the patient, on November 23, 2012, in circumstances where the member did not assess the patient in order to determine the presence or absence of infection or the degree of infection, if present;

   iii. he prescribed and dispensed orthotics and prescribed and ordered an AirCast walking boot, in circumstances where it was necessary to "off-load" the affected heel and neither device was an appropriate, practical or effective means of accomplishing that goal; given the complete medical profile of this patient; and

   iv. he treated the ulcer primarily by means of a Thor Laser and silver dressing and continued to follow that treatment plan, without making any, or any appropriate, changes to it, despite the fact that there appeared to be no significant improvement in [redacted] 's condition after several weeks of treatment.

7. By reason of the conduct described in paragraph 6 of this statement of allegations, Mr. Turcotte engaged in professional misconduct within the meaning of paragraphs 2 (Failing to meet or contravening a standard of practice of the profession), 7 (Prescribing or administering drugs for an improper use), 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 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.

8. From in or about October, 2012 to in or about December, 2012, Mr. Turcotte failed to take reasonable steps to ensure that [redacted] comprehended the assessment findings, treatment plans and prognoses relating to her one or more treatment plan options and the prognoses relating to each of the possible treatment plans. In particular, the Member:

   i. failed to provide [redacted] with complete, accurate information concerning her assessment, treatment and prognosis, in terms the patient could reasonably be expected to understand;

ii. described the ulcer as a "Grade 3 abscess", but failed to properly explain to [redacted] the meaning and implications of that assessment;

iii. failed to provide [redacted] with appropriate diabetic advice or foot care advice; and

iv. failed to explain the risks for [redacted] associated with the ulcer, including (but not limited to) the risks of infection, osteomyelitis, cellulitis or amputation.

9. By reason of the conduct described in paragraph 8 of this statement of allegations, Mr. Turcotte engaged in professional misconduct within the meaning of paragraphs 2 (Failing to meet or contravening a standard of practice of the profession) 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.

10. From in or about October, 2012 to in or about December, 2012, Mr. Turcotte failed to advise [redacted] to consult with a physician or other regulated health professional concerning the ulcer on her heel and/or to attend at a hospital emergency room. With respect to the latter, Mr. Turcotte suggested that the hospital emergency room would simply prescribe [redacted] a heavier pain killer and refer [redacted] back to him, since they didn't really know how to treat her condition. The Member failed to advise [redacted] to consult with a physician or other regulated health professional, or to go to the hospital, notwithstanding that he recognized, or ought to have recognized, that [redacted]'s condition or status fell outside of his scope of practice, competence or experience, given that:

i. [redacted] was a medically compromised 92-year-old patient with a history of (among other things) Myocardial Infarction, Diabetes Mellitus, neuropathy, and a left ankle fracture repair by open reduction internal fixation. She presented with a swollen left leg and a painful ulcer on her left heel, which Mr. Turcotte assessed as severe and/or as a Grade 3 abscess;

ii. [redacted] continued to complain of pain and experienced increased exudate/ bleeding from the ulcer during the period that she was being treated by Mr. Turcotte, despite the interventions he was applying, including (but not limited to) the prescription of two courses of the same antibiotic; and

iii. [redacted]'s left leg and foot were increasingly red, swollen and painful during the period that she received treatment from Mr. Turcotte.

11. By reason of the conduct described in paragraph 10 of this statement of allegations, Mr. Turcotte 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 750/93 under the Chiropody Act, 1991.

12. The clinical notes maintained by Mr. Turcotte in respect of his treatment of [redacted] are inaccurate and/or misleading in that they:

    i. falsely state that Mr. Turcotte (directly or through his staff) repeatedly advised [redacted] to go to the hospital when he did not in fact do so and instead only indicated, on one occasion, that if [redacted] went to the hospital emergency room, they would simply prescribe her a heavier pain killer and refer [redacted] back to him, since they didn't really know how to treat her condition;

    ii. falsely state that [redacted] was reluctant to go to the hospital due to wait time or because it was hard for her to get around

    iii. falsely state that there was trouble convincing [redacted] to come to appointments at the clinic, and that she was unable to attend at the clinic on or about December 6, 2012 due to lack of transportation;

    iv. understate the extent of the pain reported by [redacted] and the extent and nature of the swelling to the patient's left leg and foot and exudate/ bleeding from the ulcer;

    v. falsely stated that the ulcer was treated regularly with #15 sharp debridement; and

    vi. falsely stated that [redacted] was given diabetic advice and "post op" advice.

13. By reason of the conduct described in paragraph 14 of this statement of allegations, Mr. Turcotte engaged in professional misconduct within the meaning of paragraphs 2 (Failing to meet or contravening a standard of practice of the profession), 18 (falsifying a record relating to the member's practice), 20 ( signing or issuing, in the member's professional capacity, a document that contains a false or misleading statement) 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.

14. On or about December 12, 2012, [redacted] was taken by ambulance to the emergency room of the Cornwall Community Hospital. She was admitted to the hospital, where she was diagnosed with osteomyelitis involving the left calcaneus, requiring the amputation of [redacted] 's left leg below the knee.

15. On or about December 20, 2012, [redacted] (through her daughter and Power-of-Attorney, [redacted] ) cancelled her remaining appointment(s) with Mr. Turcotte and advised clinic staff of the upcoming amputation.

16. On or about January 3, 2013 [redacted] 's left leg was amputated below the knee.

Member's Plea

The Member admitted the allegations, as set out in the Agreed Statement of Facts (Exhibit 2), described below. The Panel conducted a plea inquiry and was satisfied that the Member's admissions were voluntary and unequivocal.

Agreed Statement of Facts

**MEMBER**

1. Mr. Michael Edward Turcotte D. Ch. ("Member") is a member of the College of Chiropodists of Ontario ("College"). At all material times, he practised chiropody at the Foot and Ankle Clinic located at 1077 Pitt Street in Cornwall, Ontario ("Clinic").

**ALLEGATIONS**

2. The allegations of professional misconduct referred to the Discipline Committee in respect of the Member are set out in the Amended Notice of Hearing dated September 3, 2014, which is at Tab 1 of the enclosed Joint Book of Documents. These allegations relate to the Member's assessment and treatment of a pressure ulcer on patient M.M.'s left heel from October 15, 2012 to December 10, 2012.

**FACTS**

**Background**

3. M.M. was 92 years old and lived alone in her own home at the relevant time. She suffered from Type 2 diabetes and had a complex medical history which included Chronic Obstructive Pulmonary Disease, Peripheral Vascular Disease, and a prior left ankle fracture that was treated by open reduction internal fixation ("ORIF"). M.M. was not under the care of a family physician at the relevant time.

4. M.M.'s primary caregiver was her daughter, C.S., who lived on the same street as M.M.

5. The Member treated M.M.'s pressure ulcer at the Clinic from October 15, 2012 to December 10, 2012 using a combination of orthotics, debridement, laser treatment, silver dressings and prophylactic antibiotics (namely Cephalexin 250 mg qid X 10 days). Compression stockings (20-30 mmHg) were also recommended and ordered early on. During this time period, the Member saw M.M. for a total of nine weekly appointments. C.S. attended each weekly appointment with her mother.

6. The facts that support the allegations in the Notice of Hearing were brought to the College's attention by way of a complaint made by both M.M. and C.S. on April 29, 2013 ("Complaint"). The Complaint alleged that the Member provided treatment to M.M. where he knew or ought to have known that the provision of treatment was ineffective, unnecessary or deleterious or was inappropriate to meet M.M.'s needs. The Complaint also alleged that the Member failed to advise M.M. to consult a physician when her condition deteriorated. The Complaint was supported by, among other things, photographs of M.M.'s left heel taken on November 7, 2012 and photographs of her lower left leg following an amputation conducted at Cornwall Community Hospital on or about January 3, 2013. The Complaint, including all enclosures, is at Tab 2.

7. After receiving and responding to the Complaint, and at the College's request, the Member supplied to the College his Patient Health Record ("Patient Health Record") of all visits with M.M., including a typed transcription. That Patient Health Record is at Tab 3. If the Member were to testify, he would say that his practice is to document the care he provides to a patient in the patient's clinical record contemporaneous with the visit, i.e. at the time of the patient visit or within 24 hours. He would also say that the Member's staff, including a Registered Practical Nurse, had a similar practice of documenting care and/or other patient interactions relevant to care.

8. If the Member were to testify, he would say that the documentation in the Patient Health Record regarding M.M. was contemporaneous to the events recorded.

9. At the relevant time, it was C.S.' practice to make a contemporaneous journal entry summarizing the events of each day. Her journal entries were usually recorded each evening, although they were sometimes recorded during the day. If C.S. were to testify, she would say that she has been in the practice of keeping a personal daily journal since 2001. She would also say that she recorded, among other things, her recollections of the progress of her mother's foot ulcer and her interactions with the Member in e-mails to her sister following each appointment at the Clinic. Copies of C.S.' journal entries from Monday, October 15, 2012 to Monday, December 17, 2012 are at Tab 4. Copies of all relevant e-mails from C.S. to her sister S.N. from Monday, October 15, 2012 to Monday, December 10, 2012 are at Tab 5. All relevant e-mails from C.S. to S.N. at Tab 5 were sent or received on the dates and times stamped on the face of each e-mail, i.e. they were sent or received on or about the events in question, and prior to any issues raised about the member's treatment of M.M. as set out in the Complaint.

10. The information contained in the Patient Health Record is inconsistent in a number of respects with C.S.' contemporaneous journal entries and her contemporaneous e-mails to her sister S.N., as described below.

**M.M.'s initial appointment with the Member on October 15, 2012**

11. On Monday, October 15, 2012, M.M. and C.S. attended at the Clinic for the first time for treatment of what was reported as "swelling of ankle and cracked heels" in M.M.'s patient information form. This form further revealed that the problem was getting worse and that M.M. had not had medical treatment for the problem. According to the form, M.M. had Type 2 diabetes, heart trouble, stroke, high blood pressure, cholesterol and a history of cancer. The form also indicated that M.M. was on ten prescription medications. M.M.'s signed patient information form dated October 15, 2012 is at Tab 6.

12. During this first appointment the Member prescribed Cephalex (Cephalexin) 250 mg, with instructions to take one tablet four times a day for a total of ten days. The Member's treatment plan also included a recommendation for compression stockings, a prescription for an orthotic and orthopaedic shoes, Thor laser treatment, callus / wound debridement using a #15 scalpel, silver dressing with instructions to change the gauze daily (leaving the silver dressing in place) and a return to the Clinic in one week.

13. C.S.' journal entry for Monday, October 15, 2012 reads, in part, "foot clinic – foot abscess – grade 3 – on antibiotics – another appt N. Monday."

14. C.S.' e-mail to her sister, which was sent on the same day at 5:07 p.m., also refers to a third degree abscess. It reads, in part:

> "Foot clinic. Appointments are underway. She a "punched in abscess" about 1 inch in diameter on the heel of her foot. That means she has a hole in the heel her foot. He did a laser treatment, applied some kind of silver impregnated mesh and over it some gauze and tape. She has instructions for changing the gauze daily. <u>On the scale of 1 to 10 he said it is a 20 and a third degree abscess</u>. She had some impressions of her feet taken to make some orthotics to be fitted to go inside her "slippers" That is to take the pressure off her heel. He would have done some kind of bubble cast but because she is not stable in walking it would be too risky. Hence the orthotics. I don't know why she needs it for both feet but whatever. I guess he knows what he is doing. She is on antibiotics and will see him again next Monday. So that is the scoop. Hopefully he can get it under control. He said it had nothing to do with her pins or plates in her ankles…..he suspected diabetes as the culprit. Later on he suggests a compression stocking but first the abscess has to get cleared up. May take some time, don't know how long." [Emphasis added]

15. The Member's Patient Health Record of M.M.'s October 15, 2012 visit does not refer to a grade 3 abscess, which is a variation of a medical term denoting a deep infection. His Patient Health Record, instead, reads in part:

> "Upon examination pedal pulses weak, CRT moderate no sign of infection...Advised patient of severity of the condition and diabetic advice given. High Risk. The patient has no family doctor at this time. Will take a long time to heal."

The Member's Patient Health Record includes a diagram of the Member's observations of the ulcer. The Member's Patient Health Record does not clearly state if he probed or assessed the depth or appearance of the ulceration. Moreover, the Patient Health Record does not describe the presence or absence of drainage; the characteristics of the wound bed; the presence or absence of odour; the quality of the wound margins; or the condition of the peri-ulcer skin.

16. In addition, the Member's Patient Health Record of M.M.'s October 15, 2012 visit:

    a) does not include an assessment of any possible symptoms and aggravating factors associated with the ulcer, including whether the wound was close to the calcaneus (heel bone) or whether there was a possibility of osteomyelitis of the calcaneus;

    b) does not include information about the onset, duration and progression of the ulcer;

    c) does not include information about the potential cause or causes of the ulcer;

    d) does not include the detailed advice given to M.M., including detailed diabetic advice, foot care advice, and advice about the risks associated with M.M.'s ulcer, including risks of osteomyelitis, cellulitis, or amputation;

    e) does not include all relevant clinical findings required to perform an appropriate assessment; and,

    f) does not include relevant and pertinent information necessary to implement and evaluate the success of his treatment plan.

17. With respect to paragraphs 15 and 16 above, if the Member were to testify, he would say that it is his practice to document by exception, i.e. he is not in the practice of documenting irrelevant or unavailable information. The Member acknowledges that the College's standards of practice do not contemplate documenting by exception. He would also testify that he did not inquire in detail about the information identified at (b). The Member would also say that at no time did he describe M.M.'s ulcer as a "grade 3 abscess".

18. If C.S. were to testify, she would say that the Member did not provide instructions on diabetic care and did not provide information about the dangers to look out for during this initial visit. On the other hand, if the Member were to testify, he would say that he did provide instructions on diabetic care, and that he also advised on the severity of the condition and that it was high risk. The Member would also say that where the Member provides routine advice of this nature, it is his practice to simply document that advice was provided.

**M.M.'s follow-up appointments with the Member from October 22, 2012 to December 10, 2012**

19. During M.M.'s second visit with the Member on Monday, October 22, 2012, orthotics were dispensed, measurements were taken for compression stockings, Thor laser was performed, the ulcer was debrided, and dressings were applied. The Member noted in the Patient Health Record that the wound was looking good. His Patient Health Record also states "No signs of NERDS", i.e. no signs of non-healing, exudate, red friable tissue, debris (discolouration) and smell. He made no note of drainage. C.S.'s October 22, 2012 journal entry reads in part, "took mom to Turcotte / foot is healing / got her orthotics / new silver mess [sp] – back again in 1 wk."

20. C.S. was concerned, however, about drainage of the ulcer on October 24, 2012 and wondered if another abscess was starting. In an e-mail to her sister on the same date, C.S. wrote: "I think this dressing change could go on for a very very long time. He did say months to years."

21. On October 27, 2012, C.S. documented in her journal that "mom's toes, foot seemed less swollen today". In an e-mail to her sister on the same date, C.S. wrote: "The ulcer is still draining but I would say it is looking better than originally it did. The diameter is shrinking as well as the depth. It does not look as ugly as it was. Today, the redness and swelling in her leg was down and I thought even her foot and toes were not as puffy as before. But of course the swelling seems to come and go so we will see what tomorrow brings."

22. On Monday, October 29, 2012, M.M. was measured again for compression stockings. The Member's Patient Health Record states again that there was no N.E.R.D.S. This visit, as well as M.M.'s follow-up visits on Monday, November 5, 2012, and Monday, November 13, 2012, were similar.

23. On Wednesday, November 7, 2012, a photograph was taken by C.S. of the ulcer on M.M.'s heel with the gauze and the silver dressing removed (see Tab 7). This photograph was not taken during the weekly silver dressing change at the Member's Clinic. The photograph shows the condition of the ulcer on November 7, 2012.

24. On Thursday, November 15, 2012, C.S. noted in her journal that M.M. was on her foot a lot, which caused more drainage. C.S. also made a note of M.M.'s pain in the arch area and that M.M. "really needs proper medical attention."

25. On Monday, November 19, 2012, M.M. saw the Member at the Clinic again. According to the Member's Patient Health Record, there was again "no sign of N.E.RD.S. RTC 1 week." There is no notation in the Patient Health Record of complaints of pain.

26. On the other hand, C.S. noted in her journal on the same day that "mom's foot continues to be sore – Mike T is not v. communicative – I see this going on for a v. long time – she is so discouraged,." This was corroborated in C.S.' e-mail of the same date, where she wrote in part:

> "Mom's foot has been sore for the past couple of days. Don't know why. The drainage is about the same as it has been for quite a while now, I am not seeing new improvement over the first couple of weeks. I asked Mike what caused this ulcer and he sure doesn't like to give away any more words than he has to. His one word answer was "pressure." Not very helpful. Mom asked him if she had come sooner would it have made a difference. He just kind of shrugged and said "Maybe not." I then said that maybe it might not have got as bead [sp]. He replied "Maybe." He scraped off a lot of that callous buildup on her heel, she had the laser treatment and the sliver [sp] put back on and we go again next week. I can see this is going to go on for a very long time. Next visit I may ask him if another round of antibiotics would be helpful."

27. On Friday, November 23, 2012, C.S. observed that M.M.'s heel was bleeding and that she was in pain. C.S.' journal entry of the same date states "wont' go to the hospital – she called Turcotte – she is back on anti-biotics." C.S. wrote the following in an email to her sister time-stamped 1:31 p.m. on the same day:

> "While I was out getting mom some lunch she called Mike and he put her on antibiotics again. She will give you the details. I knew it was draining a lot more the last couple of days. Today there was a lot of blood through four pieces of gauze and her stocking. She denied it. I'm not blind and I am the one changing the gauze."

28. C.S. also mentioned in a second e-mail to her sister that day that "Initially it did bleed. Drainage is a bit darker than before for the past couple of days."

29. According to the Member's Patient Health Record, M.M. "called in with pain and more exudate, clinic was closed. Patient reluctant to go to the hospital due to wait time. Called in an Rx of Cephalexin 250 mg qid 10 days, given the patient's medical history. RTC next clinic day, Monday."

30. If C.S. were to testify, she would say that because both M.M. and C.S. were of the view that antibiotics were effective the first time around, further antibiotic treatment would continue to help and that there was no need to attend at the hospital. C.S. would testify that the severity of M.M.'s wound was not adequately explained to either M.M. or C.S. They did not know at the time that the wound may have been infected.

31. M.M.'s pain and bleeding continued on the following weekend, i.e. on Saturday, November 24, 2012 and Sunday, November 25, 2012, in spite of antibiotic treatment. On Saturday, November 24, 2012, C.S. wrote in an e-mail to her sister that M.M.'s "foot is in pretty bad shape. Much more bleeding and she was in a lot of pain. She took some Advil while I was there and it wasn't helping so I MADE her take another one. By the time I left it was feeling better."

32. On Monday, November 26, 2012, M.M. and C.S. attended at the Clinic for another appointment. According to the Member's Patient Health Record of this visit, there were no signs of infection, although there was some bleeding. No notation was made about pain, complaints of pain, whether continued antibiotic treatment was effective, whether a different course of treatment and/or management was warranted, whether a referral to a physician was warranted, or M.M.'s call to the Member a few days prior. The Member also wrote "trouble getting mother convinced to come to appointments."

33. C.S.'s e-mail on the same day states that the Member "said not to worry about the bleeding. It is a good sign that there is circulation in her foot. He felt her foot and leg and said it is not "warm" and that was a good thing." Her journal entry of the same day states, "Mike says bleeding is better than dry."

34. On Friday, November 30, 2012, C.S. observed that M.M.'s foot was not improving.

35. On Saturday, December 1, 2012, C.S. described the changing state of M.M.'s foot to her sister in an e-mail:

> "Foot is still bleeding. Maybe less oozing but still there. The wound itself looked marginally better but on the skin on top of the sore, there is bluish green tinge. I noticed it yesterday and it is more pronounced today. Maybe it has something to do with the sliver [sp]. I'll mention it on Monday. She has to take Advil every afternoon. Monday is the last day for the antibiotic."

36. On Sunday, December 2, 2012, C.S. observed in an e-mail that M.M.'s foot looked ugly:

> "I'm just back from attending to her foot. It may be bleeding still a bit less but still looks ugly. I am going to ask about the bubble cast tomorrow."

37. On Monday, December 3, 2012, M.M. and C.S. attended at the Clinic for another appointment. The Member noted that M.M. had "complain[ed] of discomfort" and that both legs were mildly swollen. He further noted "try to off load as much as possible…wound looks good, no N.E.R.D.S. RTC 1 week." No notation was made about the effectiveness of the antibiotic he prescribed, whether a different course of treatment and/or management was warranted in light of the edema, the risk of amputation or developing an infection or gangrene, or whether a referral to a physician was warranted at that point. The Member prescribed and ordered an AirCast removable cast walker, which is corroborated by C.S.'s e-mail and journal entry of the same date.

38. The Member's chart dated [Thursday] December 6, 2012 consists of a notation by the Clinic's receptionist, which reads:

> "Patient called in wanted another prescription for antibiotics. Clinic now closed. Talked to D.Ch. – will wait for her to come in. Patient had no ride. D.Ch. advised to go to hospital as soon as she can."

39. On Friday, December 7, 2012, C.S. observed that her mother's air cast would not fit; that her foot was so swollen that the pads with Velcro would not go around her foot; and that "her foot is paining badly." C.S. further noted that:

> "[M.M.] is in so much pain she says she could scream, had taken 1 Advil . . . no results . . . can she take another one?????? How can she not know she can take two. We have been through this so many times…….So I expect it is going to be a very "painful" weekend for her and me."

40. On Saturday, December 8, 2012, M.M. continued to experience a lot of pain. C.S. called the Clinic and spoke with J.N., the Member's daughter who was employed at the Clinic as an office assistant. J.N. recorded the following note in M.M.'s chart:

> "Patient's daughter called – Mother was in a lot of pain – Called D. Ch. – Advised to go to ER. For pain relief and was worried there could be a possible infection. Daughter didn't think she could convince her mom to go in because it is hard for her to get around. Patient wanted to wait for her appointment on Monday."

41. C.S.' journal entry dated Saturday, December 8, 2012 reads "Mom in a lot of pain – I called Mike's office – said if it was that severe – she should go to the E.R. – she will alter her meds ADVIL / Tylenol." Her e-mail to her sister of the same date reads:

> "Just back from mom. She was in a lot of pain so I called the foot clinic even though I knew they were closed but the shoe store was open. They called Mike who said if the pain was that bad she should go to the ER. He said they would prescribe a heavier pain killer and then they would refer her back to him since they don't

> really know how to treat her condition. I can understand that. Same with dentistry and eye stuff. They don't know what to do and refer back to the specialist. Anyhow she is to try taking 1 Advil followed by 1 Tylenol 2 hours later. Advil treats inflammation but not so much pain like Tylenol does. So I gave her the instructions. By the time I left the pain had subsided. I told her not to wait until it was a full blown pain....i.e., nip it in the bud and follow the Advil / Tylenol regimen." [Emphasis added].

42. C.S. did not speak with the Member directly on this day.

43. If J.N. were to testify, she would say that she had relayed to C.S. that the Member was concerned that the pain could be an indication of infection and that the Member said that M.M. should go to the hospital Emergency Room (E.R.). Despite reiterating this advice several times during the call, there seemed to be a reluctance to go to the hospital. J.N. would say that she suggested to C.S. that even if the E.R. did not treat M.M. and sent her back to the Member, at least they would have peace of mind of knowing it is not an infection. J.N. would also say that when it became apparent that M.M. may not go to the hospital, she provided personal advice that M.M. may want to consider alternating Tylenol and Advil.

44. If C.S. were to testify, she would say that they did not go to the E.R. because: (1) they knew that they would see the Member again on the following Monday; (2) they were dissuaded by the Member's comment (recorded above) that the ER would just "prescribe a heavier pain killer and then they would refer her back to him since they don't really know how to treat her condition" and, (3) both C.S. and M.M. did not appreciate the severity of the ulcer. C.S. thought that M.M.'s pain could be managed by alternating Tylenol with Advil, as suggested by J.N.

45. On Sunday, December 9, 2012, C.S. observed that her mother's foot pain was relieved.

46. On Monday, December 10, 2012, M.M. and C.S. attended at the Clinic for another appointment. There was an attempt to fit M.M. with the air cast boot, but it would not fit. The Member's chart notation from this visit states:

> "Patient called on the weekend and advised to go to Hospital. Wanted more antibiotics, ref to Cornwall Community Hospital. Patient still has some pain, both legs still pitting edema, Air Cast ordered too small, wound edge looks o.k., no temperature differential of legs, concerned about patient's gait with Air Cast. Patient and daughter very reluctant to go to Hospital due to wait time, no debridement necessary. Non-healing ulcer at this point. Advice as per staff given. Continue with silver and laser. RTC 1 week."

47. No notation was made about whether a different course of treatment and/or management was warranted in light of the edema, pain and non-healing ulcer, the risk of amputation or developing an infection or gangrene, or whether a referral to a physician was warranted at that point.

48. If C.S. were to testify, she would say that, contrary to what is indicated in M.M.'s chart, the Member did not instruct them to go to the hospital. According to her e-mail on the same day, the Member indicated that the wound was healing well and that he did not know why M.M. was in pain. He suggested taking Aleve as a painkiller and this is corroborated in C.S.' journal entry on the same date. C.S. has also provided a copy of a pharmacy receipt from December 10, 2012 for C.S.' purchase of Aleve.

49. If the Member were to testify, he would say that he did not suggest taking Aleve as a painkiller.

50. On Wednesday, December 12, 2012, M.M. telephoned S.G., a friend and in-law who lived in the neighbourhood. M.M. complained about intense pain. When S.G. came by to check on M.M., she saw that M.M.'s left foot was bandaged tightly and was very swollen. If S.G. were to testify, she would say that M.M. had taken Aleve medication but was still in pain.

51. M.M. attended at the Cornwall Community Hospital ("hospital") later that day. The emergency physician, Dr. Davis, charted that M.M. had left calf / lower leg edema, erythema, and diagnosed her as having cellulitis. M.M. was thereafter admitted to hospital, where she stayed until her discharge to rehab on January 17, 2013.

52. On December 12 and 13, 2012, cultures were taken of M.M.'s wound. According to the associated culture reports, the multiple bacteria present in M.M.'s wound were resistant to cephalosporin antibiotics, i.e. the same antibiotics prescribed by the Member during the relevant time. Both culture reports are attached at Tab 8.

53. On Friday, December 14, 2012, a second foot ulcer was noted on M.M.'s left foot.

54. On Sunday, December 16, 2012, M.M. was seen by surgeon Dr. Wasseem Moussa. He debrided both ulcers down to the bone and noted bone destruction. He ordered x-rays and was surprised that none had been ordered during M.M.'s hospital admission. He further noted that M.M. would likely require a below the knee amputation ("BKA"). Dr. Moussa's consultation report dated December 16, 2012 is attached at Tab 9.

55. A diagnostic imaging report dated Sunday, December 16, 2012 further revealed advanced demineralization on the left foot and calcaneus. M.M.'s left calcaneus had a mottled appearance in its posterior segment, which was suggestive of early destruction and possible osteomyelitis. Follow-up bone-gallium nuclear scans were recommended. A copy of this report, as well as relevant bone scans of the same date, are at Tab 10.

56. On Monday, December 17, 2012, a nuclear medicine report revealed "findings consistent with osteomyelitis involving the left calcaneus and surrounding soft tissue infection." A copy of this report is at Tab 11.

57. On the same day, Dr. Moussa diagnosed M.M. as having chronic osteomyelitis involving the body of the calcaneus. He further noted that debridement would be so extensive that M.M. would have no heel on which to ambulate. He noted that amputation would get rid of the pain and osteomyelitis and restore ambulation with a successful prosthetic.

58. On Friday, December 21, 2012, Dr. C.P. Chang, an orthopedic surgeon at the hospital, also diagnosed M.M. as having a left heel infection with osteomyelitis and agreed with a BKA.

59. On January 2, 2013, Dr. Y. Dang, a general surgeon at the hospital, charted that "unfortunately this has progressed over the ensuing 2 months." He confirmed two ulcerations on M.M.'s left heel which were "deep to the bone." He concluded that M.M.'s heel ulceration had progressed to involve osteomyelitis and that a BKA was required for control. A copy of Dr. Dang's January 2, 2013 consultation note is at Tab 12.

60. M.M.'s left leg was amputated below the knee on January 3, 2013. She thereafter relied on a wheelchair for mobility.

61. On Monday, February 11, 2013, M.M. was discharged from the rehab wing of the hospital and went to live at the Heritage Heights Retirement Home.

62. If he were to testify, the Member would say that, directly or through his staff, he raised with M.M. the possibility of going to the hospital on three occasions during the relevant time. However, he admits the following allegations set out in the Notice of Hearing:

**ADMISSIONS OF PROFESSIONAL MISCONDUCT**

63. The Member admits that, while M.M. was under his care from on or about October 15, 2012 to on or about December 10, 2012, he failed to meet or he contravened a standard of practice of the profession, as alleged in paragraphs 5, 7, 9, 11 and 13 of the Notice of Hearing by:

    a) failing to perform and record an adequate assessment of M.M.'s condition and by failing to establish a proper management plan for M.M. when she first attended the Clinic on Monday, October 15, 2012. In particular he:

        i. failed to appropriately assess the ulceration and to note and record relevant specific physical characteristics of the lesion, including but not limited to findings such as: the dimensions, depth and appearance of the lesion; the presence or absence of drainage; the characteristics of the wound bed; the presence or absence of odour; the quality of the wound margins; and the condition of the peri-ulcer skin;

ii. failed to appropriately assess and to note and record any possible symptoms and aggravating factors associated with the ulcer;

iii. failed to obtain and record pertinent information about the onset, duration and progression of the ulcer;

iv. failed to obtain and record information regarding the potential cause or causes of the ulcer;

v. failed to gather and record the pertinent information from the patient's medical history and relevant clinical findings required to perform an appropriate assessment; and

vi. failed to state and record a differential diagnosis with a treatment plan and anticipated prognosis;

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

c) providing treatment to M.M. which he knew or ought to have known was ineffective, unnecessary, deleterious or inappropriate to meet her needs in that:

i. he prescribed and provided compression stockings in circumstances where he understood the patient to be suffering from conditions for which they may be contra-indicated, including Chronic Obstructive Pulmonary Disease ("COPD") and Peripheral Vascular Disease ("PVD");

ii. he prescribed antibiotics (namely Cephalexin 250mg qid x 10 days) prophylactically, on or about October 15, 2012 and again, without seeing the patient, on November 23, 2012, in circumstances where he did not assess the patient in order to determine the presence or absence of infection or the degree of infection, if present;

iii. he prescribed and ordered an AirCast walking boot (or AirCast removable cast walker), in circumstances where it was necessary to "off-load" the affected heel and the device was not an appropriate, practical or effective means of accomplishing that goal; given the complete medical profile of M.M.; and

iv. he treated the ulcer primarily by means of a Thor Laser and silver dressing and continued to follow that treatment plan, without making any, or any appropriate, changes to it, despite the fact that there appeared to be no significant improvement in M.M.'s condition after several weeks of treatment.

d) failing to take reasonable steps to ensure that M.M. comprehended the assessment findings, treatment plans and prognoses relating to her one or more treatment plan options and the prognoses relating to each of the possible treatment plans. In particular, the Member:

   i. failed to provide M.M. with complete, accurate information concerning her assessment, treatment and prognosis, in terms the patient could reasonably be expected to understand;

   ii. failed to provide M.M. with appropriate diabetic advice or foot care advice; and

   iii. failed to explain the risks for M.M. associated with the ulcer, including (but not limited to) the risks of infection, osteomyelitis, cellulitis or amputation.

e) failing to advise M.M. to consult with a physician or other regulated health professional, or to go to the hospital, notwithstanding that he recognized, or ought to have recognized, that M.M.'s condition or status fell outside of his scope of practice, competence or experience, given that:

   i. M.M. was a medically compromised 92-year-old patient with a history of (among other things) Myocardial Infarction, Type 2 Diabetes Mellitus, neuropathy, and a left ankle fracture repair by ORIF. She presented with a swollen left leg and a painful ulcer on her left heel, which the Member assessed as severe;

   ii. M.M. continued to complain of pain and experienced increased exudate/ bleeding from the ulcer during the period that she was being treated by the Member, despite the interventions he was applying, including (but not limited to) the prescription of two courses of the same antibiotic; and

   iii. M.M.'s left leg and foot were increasingly red, swollen and painful during the period that she received treatment from the Member.

f) maintaining inaccurate clinical notes in respect of his treatment of M.M. in that they:

   i. inaccurately state that the Member (directly or through his staff) repeatedly advised M.M. to go to the hospital, when he did not do so unequivocally;

   ii. inaccurately state that there was trouble convincing M.M. to come to appointments at the clinic, and that she was unable to attend at the clinic on or about December 6, 2012 due to lack of transportation; and

iii. fail to accurately and sufficiently record the extent of the pain reported by M.M. and the extent and nature of the swelling to the patient's left leg and foot and exudate/ bleeding from the ulcer.

64. The Member admits that while M.M. was under his care from on or about October 15, 2012 to on or about December 10, 2012, he failed to keep records, as required by the regulations, and as alleged in paragraph 5 of the Notice of Hearing by failing to do what is set out at paragraph 63(a) above.

65. The Member admits that, while M.M. was under his care from on or about October 15, 2012 to on or about December 10, 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 paragraphs 5, 7, 9, 11 and 13 of the Notice of Hearing by failing to do what is set out at paragraphs 63(a) to (f) above.

66. The Member admits that, while M.M. was under his care from on or about October 15, 2012 to on or about December 10, 2012, he prescribed or administered drugs for an improper use, as alleged in paragraph 7 of the Notice of Hearing by doing what is set out at paragraph 63(c) above.

67. The Member admits that, while M.M. was under his care from on or about October 15, 2012 to on or about December 10, 2012, he provided treatment to a 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 paragraph 7of the Notice of Hearing by doing what is set out at paragraph 63(c) above.

68. The Member admits that, while M.M. was under his care from on or about October 15, 2012 to on or about December 10, 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 paragraph 11 of the Notice of Hearing given what is set out at paragraph 63(e) above.

69. The Member admits that, while M.M. was under his care from on or about October 15, 2012 to on or about December 10, 2012, he signed or issued, in his professional capacity, a document containing a false or misleading statement, as alleged in paragraph 13 of the Notice of Hearing and as set out at paragraph 63(f) above.

**Decision**

Having considered the evidence set out in the Agreed Statement of Facts, the Member's admissions, and the onus and standard of proof, the panel finds that the Member committed acts of professional misconduct as alleged in the Agreed Statement of Facts.

**Reasons for Decision**

Upon arriving at its decision, the Panel considered the following factors as determinative:

- The extensive facts agreed upon by the parties and set out in the Agreed Statement of Facts (Exhibit #2) clearly established that the Member engaged in the misconduct he admitted; and

- The Member freely admitted that in certain respects, his treatment of M.M. fell below the standard and ultimately amounted to professional misconduct.

The Panel was satisfied that the conduct described in the Statement of Agreed Facts and as admitted to by the Member did constitute professional misconduct as alleged in the Amended Notice of Hearing.

**Penalty**

Penalty Submissions

The parties presented the panel with a proposed order, which provides as follows:

1. **THE DISCIPLINE COMMITTEE FINDS** that Michael Turcotte engaged in professional misconduct within the meaning of paragraphs 2 (Failing to meet or contravening a standard of practice of the profession), 7 (Prescribing or administering drugs for any improper use), 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), 15 (Failing to advise the patient unequivocally 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), 20 (Signing or issuing, in the member's professional capacity, a document that contains a false or misleading statement) 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*.

2. **THE DISCIPLINE COMMITTEE ORDERS** that Michael Turcotte shall appear before the Panel of the Discipline Committee to be reprimanded, the fact of which shall be recorded on the public register of the College.

3. **THE DISCIPLINE COMMITTEE DIRECTS** the Registrar to suspend Michael Turcotte's certificate of registration for a period of six (6) months, three (3) months of which shall be remitted in the event that the Member complies with subparagraphs 4(a) and (b) of this Order within eighteen (18) months from the date of this Order. The first three (3) months of the suspension shall commence thirty (30) days following the date of this Order and any further period of suspension which is not remitted shall be served beginning eighteen (18) months after the date of this Order.

4. **THE DISCIPLINE COMMITTEE** directs the Registrar to impose a term, condition and limitation on the Member's certificate of registration,

a. Requiring that he successfully complete the ProBe course in ethics, to the satisfaction of the Registrar, and at the Member's own expense.

b. Requiring that the Member successfully complete the University of Toronto's International Interprofessional Wound Care Course (IIWCC-CAN) and the University of Western Ontario's Course in Diabetic Foot Complications, to the satisfaction of the Registrar, and at the Member's own expense.

c. Limiting the Member such that he 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 three courses noted above and until an Expert Report is submitted to the satisfaction of the Registrar as described in subparagraphs 4(e) and (f)(2) below.

d. Requiring the Member to at his own expense, attend six (6) mentoring sessions with a Chiropody / 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:

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

        a. Competence;

        b. Infection Control;

        c. Patient Relations; and,

        d. Records.

    2. the Member's understanding of the College's standards of practice as set forth in paragraph 4(d)(1) above;

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

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

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

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

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

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

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

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

f. 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.

g. The terms, conditions and limitations referred to in paragraphs 4(a) to (e) above shall be removed when the Registrar receives:

1. satisfactory confirmation of successful completion of all three courses noted above; and,

2. 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.

5. **THE DISCIPLINE COMMITTEE ORDERS** the Member to pay to the College its costs fixed in the amount of $15,000.00.

**Penalty Decision**

The panel accepted the parties' joint submission and orders as follows:

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 Panel directs the Registrar to suspend the Member's certificate of registration for a period of six (6) months, three (3) months of which shall be remitted if the Member complies with subparagraphs (c)(i) and (ii) of this Order within eighteen (18) months from the date the Penalty Order is signed by the Discipline Committee. The first three (3) months of the suspension shall commence thirty (30) days following the date that the Penalty Order is signed by the Panel and any further period of suspension which is not remitted shall be served beginning eighteen (18) months after the Penalty Order is signed.

c. The Panel directs 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.

    ii. the Member is to successfully complete the University of Toronto's International Interprofessional Wound Care Course (IIWCC-CAN) and the University of Western Ontario's Course in Diabetic Foot Complications, to the satisfaction of the Registrar, and at the Member's own expense.

    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 three 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, attend six (6) mentoring sessions with a Chiropody / 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 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 all three courses noted above; and,

(B) 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 Panel orders that the Member to pay the College's costs fixed in the amount of $15,000.

**Reasons for Penalty Decision**

The panel accepted the parties' Joint Submission on Order. Although there were no similar cases provided to the panel as a guide, the Panel understands its obligations not to reject a joint submission unless it is contrary to the public interest.

The Panel believes the proposed order will offer remediation to the practitioner in areas where he was shown to be acting in this case below acceptable standards. The order will also act as a deterrent for other practitioners to engage in such practices.

Overall, the order will serve to protect the public and deter the Member from repeating his mistakes.

The Panel notes that in deciding to accept the joint proposal, it also considered the following mitigating factors, which weighed in favour of the Member:

- This is the first time the Member has been before the Discipline Committee, and
- The Member admitted the allegations of professional misconduct in the Amended Notice of Hearing, thereby saving the College considerable time and expense at a contested hearing.

At the conclusion of the hearing, the Member waived his right to an appeal and the Panel delivered its Reprimand.

I, **Millicent Vorkapich-Hill**, sign this decision and reasons for the decision as Chair of this Discipline panel and on behalf of the members of the Discipline panel as listed below.

M Vorkapich-Hill

Millicent Vorkapich-Hill, Chair

6/17/15

Date:

Panel Members:

Grace King, Member
Khalid Daud, Member

**DISCIPLINE COMMITTEE OF**

**THE COLLEGE OF CHIROPODISTS OF ONTARIO**

| | | |
|---|---|---|
| Millicent Vorkapich-Hill, Chair Professional Member<br>Khalid Daud, Public Member<br>Grace King, Public Member | )<br>)<br>) | Thursday the 2nd day of<br>April, 2015 |

BETWEEN:

COLLEGE OF CHIROPODISTS OF ONTARIO

- and -

MICHAEL TURCOTTE

**ORDER**
(Dated April 2, 2015)

**THIS HEARING,** was heard on March 27 and April 1, 2015 by the Discipline Committee at 222 Bay Street, 9th floor, Toronto, Ontario.

**ON READING** the Amended Notice of Hearing dated September 3, 2014 and the Exhibits filed, including the Agreed Statements of Facts and the Joint Submission as to Penalty and on hearing the submissions of counsel for the College of Chiropodists of Ontario ("the College") and the Member, Michael Turcotte:

1. **THE DISCIPLINE COMMITTEE FINDS** that Michael Turcotte engaged in professional misconduct within the meaning of paragraphs 2 (Failing to meet or contravening a standard of practice of the profession), 7 (Prescribing or administering drugs for any improper use), 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), 15 (Failing to advise the patient unequivocally 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), 20 (Signing or issuing, in the member's professional capacity, a document that contains a false or misleading statement) 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*.

2. **THE DISCIPLINE COMMITTEE ORDERS** that Michael Turcotte shall appear before the Panel of the Discipline Committee to be reprimanded, the fact of which shall be recorded on the public register of the College.

3. **THE DISCIPLINE COMMITTEE DIRECTS** the Registrar to suspend Michael Turcotte's certificate of registration for a period of six (6) months, three (3) months of which shall be remitted in the event that the Member complies with subparagraphs 4(a) and (b) of this Order within eighteen (18) months from the date of this Order. The first three (3) months of the suspension shall commence thirty (30) days following the date of this Order and any further period of suspension which is not remitted shall be served beginning eighteen (18) months after the date of this Order.

4. **THE DISCIPLINE COMMITTEE** directs the Registrar to impose a term, condition and limitation on the Member's certificate of registration,

   a. Requiring that he successfully complete the ProBe course in ethics, to the satisfaction of the Registrar, and at the Member's own expense.

   b. Requiring that the Member successfully complete the University of Toronto's International Interprofessional Wound Care Course (IIWCC-CAN) and the University of Western Ontario's Course in Diabetic Foot Complications, to the satisfaction of the Registrar, and at the Member's own expense.

c. Limiting the Member such that he 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 three courses noted above and until an Expert Report is submitted to the satisfaction of the Registrar as described in subparagraphs 4(e) and (f)(2) below.

d. Requiring the Member to at his own expense, attend six (6) mentoring sessions with a Chiropody / 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:

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

        a. Competence;

        b. Infection Control;

        c. Patient Relations; and,

        d. Records.

    2. the Member's understanding of the College's standards of practice as set forth in paragraph 4(d)(1) above;

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

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

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

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

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

1. confirm the dates of all sessions attended by the Member;
2. confirm that the standards of practice referred to above were covered with the Member; and,
3. include an assessment of the Member's insight into his conduct as described in the Agreed Statement of Facts.

f. 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.

g. The terms, conditions and limitations referred to in paragraphs 4(a) to (e) above shall be removed when the Registrar receives:

1. satisfactory confirmation of successful completion of all three courses noted above; and,
2. 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.

5. **THE DISCIPLINE COMMITTEE ORDERS** the Member to pay to the College its costs fixed in the amount of $15,000.00[1].

---

[1] The College has agreed that the costs ordered payable may be provided to the College by the Member as follows:

a. $5,000.00 payable within thirty (30) days of the date of this Order;
b. $5,000.00 payable on or before September 30, 2015; and
c. $5,000.00 payable on or before December 31, 2015.

I, **Millicent Vorkapich-Hill**, sign this Order as Chair of the panel of the Discipline Committee on behalf of the members of the panel that heard this matter.

M Vorkapich-Hill, DDM 4/2/15

Dated at Windsor this 2nd day of April, 2015

# DISCIPLINE COMMITTEE OF
# THE COLLEGE OF CHIROPODISTS OF ONTARIO

| | | |
|---|---|---|
| Millicent Vorkapich-Hill, Chair, Professional Member<br>Khalid Daud, Public Member<br>Grace King, Public Member | )<br>)<br>) | April 29, 2016 |

BE T W E E N:

COLLEGE OF CHIROPODISTS OF ONTARIO

- and –

MICHAEL TURCOTTE

**REVISED ORDER**
(Dated April 29, 2016, replacing the Panel order Dated April 2, 2015)

**THIS HEARING**, was heard on March 27 and April 1, 2015 by the Discipline Committee at 222 Bay Street, 9th floor) Toronto, Ontario.

**ON READING** the Amended Notice of Hearing dated September 3, 2014 and the Exhibits filed, including the Agreed Statements of Facts and the Joint Submission as to Penalty and on hearing the submissions of counsel for the College of Chiropodists of Ontario ("the College") and the Member, Michael Turcotte and on reading the parties' request for a variation of the Discipline Committee's original order, dated April 2, 2015:

1. **THE DISCIPLINE COMMITTEE FINDS** that Michael Turcotte engaged in professional misconduct within the meaning of paragraphs 2 (Failing to meet or contravening a standard of practice of the profession), 7 (Prescribing or administering

drugs for any improper use), 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), 15 (Failing to advise the patient unequivocally 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), 20 (Signing or issuing, in the member's professional capacity, a document that contains a false or misleading statement) 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.*

2. **THE DISCIPLINE COMMITTEE ORDERS** that Michael Turcotte shall appear before the Panel of the Discipline Committee to be reprimanded, the fact of which shall be recorded on the public register of the College.

3. **THE DISCIPLINE COMMITTEE DIRECTS** the Registrar to suspend Michael Turcotte's certificate of registration for a period of six (6) months, three (3) months of which shall be remitted in the event that the Member complies with subparagraphs 4(a) and (b) of this Order within eighteen (18) months from the date of this Order. The first three (3) months of the suspension shall commence thirty (30) days following the date of this Order and any further period of suspension which is not remitted shall be served beginning eighteen (18) months after the date of this Order.

4. **THE DISCIPLINE COMMITTEE** directs the Registrar to impose a term, condition and limitation on the Member's certificate of registration,

a. Requiring that he successfully complete the ProBe course in ethics, to the satisfaction of the Registrar, and at the Member's own expense.

b. Requiring that the Member successfully complete the University of Toronto's International Interprofessional Wound Care Course (IIWCC-CAN) and the St. Michael's Diabetic Foot Course, or only if that course is not available, another equivalent course that is approved by the Registrar, to the satisfaction of the Registrar, and at the Member's own expense.

c. Limiting the Member such that he 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 three courses noted above and until an Expert Report is submitted to the satisfaction of the Registrar as described in subparagraphs 4(e) and (f)(2) below.

d. Requiring the Member to at his own expense, attend six (6) mentoring sessions with a Chiropody / 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:

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

        a. Competence;

        b. Infection Control;

        c. Patient Relations; and,

        d. Records.

    2. the Member's understanding of the College's standards of practice as set forth in paragraph 4(d)(l ) above;

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

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

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

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

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

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

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

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

f. 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.

g. The terms, conditions and limitations referred to in paragraphs 4(a) to (e) above shall be removed when the Registrar receives:

    1. satisfactory confirmation of successful completion of all three courses noted above; and,

    2. 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.

5. **THE DISCIPLINE COMMITTEE ORDERS** the Member to pay to the College its costs fixed in the amount of $15.000.00 [1]

---

[1] The College has agreed that the costs ordered payable may be provided to the College by the Member as follows:

a. $5,000.00 payable within thirty (30) days of the date of this Order;
b. $5,000.00 payable on or before September 30, 2015; and
c. $5,000.00 payable on or before December 31, 2015.

I, **Millicent Vorkapich-Hill,** sign this Revised Order as Chair of the panel of the Discipline Committee on behalf of the members of the panel that heard this matter.

Millicent Vorkapich-Hill, RM

Dated at Windsor this April 29, 2016