DISCIPLINE COMMITTEE OF THE
COLLEGE OF NATUROPATHS OF ONTARIO

IN THE MATTER OF a hearing directed
by the Inquiries, Complaints and Reports Committee of
the College of Naturopaths 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.

B E T W E E N:

COLLEGE OF NATUROPATHS OF ONTARIO

- and -

KURT STAUFFERT

DECISION AND REASONS

A panel of the Discipline Committee of the College of Naturopaths of Ontario (the "Panel") held a hearing on October 11, 2022. The hearing proceeded electronically pursuant to the *Regulated Health Professions Act, 1991*, Schedule 2, the Health Professions Procedural Code (the "Code"), the *Hearings in Tribunal Proceedings (Temporary Measures) Act, 2020* and the Discipline Committee Rules.

Rebecca Durcan and Ahmad Mozaffari were counsel to the College of Naturopaths of Ontario (the "College"). Andrew Parr attended on behalf of the College. Kurt Stauffert (the "Registrant") was represented by Allan Freedman. Lonny Rosen acted as independent legal counsel ("ILC") to the Panel.

ALLEGATIONS

The Notice of Hearing, dated December 13, 2021, was filed as Exhibit 1 and set out the following:

The Registrant

1. The Registrant registered with the Board of Directors of Drugless Therapy – Naturopathy on or about April 7, 2004. The Registrant then became registered with the College of Naturopaths of Ontario (the "College") on July 1, 2015.

2. At all relevant times, the Registrant worked at and/or owned EcoClinic for Integrative Healthcare in Barrie, ON (the "Clinic").

The Patient

3. On or about December 17, 2016, the Patient became a patient of the Registrant.

4. On or about October 2018, the Patient advised the Registrant that she had been diagnosed with breast cancer.

5. It is alleged that the Registrant:

    a. Communicated to the Patient that he could treat cancer;
    b. Permitted the Patient to believe that he could treat cancer so that it would not progress or words to that effect;
    c. Did not provide the Patient with sufficient information so that she could make valid decisions about her care;
    d. Dissuaded the Patient from taking Western and/or allopathic medicine to treat the cancer;
    e. Ordered tests for the Patient to treat her cancer and/or to infer that he was treating the cancer and/or that he knew or ought to have known were unnecessary or ineffective;
    f. Recommended that the Patient attend his Clinic regularly for testing and/or unnecessary testing;
    g. Communicated to the Patient that the cancer was under control or words to that effect;
    h. Provided false and/or misleading information to the Patient about the efficacy of the ordered tests and/or products that he prescribed and/or compounded and/or sold;
    i. Ordered tests and/or communicated information to the Patient on issues that were not within his scope of practice;
    j. Ordered a breast ultrasound for the Patient;
    k. Recommended a supplement to the Patient in order to "avoid antibiotics" for a kidney infection diagnosed by a physician;
    l. Requested information from the patient's family physician and/or oncologist about the Patient's cancer and/or lab results;
    m. Prescribed and/or compounded and/or sold products to the Patient to treat her cancer and/or to infer that he was treating the cancer and/or that he knew or ought to have known were unnecessary or ineffective;

n. Advised the Patient that a wound on her breast was the poison coming out of her or words to that effect;
o. Did not communicate with the Patient's family physician and/or oncologist and/or other relevant health care practitioner about the Patient's cancer and/or symptoms and/or lab results and/or did not ask the Patient if he could communicate with same;
p. Did not refer and/or discuss a referral with the Patient when the treatment was not adequate and/or not likely to improve and/or when the Registrant knew or ought to have known that the Patient required a service that the Registrant did not have the knowledge, skill or judgment to offer or was beyond his scope of practice;
q. Discussed having the Patient sign a special consent form to protect him from the Patient's family;
r. Did not maintain contemporaneous records for the Patient;
s. Did not obtain informed consent for all treatments;
t. Did not document the consent process with the Patient;
u. Did not communicate all discussions with the Patient related to patient care;
v. Falsified information in the Patient's record; and/or
w. Did not form and/or did not document a naturopathic diagnosis for the Patient.

6. It is also alleged that the Registrant;

a. Added additional information to the Patient's record during the College investigation;
b. Did not indicate in the Patient record that he had made amendments; and/or
c. Falsified information in the Patient's record during the College investigation.

Allegations of Professional Misconduct

7. It is alleged that the above noted conduct constitutes professional misconduct pursuant to section 51(1)(c) of the *Health Professions Procedural Code*, being Schedule 2 to the *Regulated Health Professions Act, 1991* (the "Code") as set out in one or more of the following paragraphs of section 1 of Ontario Regulation 17/14 made under the *Naturopathy Act, 2007*:

a. **Paragraph 1.** Contravening, by act or omission, a standard of practice of the profession or failing to maintain the standard of practice of the profession, including but not limited to the following:
    i. Record Keeping;
    ii. Core Competencies;
    iii. Conflict of Interest;
    iv. Code of Ethics;
    v. Consent;
    vi. Scope of Practice;
    vii. Therapeutic Relationships and Professional Boundaries; and/or

viii. Requisitioning Laboratory Tests.

b. **Paragraph 3.** Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic or other health-related purpose except,
   i. with the informed consent of the patient or the patient's authorized representative, or
   ii. as required or authorized by law;

c. **Paragraph 7.** Recommending or providing treatment that the member knows or ought to know is unnecessary or ineffective;

d. **Paragraph 8.** Providing or attempting to provide services or treatment that the member knows or ought to know to be beyond the member's knowledge, skill or judgment;

e. **Paragraph 9.** Failing to advise a patient or the patient's authorized representative to consult another member of a health profession within the meaning of the *Regulated Health Professions Act, 1991*, when the member knows or ought to know that the patient requires a service that the member does not have the knowledge, skill or judgment to offer or is beyond his or her scope of practice;

f. **Paragraph 14.** Prescribing, dispensing, compounding or selling a drug or a substance for an improper purpose;

g. **Paragraph 36.** Contravening, by act or omission, a provision of the Act, the *Regulated Health Professions Act, 1991* or the regulations under either of those Acts;

h. **Paragraph 23.** Failing to keep records in accordance with the standards of the profession;

i. **Paragraph 25.** Falsifying a record relating to the member's practice;

j. **Paragraph 46.** Engaging in conduct or performing an act relevant to the practice of the profession that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional;

k. **Paragraph 47.** Engaging in conduct that would reasonably be regarded by members as conduct unbecoming a member of the profession; and/or

l. **Paragraph 48.** Failing to make reasonable attempts to collaborate with the patient's other relevant health care providers respecting the care of the patient,

where such collaboration is necessary for the patient's health, unless the patient refuses to consent.

ADMISSION AND PLEA INQUIRY

The Registrant admitted to the allegations of professional misconduct set out the Notice of Hearing and Agreed Statement of Facts.

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

AGREED STATEMENT OF FACTS

The College advised the Panel that the evidence would be provided by way of an Agreed Statement of Facts and Admission of Professional Misconduct (the "ASF"), which was filed as Exhibit 2 and set out the following:

The parties hereby agree that the following facts and attachments may be accepted as true by the Discipline Committee of the College of Naturopaths of Ontario:

The Registrant

1. The Registrant was a registrant of the College at all relevant times. The Registrant first became registered with the Board of Directors of Drugless Therapy (Naturopathy) on or about April 7, 2004. The ASF included at **Tab "A"** a printout from the College's Naturopathic Doctor Register.

2. At all relevant times, the Registrant worked at the Clinic.

The Patient

3. The College received a complaint on October 16, 2020 from the daughter of the Registrant's former patient (the "Patient").

4. The Patient became a patient of the Registrant on or about December 17, 2016. The Patient attended regular appointments with the Registrant over the next four years. She ceased being a patient of the Registrant in September, 2020.

Cancer Diagnosis and Subsequent Attendances before the Registrant

5. On September 30, 2018, the Patient emailed the Registrant and advised him that she had recently had a mammogram which showed a lump on her right breast. She further advised that she was scheduled to have a biopsy on October 1, 2018, and requested to book an

appointment with the Registrant "to discuss the problem and treatment".

6. On October 10, 2018, the Patient visited the Registrant at which time she advised the Registrant that she had undergone the biopsy of her right breast as a result of a lump found by her medical provider. At that time, according to the Registrant's patient record, he prescribed Gemmo #1 botanical to "induce sleep, improve immune function especially in the right breast". He also prescribed Gemmo #2 to "eliminate the larvicide temephos from the superior vena cava, the vocal chords and the sphincter of oddi". The Registrant made a further note in the record that he told the Patient to "call us with results of biopsy and consider reassessment of status after returning from B.C.", where the Patient was scheduled to be travelling for 10 days.

7. The Patient was subsequently diagnosed with breast cancer by Dr. Monica Chaudhuri, based on the results of the Patient's biopsy. The patient record shows that the Patient advised the Registrant of her diagnosis and provided him with a copy of the Surgical Pathology Final Report in relation to her biopsy on October 15, 2018.

8. On November 13, 2018, the Patient attended before the Registrant to discuss her diagnosis. If the Patient were to testify, she would state that the Registrant told her that he could control and treat her cancer. She would also state that the Registrant told her he did not believe in chemotherapy, which he said was poison and killed people.

9. At the November 13, 2018 appointment, the Registrant prescribed a botanical "to regenerate the nerves in the right breast and right pleural cavity and improve sleep". The Registrant made a note in the chart that the Patient's family was "not very supportive of her choices for alt health care". He further noted that he advised the Patient he could "continue/assist with monitoring progress to help her decisioning". The Registrant also noted that "after botanical consider additional imaging to reassess cancer in right breast".

10. The records of the November 13, 2018 appointment also show that the Registrant noted that they should "consider a biomarker of Breast cancer CA-15". Cancer Antigen ("CA") 15-3 is a protein made by breast cancer cells. In general, the higher the level of CA 15-3 in the blood, the more cancer there is in the body. CA 15-3 levels are monitored in order to ascertain a patient's response to breast cancer treatment and disease recurrence.

11. After her breast cancer diagnosis, the Registrant ordered numerous tests for the Patient, including CA 15-3 levels, Psychosomatic Energetics testing ("PSE") testing[1], urine testing and complete blood count ("CBC") testing. If the Patient were to testify, she would state that she was not certain what the blood tests the Registrant was ordering were for, however she trusted the Registrant's judgment and the treatment he was providing.

12. The Patient attended numerous appointments with the Registrant between October 2018 and September 2020. If the Patient were to testify, she would state that the Registrant

[1] PSE testing involves the use of a test device to quantitatively test a patient's subtle-energy system.

would repeatedly tell her that the treatment was working and her cancer was not metastasizing. Moreover, if the Patient were to testify, she would state that she believed the Registrant was treating her breast cancer and that the treatments he was providing and substances he was prescribing were for the purpose of treating her breast cancer.

13. For example, at an appointment on December 4, 2018, the Registrant prescribed Gemmo #5 to "eliminate CWD staph bacteria from the R. breast milk ducts and the lyme co-infector" and noted same in her chart. He also made a note that the patient reported that the tumor in the Patient's right breast was less than 2 cm and "seems to be moving out to the surface".

14. At a February 4, 2019 appointment, the Registrant made a note that the Patient reported that her right breast nipple was leaking watery blood and is tender. He also noted that the patient reported that the "lump is unchanged in size". His assessment included "prescriptions to support breast health and other tissue health", which in turn included a "botanical to regenerate nerves in the r. breast …" and Gemmo #9 to "eliminate sclerotic scar tissue in the R. Breast … and to eliminate … parasite … from the R. and L. Breast".

15. The Registrant also continued to recommend further testing, including PSE testing and a urine test, and made a note in the chart that he requested a copy of the Patient's mammogram and ultrasound of her right breast. At a March 8, 2019 appointment, he again requested that the Patient complete a CBC test and a CA 15-3 test and made a note of this in the Patient's chart. If the Patient were to testify, she would state that the Registrant would order a lot of blood tests for her, but she was not sure what they were for.

16. The Registrant made a note regarding an April 5, 2019 appointment with the Patient where he stated "more issues resonating in R and L Breast. Suspected pesticide, scar tissue, emotion conflicts". He continued to order additional tests for the Patient, including CA 15-3 tests and fecal occult blood tests, and recommended that she continue to attend before him for monitoring.

17. Seven months after her cancer diagnosis, the Patient developed a wound on her right breast. If the Patient were to testify, she would state that when she showed the blister to the Registrant he stated that it was good as the cancer or "poison" was coming out. In addition, she would state that the Registrant would prescribe many tinctures for her breast, that she was not sure what they were but that she trusted the Registrant's judgment and the treatment he was providing.

18. At a July 23, 2019 appointment, the Registrant noted that laboratory results showed that the Patient's CA 15-3 levels were down "10% since last check", and that the Patient's reported that her breast was "weeping constantly". As had become his practice, the Registrant conducted PSE Testing and sent the Patient for further blood draws for CA 15-3 monitoring. The Registrant made a note that the Patient was to follow up "ASAP".

19. At a September 27, 2019 appointment the Registrant noted that the Patient's CA-15 levels were "gradually rising", and wrote in her chart that the Patient was "ok to keep monitoring". He ordered further blood tests, including CBCs and CA 15-3.

20. It is admitted that the Registrant's conduct in the time following her cancer diagnosis may have created confusion in the Patient and may have led her to believe he was treating her cancer. It is further admitted that the Registrant knew or ought to have known that the treatments he was recommending were ineffective against cancer.

21. It is admitted that the Registrant may have failed to effectively communicate with the Patient and adequately explain the purpose of the tests he was ordering, as detailed above.

22. Throughout his treatment of the Patient, the Registrant never communicated with the Patient's health care practitioners about the Patient's cancer, its symptoms or lab results he obtained from the tests he was ordering. When the Registrant received a report in 2017 that showed palpable abnormalities in the left and right breast which were characterized as clinical findings, he failed to ensure this was communicated to the Patient's family doctor, nor did he proactively communicate with them despite knowing that they were involved in her care.

Practising Outside the Scope of a Naturopath

23. It is admitted that the Registrant provided services that he did not have the knowledge, skill or judgment to perform. In addition to the above, in or around February, 2017, and prior to the Patient's cancer diagnosis, the Registrant recommended to the Patient that she obtain a breast ultrasound from a specific clinic. If the Patient were to testify, she would state that the Registrant told her that this ultrasound was "better than a mammogram", and that he was "enthusiastic" about its efficacy. As noted above, when the ultrasound report indicated a critical value test result, he did not share the results with the Patient's family doctor.

24. It is admitted that the Registrant is required to refer a patient to a member of the College of Physicians and Surgeons of Ontario or a member of the College of Nurses who holds a certificate of registration as a registered nurse in the extended class when laboratory tests indicate a critical value test result.

25. Also in 2017, in response to the Patient advising the Registrant that she had been diagnosed with a kidney infection, the Registrant prescribed Berberis Formula, which he stated "might be sufficient to avoid antibiotics".

26. It is admitted that the Registrant was not fully aware that increased INR levels could indicated that the patient's cancer had metastasized. but the tests were ordered to determine if the remedies provided to the Patient had an affect on blood clotting, which was the purpose of the INR test and did not ask the Patient if he could send the results to

her family physician.

27. The Patient had been prescribed Warfarin by her family physician due to a previous blood clot in her lung. Warfarin is an anti-coagulant prescribed to help prevent blood clots, and patients taking Warfarin require continuous monitoring of INR as it can have serious side effects, including bleeding.

28. Notwithstanding it having been prescribed by her family physician, the Registrant routinely questioned whether Warfarin was appropriate. For example, in a February 12, 2018 email, the Registrant stated that as her health improved the Patient might "need Warfarin less and less", however if she were to stay on Warfarin it "may lead to negative consequences". In a June 14, 2018 note, the Registrant recorded that the Patient was suffering from vertigo. The Registrant writes "we assess that it is due to warfarin toxicity" and queries whether the Patient can cease Warfarin. His record for that date also includes an article which discusses alternative blood thinners and a handwritten note "maybe causing issues with bones (thoracic + lumbar spine CT 2012 degenerated) and immunity as Warfarin blocks K2".

29. In a July 14, 2020 note, the Registrant raised concerns about recent lab results and noted that he wondered "if it's only possibly cancer or if Warfarin (long term)" is involved. In an August 11, 2020 note, the Registrant recorded that the Patient's INR levels as increasing. The Registrant questioned why the INR levels were running "so high" and wrote a note "too much Warfarin?". Similarly, in a September 4, 2020 note summarizing a discussion he had with the Patient, the Registrant noted that the Patient's physician recommended a CT scan to investigate her back pain, which might be "part of the cancer scene". The Registrant notes, however, that the pain could also be the result of "old trauma, osteo, low K2 or Warfarin".

30. The Patient's health steadily deteriorated between October 2018 and September 2020. Her final appointment with the Registrant was in September, 2020. The Patient attended hospital on September 10, 2020 and learned that her cancer had metastasized to the bone. If the Patient were to testify, she would state that doctors told her that she had weeks to live.

31. It is admitted that, in the face of clear evidence that the Patient's condition was worsening and that the treatment he was providing was not adequate, effective or likely to improve her cancer. The Registrant did not refer, or discuss a referral, of the Patient's care to a to a doctor with the appropriate knowledge, skill and judgment to treat the Patient. The Registrant ought to have known that the Patient required a service that he did not have the knowledge, skill or judgment to offer and was beyond the scope of his practice.

32. If the Patient were to testify, she would state that the Registrant did not ask her if he could communicate with her family physician or oncologist, or any other health care practitioner in her circle of care.

Record-Keeping

33. It is admitted that the Registrant failed to maintain a complete record for the Patient and failed to maintain appropriate records. The Patient's chart did not contain adequate treatment notes. Rather, the Registrant resorted to writing brief comments on sticky notes, which were present throughout the Patient's chart.

34. It is admitted that the Registrant did not maintain a contemporaneous record for the Patient and often supplemented the record after the fact using the sticky notes. It is further admitted that the Registrant did not obtain and/or document the consent process with the Patient in the record, nor did the Registrant document a naturopathic diagnosis for the Patient.

35. During the College's investigation of the complaint, the Registrant sent records to the College's investigator in December, 2020. Later, in July, 2021, the College's investigator obtained the original records. The original records differed from the records that were provided by the Registrant in December, 2020. Specifically, the Registrant added information to the record prior to providing it to the College, including altering telephone logs and adding new entries to notes addressing the Patient's various appointments. It was also discovered that the Registrant had added handwritten notes to laboratory tests, including a note that the Patient should share test results with her medical doctor, which note was not present in the original record.

36. It is admitted that the Registrant added additional information to the Patient's record during the College's investigation without indicating in the record that he had made amendments thereto. It is further admitted that the Registrant falsified the Patient's records in the face of a College investigation into his conduct.

Consent

37. It is admitted that the Registrant failed to obtain consent for all treatments. The Patient signed a general consent form when she first attended before the Registrant in or around December, 2016. This general form did not amount to informed consent. If the Patient were to testify, she would state that no further discussions regarding consent to treatment took place thereafter. Nor is there any documentation regarding consent to treatment in the Patient's record.

38. It is further admitted that, towards the end of the period in which he was treating her, the Registrant improperly attempted to have the Patient sign a special consent form to protect him from her family.

Boundaries and Conflict of Interest

39. If the Patient were to testify, she would state that she refused chemotherapy when it was recommended to her by her medical doctor as she felt that she was under the Registrant's

care, and that he was taking care of her cancer. She would further testify that she trusted the Registrant, though she did not always understand the nature or purpose of the treatments he was recommending or the tests he was ordering.

40. It is admitted that the Registrant failed to recognize the influence he wielded over the Patient and failed to foster an appropriate therapeutic relationship with the Patient in a transparent and patient-centered manner.

41. It is further admitted that the Registrant used his influence over the Patient to encourage her to sign a special consent form to protect him from her family, whom he assumed would have serious concerns that he provided care to the Patient rather than encouraging her to seek appropriate care for her breast cancer. This letter was never written nor signed.

Core Competencies and Code of Ethics

42. As detailed above the Registrant failed to formulate a naturopathic diagnosis, failed to develop and maintain relationships with other healthcare professionals in the care of the Patient and failed to effectively communicate with the Patient. He further failed to ensure the Patient was fully knowledgeable regarding the treatment he was providing. If the Patient were to testify, she would state that she did not always understand what the Registrant was prescribing for her, the treatment options he recommended or the tests he was requiring that she complete, but she trusted him.

43. It is admitted that the Registrant knew or ought to have known that the Patient required a service that he did not have the knowledge, skill or judgment to offer and was beyond the scope of his practice. Moreover, the Registrant failed to provide the Patient with the information she needed to make informed decisions about her care.

44. The Registrant failed to practice only within the limits of his professional competence, thereby compromising the quality of care provided to the Patient.

Standards and Guidelines of the College

45. During the relevant periods of time, it is agreed that the following written standards and guidelines applied to the Registrant (all of which were attached to the ASF at **Tab "B"**):

    a) Core Competencies;
    b) Code of Ethics;
    c) Consent;
    d) Record Keeping;
    e) Scope of Practice; and
    f) Therapeutic Relationships and Professional Boundaries.

Admissions of Professional Misconduct

46. It is agreed that the above-noted conduct constitutes professional misconduct pursuant

to section 51(1)(c) of the Code, as set out in one or more of the following paragraphs of section 1 of Ontario Regulation 17/14 made under the *Naturopathy Act, 2007*:

a) **Paragraph 1**. Contravening, by act or omission, a standard of practice of the profession or failing to maintain the standard of practice of the profession including but not limited to the following;

   i. Record Keeping;
   ii. Core Competencies;
   iii. Conflict of Interest;
   iv. Code of Ethics;
   v. Consent;
   vi. Scope of Practice;
   vii. Therapeutic Relationships and Professional Boundaries; and/or
   viii. Section 13 (3) of the Ontario Regulation 168/15 (the "General Regulation").

b) **Paragraph 3.** Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic or other health-related purpose except,

   i. with the informed consent of the patient or the patient's authorized representative, or
   ii. as required or authorized by law.

c) **Paragraph 7.** Recommending or providing treatment that the member knows or ought to know is unnecessary or ineffective;

d) **Paragraph 8**. Providing or attempting to provide services or treatment that the member knows or ought to know to be beyond the member's knowledge, skill or judgment;

e) **Paragraph 9.** Failing to advise a patient or the patient's authorized representative to consult another member of a health profession within the meaning of the *Regulated Health Professions Act, 1991*, when the member knows or ought to know that the patient requires a service that the member does not have the knowledge, skill or judgment to offer or is beyond his or her scope of practice;

f) **Paragraph 14.** Prescribing, dispensing, compounding or selling a drug or a substance for an improper purpose;

g) **Paragraph 36.** Contravening, by act or omission, a provision of the Act, the *Regulated Health Professions Act, 1991* or the regulations under either of those Acts, including but not limited to sections 13(3) of the General Regulation;

h) **Paragraph 23**. Failing to keep records in accordance with the standards of the

profession;

i) **Paragraph 25**. Falsifying a record relating to the member's practice;

j) **Paragraph 46**. Engaging in conduct or performing an act relevant to the practice of the profession that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional;

k) **Paragraph 47.** Engaging in conduct that would reasonably be regarded by members as conduct unbecoming a member of the profession and

l) **Paragraph 48.** Failing to make reasonable attempts to collaborate with the patient's other relevant health care providers respecting the care of the patient, where such collaboration is necessary for the patient's health, unless the patient refuses to consent.

Acknowledgements

47. By this document, the Registrant states that:

a) He understands fully the nature of the allegations made against him;

b) He has no questions with respect to the allegations against him;

c) He admits to the truth of the facts contained in this document and that the facts constitute professional misconduct;

d) He understands that by signing this document he is consenting to the evidence as set out in this document being presented to the Discipline Committee;

e) He understands that by admitting the allegations made against him, he is waiving his right to require the College to prove the allegations against him at a contested hearing;

f) He understands that the decision of the Committee and a summary of its reasons, including reference to his name, will be published in the College's annual report and any other publication or website of the College;

g) He understands that any agreement between him and the College with respect to the penalty proposed does not bind the Discipline Committee ; and

h) He understands and acknowledges that he is executing this document voluntarily, unequivocally, free of duress, and free of bribe and that he has been advised of his right to seek legal advice.

DECISION AND REASONS ON LIABILITY

The Panel accepted as correct all of the facts set out in the ASF. The Panel found that the evidence contained in that document proved, on a balance of probabilities, the allegations alleged in the Notice of Hearing (with the exception of one particular of the allegation in paragraph 7(a) of the Notice of Hearing, that the Registrant contravened, by act or omission, a standard of practice of the profession or failed to maintain the standard of practice of the profession with respect to requisitioning laboratory tests, which the parties agreed did not apply) and admitted to in the ASF.

The Registrant admitted that he engaged in the following acts of professional misconduct pursuant to section 51(1)(c) of the Code, as set out in one or more of the following paragraphs of section 1 of Ontario Regulation 17/14 made under the *Naturopathy Act, 2007*:

> **Paragraph 1.** Contravening, by act or omission, a standard of practice of the profession or failing to maintain the standard of practice of the profession including but not limited to the following;
>
> i. Record Keeping;
> ii. Core Competencies;
> iii. Conflict of Interest;
> iv. Code of Ethics;
> v. Consent;
> vi. Scope of Practice;
> vii. Therapeutic Relationships and Professional Boundaries; and
> viii. Section 13 (3) of the General Regulation.
>
> **Paragraph 3.** Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic or other health-related purpose except,
>
> i. with the informed consent of the patient or the patient's authorized representative, or
> ii. as required or authorized by law.
>
> **Paragraph 7.** Recommending or providing treatment that the member knows or ought to know is unnecessary or ineffective;
>
> **Paragraph 8**. Providing or attempting to provide services or treatment that the member knows or ought to know to be beyond the member's knowledge, skill or judgment;
>
> **Paragraph 9.** Failing to advise a patient or the patient's authorized representative to consult another member of a health profession within the meaning of the Regulated Health Professions Act, 1991, when the member knows or ought to know that the patient requires a service that the member does not have the knowledge, skill or judgment to offer or is beyond his or her scope of practice;

Paragraph 14. Prescribing, dispensing, compounding or selling a drug or a substance for an improper purpose;

Paragraph 36. Contravening, by act or omission, a provision of the Act, the Regulated Health Professions Act, 1991 or the regulations under either of those Acts, including but not limited to sections 13(3) of the General Regulation;

Paragraph 23. Failing to keep records in accordance with the standards of the profession;

Paragraph 25. Falsifying a record relating to the member's practice;

Paragraph 46. Engaging in conduct or performing an act relevant to the practice of the profession that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional;

Paragraph 47. Engaging in conduct that would reasonably be regarded by members as conduct unbecoming a member of the profession and

Paragraph 48. Failing to make reasonable attempts to collaborate with the patient's other relevant health care providers respecting the care of the patient, where such collaboration is necessary for the patient's health, unless the patient refuses to consent.

In addition to the Registrant's admissions, as outlined above, the ASF contained facts which supported each of the allegations of professional misconduct outlined above. The facts supporting each allegation of misconduct are outlined below.

Record Keeping and Falsifying a Record

With respect to the allegation that the Registrant failed to keep records as required, this allegation is proven by the facts and admissions in paragraphs 33 - 36, 45(d), and 46(a), (h) and (i) of the ASF.

The Registrant admitted that he failed to maintain a complete record for the Patient and failed to maintain appropriate records. The Patient's chart did not contain adequate treatment notes. Rather, the Registrant resorted to writing brief comments on sticky notes, which were present throughout the Patient's chart.

The Registrant also admitted that he did not maintain a contemporaneous record for the Patient and often supplemented the record after the fact using the sticky notes. He further admitted that he did not obtain and/or document the consent process with the Patient in the record, nor did the Registrant document a naturopathic diagnosis for the Patient.

During the College's investigation of the complaint, the Registrant sent records to the College's investigator in December, 2020. Later, in July, 2021, the College's investigator obtained the original records. The original records differed from the records that were provided by the Registrant in December, 2020. Specifically, the Registrant added information to the record prior

to providing it to the College, including altering telephone logs and adding new entries to notes addressing the Patient's various appointments. It was also discovered that the Registrant had added handwritten notes to laboratory tests, including a note that the Patient should share test results with her medical doctor, which note was not present in the original record.

The Registrant admitted that he added additional information to the Patient's record during the College's investigation without indicating in the record that he had made amendments thereto. It was further admitted that the Registrant falsified the Patient's records in the face of a College investigation into his conduct.

Core Competencies

With respect to the allegation that the Registrant failed to upheld the Core Competencies of the profession, this allegation is proven by the facts and admissions in paragraphs 42 - 44, 45(a), and 46(a) of the ASF.

As detailed above, the Registrant failed to formulate a naturopathic diagnosis, failed to develop and maintain relationships with other healthcare professionals in the care of the Patient and failed to effectively communicate with the Patient. He further failed to ensure the Patient was fully knowledgeable regarding the treatment he was providing. The Patient did not always understand what the Registrant was prescribing for her, the treatment options he recommended or the tests he was requiring that she complete, but she trusted him.

The Registrant admitted that he knew or ought to have known that the Patient required a service that he did not have the knowledge, skill or judgment to offer and was beyond the scope of his practice. Moreover, the Registrant failed to provide the Patient with the information she needed to make informed decisions about her care.

The Registrant failed to practice only within the limits of his professional competence, thereby compromising the quality of care provided to the Patient.

Conflict of Interest

With respect to the allegation that the Registrant failed to maintain the standard of practice of the profession by having a conflict of interest, this allegation is proven by the facts and admissions in paragraphs 39 - 41, and 46(a) of the ASF.

The Registrant admitted that the Patient would have stated that she refused chemotherapy when it was recommended to her by her medical doctor as she felt that she was under the Registrant's care, and that he was taking care of her cancer. She would further testify that she trusted the Registrant, though she did not always understand the nature or purpose of the treatments he was recommending or the tests he was ordering.

The Registrant admitted that he failed to recognize the influence he wielded over the Patient and failed to foster an appropriate therapeutic relationship with the Patient in a transparent and

patient-centered manner. He further admitted that he used his influence over the Patient to encourage her to sign a special consent form to protect him from her family, whom he assumed would have serious concerns that he provided care to the Patient rather than encouraging her to seek appropriate care for her breast cancer. This letter was never written nor signed.

Code of Ethics

With respect to the allegation that the Registrant failed to adhere to the Code of Ethics of the profession, this allegation is proven by the facts and admissions in paragraphs 42 - 44, 45(b), and 46(a) of the ASF.

As detailed above, the Registrant failed to formulate a naturopathic diagnosis, failed to develop and maintain relationships with other healthcare professionals in the care of the Patient and failed to effectively communicate with the Patient. He further failed to ensure the Patient was fully knowledgeable regarding the treatment he was providing. The Registrant admitted that the Patient, if she were to testify, would state that she did not always understand what the Registrant was prescribing for her, the treatment options he recommended or the tests he was requiring that she complete, but she trusted him.

The Registrant admitted that he knew or ought to have known that the Patient required a service that he did not have the knowledge, skill or judgment to offer and was beyond the scope of his practice. Moreover, the Registrant failed to provide the Patient with the information she needed to make informed decisions about her care. The Registrant failed to practice only within the limits of his professional competence, thereby compromising the quality of care provided to the Patient.

All of the foregoing contravened the Registrant's obligations under the College's Code of Ethics, which defines the expectations the College has for every registrant and is intended to guide naturopathic practice and assist in ethical decision making. The Code of Ethics provides that:

> Naturopathic Doctors have an obligation to act in a manner that justifies public trust and confidence, that upholds and enhances the integrity of the profession, that serves the interests of society and above all, that safeguards the interests of the individual patients.

The Code of Ethics, along with the Standards of Practice, forms the foundation of professionalism for all registrants, who must adhere not only to these guidelines, but also to the underlying principles of Naturopathic Medicine. The Registrant admitted that he failed to do so.

Consent

With respect to the allegations that the Registrant failed to meet the standard of practice of the profession with respect to consent, and that he did anything for a therapeutic or preventative purpose without the informed consent of the Patient, these allegations are proven by the facts and admissions in paragraphs 37 - 38, 45(c), and 46(a) and (b) of the ASF.

The Registrant admitted that he failed to obtain consent for all treatments. The Patient signed a general consent form when she first attended before the Registrant in or around December, 2016. This general form did not amount to informed consent. If the Patient were to testify, she would state that no further discussions regarding consent to treatment took place thereafter. Nor is there any documentation regarding consent to treatment in the Patient's record.

The Registrant further admitted that, towards the end of the period in which he was treating her, he improperly attempted to have the Patient sign a special consent form to protect him from her family.

Practising Outside of the Registrant's Scope of Practice, Failing to Collaborate with Other Health Care Providers

With respect to the allegations that the Registrant contravened the standard of practice with respect to scope of practice, that he failed to advise the Patient when he knew or ought to know that she required a service that the Registrant does not have the knowledge, skill or judgment to offer or is beyond his scope of practice, and that he failed to collaborate with other health care providers, these allegations are proven by the facts and admissions in paragraphs 23 - 32, 45(e), and 46(a) and (e) and 48 of the ASF.

The Registrant admitted that he provided services that he did not have the knowledge, skill or judgment to perform. In or around February, 2017, and prior to the Patient's cancer diagnosis, the Registrant recommended to the Patient that she obtain a breast ultrasound from a specific clinic. If the Patient were to testify, she would state that the Registrant told her that this ultrasound was "better than a mammogram", and that he was "enthusiastic" about its efficacy. When the ultrasound report indicated a critical value test result, the Registrant did not share the results with the Patient's family doctor.

The Registrant admitted that he is required to refer a patient to a member of the College of Physicians and Surgeons of Ontario or a member of the College of Nurses who holds a certificate of registration as a registered nurse in the extended class when laboratory tests indicate a critical value test result.

Also in 2017, in response to the Patient advising the Registrant that she had been diagnosed with a kidney infection, the Registrant prescribed Berberis Formula, which he stated "might be sufficient to avoid antibiotics".

The Registrant admitted that he was not fully aware that increased INR levels could indicated that the patient's cancer had metastasized, but the tests were ordered to determine if the remedies provided to the Patient had an affect on blood clotting, which was the purpose of the INR test. The Registrant did not ask the Patient if he could send the results to her family physician.

The Patient had been prescribed Warfarin by her family physician due to a previous blood clot in her lung. Warfarin is an anti-coagulant prescribed to help prevent blood clots, and patients taking Warfarin require continuous monitoring of INR as it can have serious side effects, including bleeding.

Notwithstanding that it was prescribed to the Patient by her family physician, the Registrant routinely questioned whether Warfarin was appropriate. For example, in a February 12, 2018 email, the Registrant stated that as her health improved the Patient might "need Warfarin less and less", however if she were to stay on Warfarin it "may lead to negative consequences". In a June 14, 2018 note, the Registrant recorded that the Patient was suffering from vertigo. The Registrant wrote "we assess that it is due to warfarin toxicity" and queried whether the Patient could cease Warfarin. The Registrant's record for that date also includes an article which discusses alternative blood thinners and a handwritten note "maybe causing issues with bones (thoracic + lumbar spine CT 2012 degenerated) and immunity as Warfarin blocks K2".

In a July 14, 2020 note, the Registrant raised concerns about recent lab results and noted that he wondered "if it's only possibly cancer or if Warfarin (long term)" is involved. In an August 11, 2020 note, the Registrant recorded that the Patient's INR levels were increasing. The Registrant questioned why the INR levels were running "so high" and wrote a note "too much Warfarin?". Similarly, in a September 4, 2020 note summarizing a discussion he had with the Patient, the Registrant noted that the Patient's physician recommended a CT scan to investigate her back pain, which might be "part of the cancer scene". The Registrant noted, however, that the pain could also be the result of "old trauma, osteo, low K2 or Warfarin".

The Patient's health steadily deteriorated between October 2018 and September 2020. Her final appointment with the Registrant was in September, 2020. The Patient attended hospital on September 10, 2020 and learned that her cancer had metastasized to the bone. If the Patient were to testify, she would state that doctors told her that she had weeks to live.

The Registrant admitted that, in the face of clear evidence that the Patient's condition was worsening, the treatment he was providing was not adequate, effective or likely to improve her cancer. The Registrant did not refer, or discuss a referral, of the Patient's care to a to a doctor with the appropriate knowledge, skill and judgment to treat the Patient. The Registrant admits that he ought to have known that the Patient required a service that he did not have the knowledge, skill or judgment to offer and was beyond the scope of his practice.

Therapeutic Relationships and Professional Boundaries

With respect to the allegation that the Registrant contravened the standard of practice with respect to therapeutic relationships and professional boundaries, this allegation is proven by the facts and admissions in paragraphs 39 - 41, 45(f), and 46(a) of the ASF.

The Registrant admitted that if the Patient were to testify, she would state that she refused chemotherapy when it was recommended to her by her medical doctor as she felt that she was

under the Registrant's care, and that he was taking care of her cancer. She would further testify that she trusted the Registrant, though she did not always understand the nature or purpose of the treatments he was recommending or the tests he was ordering. The Registrant admitted that he failed to recognize the influence he wielded over the Patient and failed to foster an appropriate therapeutic relationship with the Patient in a transparent and patient-centered manner. He further admitted that he used his influence over the Patient to encourage her to sign a special consent form to protect him from her family, whom he assumed would have serious concerns that he provided care to the Patient rather than encouraging her to seek appropriate care for her breast cancer. This letter was never written nor signed.

Contravention of Section 13(3) of the General Regulation

The Registrant admitted to contravening the standard of practice of the profession by contravening subsection 13(3) of the General Regulation, which provides that if treatment of the patient's condition is beyond the scope of practice of the profession, it is a standard of practice of the profession that the registrant shall refer the patient to a member of the College of Physicians and Surgeons of Ontario, a member of the College of Nurses of Ontario who holds a certificate of registration as a registered nurse in the extended class, or a member of another health profession College where the patient's condition would fall within that member's scope of practice under his or her health profession Act. Paragraphs 23-32 of the ASF provide proof that the Registrant breached this standard of practice, thereby also engaging in professional misconduct pursuant to paragraph 36 of section 1 of Ontario Regulation 17/14 made under the Naturopathy Act, 2007, which makes it an act of misconduct to contravene a provision of the Naturopathy Act, 2007 or a regulation thereunder.

Recommending or Providing Unnecessary or Ineffective Treatment, and Providing Treatment for an Improper Purpose

The allegations of misconduct that the Registrant recommended or provided unnecessary or ineffective treatment and provided treatment for an improper purpose were proven by the Registrant's admissions in paragraphs 5-32 and 39-41 of the ASF.

The Registrant was advised by the Patient that she had been diagnosed with cancer in her right breast. The Registrant prescribed Gemmo #1 botanical to "induce sleep, improve immune function especially in the right breast". He also prescribed Gemmo #2 to "eliminate the larvicide temephos from the superior vena cava, the vocal chords and the sphincter of oddi". He subsequently prescribed a botanical "to regenerate the nerves in the right breast and right pleural cavity and improve sleep". The Registrant ordered numerous tests for the Patient after her breast cancer diagnosis, including CA 15-3 levels, Psychosomatic Energetics testing ("PSE") testing, urine testing and complete blood count ("CBC") testing. If the Patient were to testify, she would state that she was not certain what the blood tests the Registrant was ordering were for, however she trusted the Registrant's judgment and the treatment he was providing.

For example, at an appointment on December 4, 2018, the Registrant prescribed Gemmo #5 to

"eliminate CWD staph bacteria from the R. breast milk ducts and the lyme co-infector" and noted same in her chart. He also made a note that the patient reported that the tumor in the Patient's right breast was less than 2 cm and "seems to be moving out to the surface". The Registrant also continued to recommend further testing, including PSE testing and a urine test, and made a note in the chart that he requested a copy of the Patient's mammogram and ultrasound of her right breast. At a March 8, 2019 appointment, he again requested that the Patient complete a CBC test and a CA 15-3 test and made a note of this in the Patient's chart. If the Patient were to testify, she would state that the Registrant would order a lot of blood tests for her, but she was not sure what they were for.

The Registrant admitted that his conduct in the time following her cancer diagnosis may have created confusion in the Patient and may have led her to believe he was treating her cancer. The Registrant further admitted that he knew or ought to have known that the treatments he was recommending were ineffective for treatment of cancer.

Disgraceful, Dishonourable or Unprofessional Conduct or Conduct Unbecoming a Registrant

The totality of the facts in the ASF support the Registrant's admissions that he engaged in conduct that members of the profession of naturopathy would reasonably regard as disgraceful, dishonourable or unprofessional conduct and as conduct unbecoming a naturopath.

SUBMISSIONS OF THE PARTIES ON PENALTY AND COSTS

The parties made a joint submission as to an appropriate order for penalty and costs (the "Proposed Order"), which was filed as Exhibit 3 and included the following:

> The College of Naturopaths of Ontario and the Registrant agree and jointly submit that the Discipline Committee make an order:
>
> 1. Requiring the Registrant to appear before the Panel to be reprimanded immediately following the hearing of this matter;
> 2. Requiring the Registrant to pay a fine of not more than $350 by cheque made out to the Minister of Finance, and to be mailed to the College, within one month of the date of this order; and
> 3. The Registrant shall pay the College's costs fixed in the amount of $7,500 payable within one month of the date of this hearing of this matter.
>
> The Registrant acknowledges that this Joint Submission as to Penalty and Costs is not binding upon the Discipline Committee.
>
> The Registrant acknowledges and understands that he is executing this document voluntarily, unequivocally, free of duress, free of bribe, and that he has been advised of his right to seek legal advice.

The parties advised that the joint submission outlined above was signed by the Registrant on August 29, 2022. On the same date, the Registrant executed an Acknowledgment and Undertaking (the "Undertaking"), filed as Exhibit 5, which provided as follows:

I, **KURT STAUFFERT**, hereby acknowledge and undertake as follows:

1. I acknowledge that I am currently a Registrant of the College of Naturopaths of Ontario (the "College") although my certificate of registration is suspended:
    a. On April 1, 2022 my certificate of registration was suspended by the CEO for failure to have (or maintain) professional liability insurance.
    b. On or about May 7, 2022 my certificate of registration was suspended by the CEO for failure to pay renewal fees and provide the necessary renewal information.

2. I confirm that I have tendered my resignation to the CEO and that it will become effective the day a panel of the Discipline Committee makes an order on penalty.

Allegations of Professional Misconduct

3. I acknowledge that allegations of professional misconduct were referred to the Discipline Committee on or about December 8, 2021. The Notice of Hearing is attached as Appendix "A".

4. I acknowledge that I have signed an Agreed Statement of Facts and admitted to the allegations. The Agreed Statement of Facts is attached as Appendix "B".

5. I have also signed a Joint Submission on Penalty and Costs. I agree that although the College would have sought an order for a lengthy suspension and numerous terms, conditions and limitations, but in light of my decision to resign and never reapply, the College was prepared to agree to the Joint Submission on Penalty and Costs. The Joint Submission on Penalty and Costs is attached as Appendix "C".

Undertaking

6. I acknowledge that this undertaking will be provided to a panel of the Discipline Committee to explain why the College did not seek extensive terms, conditions, and limitations on my certificate of registration or a revocation of my certificate.

7. I agree that I will not appeal or request a judicial review of the decision of the Discipline Committee regarding their finding on professional misconduct or their order on penalty.
8. I acknowledge that I have had the opportunity to obtain legal advice prior to entering into this undertaking and I have either done so or I have chosen not to do so.

9. I acknowledge that I am entering into this undertaking freely, voluntarily and without duress.

Additionally, on October 5, 2022, the Registrant executed an Acknowledgment and Undertaking - Resignation (the "Undertaking - Resignation"), filed as Exhibit 4, which provided as follows:

I, **KURT STAUFFERT**, hereby acknowledge and undertake as follows:

1. I acknowledge that my Certificate of Registration with the College of Naturopaths of Ontario (the "College") is currently suspended but I am still within the jurisdiction of the College and the Discipline Committee as a result of s. 14(2) of the Health Professions Procedural Code.[2]

2. I confirm that I have ceased practising Naturopathy and that I am currently wrapping up my naturopathy practice.

Resignation

3. I acknowledge that allegations of professional misconduct related to a patient who I treated between December 2016 and September 2020 (the "Patient") were referred to the Discipline Committee of the College on December 8, 2021.

4. I acknowledge that in light of the referral and other personal reasons, I am prepared to resign my Certificate of Registration with the College and to undertake to never reapply.

5. I acknowledge that I have signed an Agreed Statement of Facts and admitted to certain allegations.

6. I acknowledge that I have signed a Joint Submission on Penalty and Costs.

7. I acknowledge that my resignation will not take effect until I am notified by the College that it has taken effect.

8. I acknowledge that all copies of my Certificate of Registration must be returned to the College or I need to confirm with the College in writing that I have destroyed them.

9. I acknowledge that pursuant to s. 19.03 of the College bylaws, I am required to maintain enduring (tail) insurance for five years after ceasing to practice the profession. I confirm that my enduring (tail) insurance covers me for five years from the date I ceased

[2] A person whose certificate of registration is suspended continues to be subject to the jurisdiction of the College for incapacity and for professional misconduct or incompetence referable to the time when the person was a member or to the period of the suspension and may be investigated under section 75.

practising. I confirm that proof of insurance has been submitted to the College along with this signed Acknowledgement & Undertaking.

10. I acknowledge that I am required to comply with the College standards that speak to closing my practice and ensuring access to and safety of patient records and that I will comply with all standards. I acknowledge that my patients may access their files by contacting my current practice location.

11. I hereby undertake never to reapply for membership, registration, licensure or similar status with this College.

12. I acknowledge that if I ever apply for membership, registration, licensure or similar status with the College in the future, the College will be entitled to rely upon this Acknowledgement & Undertaking in any registration or other similar proceeding as reason to deny my application.

13. I acknowledge that if I ever apply for membership, registration, licensure or similar status with the College in the future, the College will be entitled to prosecute me for the breach of this Acknowledgement & Undertaking, and the College will be entitled to rely upon this Acknowledgement & Undertaking for that purpose.

14. In light of my suspension, I am currently unable to use any protected title, perform any authorized controlled act, or hold myself out as a registrant. However, I acknowledge that once my resignation is effective, I will not be entitled to use the title “Naturopath”, “Naturopathic Doctor” or any other derivation or abbreviation thereof or equivalent in another language, I will not be entitled to hold myself out as a person who is qualified to practise in Ontario as a Naturopath or in a specialty of naturopathic medicine, perform any of the authorized controlled acts as set out in the Naturopathy Act, and I will not be entitled to imply that I am a Naturopath in Ontario.

15. I acknowledge and agree that after I resign, I remain subject to the jurisdiction of the College for professional misconduct and incompetence referable to the time when I was a Registrant and for the enforcement of this and any other Agreements & Undertakings into which I may have voluntarily entered with the College.

16. I agree that the College will include on the public register the fact that I resigned and undertook never to reapply. I further acknowledge that the College will be including the full text of this Acknowledgement & Undertaking on the public portion of the College’s public register on the College’s website.

17. I agree that I will not appeal or request a judicial review of the decision of the Discipline Committee regarding allegations set out in Paragraph 5 of this Acknowledgement & Undertaking.

18. I acknowledge that I have had the opportunity to obtain legal advice prior to entering into this Acknowledgement & Undertaking and I have either done so or I have chosen not to do so.

19. I acknowledge that I shall be solely responsible for payment of all fees, costs, charges, expenses, etc., if any, arising from the implementation of any of the terms of this Acknowledgement & Undertaking.

20. I give my irrevocable consent to the College to make appropriate inquiries of any person or institution who may have relevant information, in order for the College to monitor my compliance with the terms of this Acknowledgement & Undertaking.

21. I acknowledge that I am entering into this Acknowledgement & Undertaking freely, voluntarily and without duress.

22. I hereby declare that the information I have provided in this form is accurate to the best of my abilities and that I will immediately notify the College in the event that any of the information changes until such time as my resignation takes effect.

The College and the Registrant both submitted that the Panel should make an order in accordance with the Proposed Order, in light of the Registrant's agreement as well as his entry into the Undertaking and the Undertaking – Resignation.

DECISION AND REASONS ON PENALTY AND COSTS

The Panel accepted the Proposed Order, finding it to be in the public interest, proportionate to the misconduct and consistent with previous orders of this Discipline Committee in cases involving similar misconduct.

In accepting the Proposed Order, the Panel was mindful that a penalty should, first and foremost, achieve the goal of public protection, while also accounting for other generally established sanctioning principles. The Panel found that the Proposed Order would achieve this goal and account for other sanctioning principles. As such, the Panel found no reason to depart from the Proposed Order, accepting the College's argument that joint submissions should not be interfered with lightly and may be rejected only if the Panel finds that it is truly contrary to the public interest .

The Panel was also satisfied that the reprimand and fine, along with the Registrant's resignation from the College and his undertaking that never to reapply for membership, registration, licensure or similar status with this College, would discourage other registrants from engaging in similar misconduct. The Panel found that the penalty as whole (inclusive of the requirements of the Registrant's Undertaking and Undertaking-Resignation) would demonstrate to the public that

this Committee takes professional misconduct seriously – particularly the egregious conduct in which the Registrant engaged, which members of the profession would reasonably regard as disgraceful, dishonourable and unprofessional – and will severely sanction practitioners who engage in such conduct.

The Panel accepted the Proposed Order as being proportionate to the severity of the misconduct, while also reflecting the aggravating and mitigating factors present in this case.

The following mitigating factors were considered:

> a) the Registrant's cooperation with the College throughout the investigation and prosecution of the allegations, which saved the College the time and expense of a contested hearing; and
>
> b) the Registrant's acceptance of responsibility, signaled by his admitting to the conduct as set out in the Agreed Statement of Facts and entering into a joint submission with respect to penalty.

The most aggravating factor considered was that members of the public were harmed due to the Registrant's failure to practice within the limits of his professional competence. Furthermore, the Registrant failed to provide the Patient with the information she needed to make informed decisions about her care. Rather than encouraging his patient to seek appropriate care for her breast cancer, the Registrant attempted to have the patient sign a special consent form to protect himself from her family and falsified records. These acts of professional misconduct bring disgrace to the profession and necessitate a severe penalty.

The Proposed Order was within the range of penalties that have previously been ordered by this Discipline Committee for similar conduct. The College reviewed cases from this Discipline Committee and the discipline committees of other health colleges in which registrants engaged in some of the misconduct that the Registrant engaged in, to establish a range of penalties available for such misconduct.[3] The Panel was satisfied that the Proposed Order was consistent with the penalties ordered in these cases.

With respect to costs, the Panel accepted that it has the authority to award costs under section 53.1 of the Code to ensure that the entire financial burden of investigating and prosecuting registrants who engage in professional misconduct does not rest on the general membership of this profession. The proposed amount of $7500 appropriately reflected the Registrant's cooperation through the investigation and prosecution of this matter. It also fell within the range of costs awarded by previous panels in similar matters.

[3] *College of Nurses of Ontario v Ozueh*, 2017 CanLII 84900 (ON CNO), *College of Naturopaths of Ontario v Ee*, a decision of the Discipline Committee dated 2020, *College of Opticians of Ontario v Steve Rodney Sanger*, a decision of the Discipline Committee of the College of Opticians of Ontario, 2021, and *College of Naturopaths of Ontario v Turner*, a decision of the Discipline Committee dated 2021.

ORDER

The Panel stated its findings in its written order of October 11, 2022 (the "Order"), in which the Panel directed as follows on the matter of penalty and costs:

1. The Registrant to appear before the Panel to be reprimanded immediately following the hearing of this matter;
2. The Registrant to pay a fine of not more than $350 by cheque made out to the Minister of Finance, and to be mailed to the College, within one month of the date of this order; and
3. The Registrant shall pay the College's costs fixed in the amount of $7,500 payable within one month of the date of this hearing of this matter.

Dated in Ontario on December 12, 2022

DISCIPLINE PANEL

Dr. Laure Sbeit, ND – Chair, professional member
Dr. Jacob Scheer, ND – professional member
Dean Catherwood – public member
Paul Philion – public member

Signed: _____
Laure Sbeit, Chair

DISCIPLINE COMMITTEE OF THE
COLLEGE OF NATUROPATHS OF ONTARIO

IN THE MATTER OF a hearing directed
by the Inquiries, Complaints and Reports Committee of
the College of Naturopaths 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.

B E T W E E N:

COLLEGE OF NATUROPATHS OF ONTARIO

- and -

KURT STAUFFERT

REPRIMAND

Mr. Stauffert, the Panel has found that you have engaged in professional misconduct, by failing to maintain standards of practice of the profession, including with respect to record keeping, core competencies, conflict of interest, code of ethics, consent, scope of practice, therapeutic relationships and professional boundaries.

Of particular concern, the professional misconduct in which you engaged has put at risk the public's confidence in the profession's ability to govern itself, and erodes the profile of this profession in the minds of the public and other regulated healthcare professionals. Your failure to adhere to the College's standards of practice places clients at risk of harm, impacts the public's confidence in the profession, and jeopardizes the relationship between naturopaths and the public. Consequently, it is necessary to us to take steps to impress upon you the seriousness of the misconduct in which you have engaged.

The Panel acknowledges that you took responsibility for your actions, and admitted to the allegations in the Notice of Hearing. However, your actions were inappropriate and unfitting of the profession. 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.

This concludes our reprimand.