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 -
RICHARD A. DODD

DECISION AND REASONS
FILE DC22-01

A panel of the Discipline Committee of the College of Naturopaths of Ontario (the "Panel") held a hearing on December 5, 2022, December 20, 2022, and February 14, 2023. 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 was counsel to the College of Naturopaths of Ontario (the "College"). Andrew Parr attended on behalf of the College. Richard A. Dodd (the "Registrant") did not attend the hearing and was not represented. Lonny Rosen acted as independent legal counsel ("ILC") to the Panel.

ALLEGATIONS

The Notice of Hearing, dated April 4, 2022, was filed as Exhibit 2. It contained allegations from four separate investigations, as follows:

File 20-033R

The Registrant

1. The Registrant registered with the Board of Directors of Drugless Therapy – Naturopathy on or about March 1, 1994. The Registrant then became registered with the College on July 1, 2015. On or about December 8, 2021 the Registrant's certificate of registration was suspended.

2. The Registrant has not met the Standard of Practice for Prescribing and/or Intravenous Infusion Therapy (IVIT) and therefore has not been authorized since January 1, 2016 to administer IVIT.

3. At all relevant times, the Registrant worked at and/or owned the Clinic and/or P3 Health in Toronto, ON.

4. At all relevant times the Clinic and/or P3 Health were not registered as IVIT premises with the College.

Administering and/or Offering and/or Advertising Services and/or Treatments outside of their scope

5. It is alleged that since approximately January 1, 2016 the Registrant:
    a. Offered and/or administered IVIT to patients at the Clinic;
    b. Compounded drugs or substances for IVIT; and/or
    c. Advertised that IVIT could be administered at the Clinic.

6. It is alleged that the Registrant's Clinic is not authorized to offer and/or administer IVIT as the Clinic is not registered as a premises pursuant to Regulation 168/15.

7. On or about December 9, 2020 an undercover investigator attended at the Clinic as a patient. It is alleged that the Registrant:
    a. Advised and/or admitted to the undercover investigator that they provide ultraviolet blood irradiation therapy which includes but is not limited to injecting blood into a patient; and/or
    b. Recommended that the undercover investigator receive IVIT as part of their treatment plan.

8. It is alleged that since July 1, 2015 the Registrant:
    a. Offered and/or provided cancer treatment and/or treatment to prevent cancer;
    b. Offered and/or provided ultraviolet blood irradiation therapy; and/or
    c. Advertised that cancer treatment and/or ultraviolet blood irradiation therapy could be provided and/or administered at the Clinic.

Advertising

9. It is alleged that the Registrant posted on his Clinic website that his "special area of expertise and passion is Cancer prevention and treatment."

Providing non-essential services under Ontario's Emergency Order

10. In March 2020, during the state of emergency in Ontario, an Emergency Order was issued which mandated that health professionals only provide essential services.
11. It is alleged that the Registrant contravened the Emergency Order by providing non-essential services.

Allegations of Professional Misconduct

12. It is alleged that the above noted conduct constitutes professional misconduct pursuant to section 51(1)I 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. Core Competencies;
        ii. Advertising;
        iii. Compounding;
        iv. Intravenous Infusion Therapy;
        v. Injection;
        vi. Performing Authorized Acts; and/or
        vii. Scope of Practice

    b. **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;
    c. **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;
    d. **Paragraph 10.** Performing a controlled act that the member is not authorized to perform;
    e. **Paragraph 27.** Permitting the advertising of the member or his or her practice in a manner that is false or misleading or that includes statements that are not factual and verifiable;
    f. **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;
    g. **Paragraph 36.1** Without restricting the generality of paragraph 36, failing, by act or omission, to comply with any duty or requirement under Part IV (Inspection of

Premises Where Certain Procedures are Performed) of Ontario Regulation 168/15 (General) made under the Act;

h. **Paragraph 37.** Contravening, by act or omission, a law if,
    i. the purpose of the law is to protect or promote public health, or
    ii. the contravention is relevant to the member's suitability to practise.
i. **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; and/or
j. **Paragraph 47.** Engaging in conduct that would reasonably be regarded by members as conduct unbecoming a member of the profession.

13. It is also alleged that the above conduct constitutes professional misconduct pursuant to subsection 4(3) of the *Naturopathy Act, 2007.*

File 21-005R

The Registrant

1. The Registrant registered with the Board of Directors of Drugless Therapy – Naturopathy on or about March 1, 1994. The Registrant then became registered with the College on July 1, 2015. On or about December 8, 2021 the Registrant's certificate of registration was suspended.

2. The Registrant has not met the Standard of Practice for Prescribing and/or IVIT and therefore has not been authorized since January 1, 2016 to administer IVIT.

3. At all relevant times, the Registrant worked at and/or owned the Clinic and/or P3 Health in Toronto, ON.

4. At all relevant times the Clinic and/or P3 Health were not registered as IVIT premises with the College.

Interim Order

5. On or about December 15, 2020 the Inquiries Complaints and Reports Committee issued an interim order that imposed various terms, conditions, and limitations on the Registrant's certificate of registration including but not limited to the following:
    a. The Registrant was not to:
        i. perform, delegate or accept delegation of controlled acts;
        ii. advertise IVIT;
        iii. advertise or administer vaccinations; and/or
        iv. advertise or administer ultraviolet blood irradiation treatments.

    b. The Registrant was required to:

i. post a sign in their Clinic and on their professional website that he is not authorized to perform IVIT and/or injections and/or compounding; and
ii. ensure all patients signed a form indicating they were aware of the terms, conditions and limitations.

6. It is alleged that on or about December 22, 2020:
   a. The Registrant did not have the required signs posted;
   b. The Registrant did not have any signed copies of the required patient forms; and/or
   c. The Registrant's appointment book indicated he was going to administer IVIT to a patient on or about December 17, 2020.

7. It is alleged that on or about January 27, 2021:
   a. The Registrant had posted the required sign at the Clinic but not on his professional website;
   b. The Registrant administered IVIT to a patient on December 17, 2020; and/or
   c. The Registrant did not obtain a signed form from the patient.

Allegations of Professional Misconduct

8. It is alleged that the above noted conduct constitutes professional misconduct pursuant to section 51(1)I 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 38.** Contravening, by act or omission, a term, condition or limitation on the member's certificate of registration;
   b. **Paragraph 41.** Failing to comply with an order of a panel of the College;
   c. **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; and/or
   d. **Paragraph 47.** Engaging in conduct that would reasonably be regarded by members as conduct unbecoming a member of the profession.

<u>File 21-015R</u>

The Registrant

1. The Registrant registered with the Board of Directors of Drugless Therapy – Naturopathy on or about March 1, 1994. The Registrant then became registered with the College on July 1, 2015. On or about December 8, 2021 the Registrant's certificate of registration was suspended.

2. The Registrant has not met the Standard of Practice for Prescribing and/or IVIT and therefore has not been authorized since January 1, 2016 to administer IVIT.

3. At all relevant times, the Registrant worked at and/or owned the Clinic and/or P3 Health in Toronto, ON.
4. At all relevant times the Clinic and/or P3 Health were not registered as IVIT premises with the College.

Correspondence

Cease and Desist

5. On or about December 11, 2020 the College sent a cease and desist letter to the Registrant advising that:
    a. He is not authorized to provide IVIT;
    b. His Clinic was not registered as a premise;
    c. He is not authorized to provide ultraviolet blood irradiation treatment and/or blood injections; and/or
    d. He must immediately cease and desist engaging in and advertising such conduct.

6. It is alleged that on or about December 14, 2020 the Registrant conditionally accepted the offer if the College could provide certain information and/or ten million dollars.

Lawyer information

7. On or about April 26, 2021 the College asked the Registrant to provide his lawyer's first name and relevant contact information (as there was concern that his lawyer was not licensed to practise in Ontario). It is alleged that the Registrant never provided the requested information.

Response to Reports

8. The Registrant was served with two Registrar Reports and asked by the College to provide their response. It is alleged that the Registrant advised that they required proof of the authority of the College before they would provide any response.

Failure to Cooperate with Investigators

9. An investigator was appointed to investigate concerns involving the Registrant.

10. It is alleged that the Registrant:
    a. Failed to respond to the numerous requests of the investigator;
    b. Failed to cooperate with the numerous inquiries of the investigator; and/or
    c. Failed to attend an interview on or about July 29, 2021 with the investigator despite being served with a summons.

11. It is alleged that on or about July 26, 2021, the Registrant sent the College a *Notice of Objection Writ of Quo Warranto* in response to the summons.

Allegations of Professional Misconduct

12. It is alleged that the above noted conduct constitutes professional misconduct pursuant to section 51(1)I 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. Core Competencies;
        ii. Code of Ethics.
    b. **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;
    c. **Paragraph 44.** Failing to reply appropriately and within 30 days to a written inquiry or request from the College;
    d. **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; and/or
    e. **Paragraph 47.** Engaging in conduct that would reasonably be regarded by members as conduct unbecoming a member of the profession.

<u>File 21-039</u>

The Registrant

1. The Registrant registered with the Board of Directors of Drugless Therapy – Naturopathy on or about March 1, 1994. The Registrant then became registered with the College on July 1, 2015. On or about December 8, 2021 the Registrant's certificate of registration was suspended.

2. The Registrant has not met the Standard of Practice for Prescribing and/or IVIT and therefore has not been authorized since January 1, 2016 to administer IVIT.

3. At all relevant times, the Registrant worked at and/or owned the Clinic and/or P3 Health in Toronto, ON.

4. At all relevant times the Clinic and/or P3 Health were not registered as IVIT premises with the College.

COVID-19 Letters

5. It is alleged that on or about October 19, 2021 the Registrant issued and/or signed a letter for Patient 1.

6. It is alleged that on or about October 28, 2021 the Registrant issued and/or signed a letter for Patient 2.

7. It is alleged that the Registrant was aware that the letters for Patient 1 and/or Patient 2 would be provided to the employer of Patient 1 and/or Patient 2.

8. It is alleged that the Registrant provided his professional opinion in the letters that Patient 1 and/or Patient 2 were "not recommended [to] choose to receive the Co-Vid [sic] vaccine."

9. It is alleged that in the letter for Patient 2, the Registrant referred to health conditions and/or health history that were not indicated in the health record of Patient 2.

10. It is alleged that in the letter for Patient 1, the Registrant referred to the Charter of Rights and Freedoms and the Supreme Court of Canada and stated that "In this particular case the interpretation means the Act allows for religious or conscientious objection to any and all vaccines or medical treatments/procedures."

11. It is alleged that the Registrant advised the investigator that "My study and understanding makes me aware that the Covid injection is not a vaccine but a potential risky and poorly tested genetic therapy" or words to that effect.

12. It is alleged that the Registrant was aware that vaccines were outside the scope of practice of naturopaths.

13. It is alleged that on or about December 15, 2020, the Inquiries, Complaints and Reports Committee ("ICRC") imposed an interim order on the Registrant's certificate of registration that they could not advertise or administer vaccinations.

14. It is alleged that, on or about September 14, 2021, the Ontario Ministry of Health advised the province that documentation of a COVID medical exemption must be provided by either a physician or nurse practitioner.

Allegations of Professional Misconduct

15. It is alleged that the above noted conduct constitutes professional misconduct pursuant to section 51(1)I 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. Core Competencies;
ii. Scope of Practice; and/or
iii. Professional Policy – Vaccination ;

b. **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;
c. **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;
d. **Paragraph 24**. Signing or issuing, in his or her professional capacity, a document that the member knows or ought to know contains a false or misleading statement;
e. **Paragraph 37**. Contravening, by act or omission, a law if,
   i. the purpose of the law is to protect or promote public health, or
   ii. the contravention is relevant to the member's suitability to practise;
f. **Paragraph 38.** Contravening, by act or omission, a term, condition or limitation on the member's certificate of registration;
g. **Paragraph 41.** Failing to comply with an order of a panel of the College;
h. **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; and/or
i. **Paragraph 47.** Engaging in conduct that would reasonably be regarded by members as conduct unbecoming a member of the profession.

REGISTRANT'S NON-ATTENDANCE AT THE HEARING DESPITE NOTICE

The Registrant did not appear at the hearing, despite having received notice of the hearing. The College submitted an affidavit, filed as Exhibit 1, which contained copies of communications and attempted communications with the Registrant, advising him of the date and time of the hearing. The Registrant confirmed that he was available on the hearing dates proposed by the Discipline staff, however, he did not pre-register for the hearing and did not attend on any of the hearing days.

The Panel was satisfied that the Registrant received sufficient notice and directed that the hearing proceed in his absence, pursuant to section 7 of the *Statutory Powers Procedure Act*. As the Registrant did not appear and was not represented by counsel, the Panel accepted that in the Registrant's absence, the hearing would proceed on the basis that the Registrant denied all allegations of professional misconduct in the Notice of Hearing.

EVIDENCE

The evidence at the hearing consisted of the following documents and things filed by the College (Exhibits 1 – 48), as well as the testimony of seven (7) witnesses called by the College.

Document or Thing	**Exhibit Number**
Affidavit of Ashley Myers re: confirmation of hearing dates	1
Notice of Hearing	2
Appointments of Investigators dated December 3, 2020	3
Patient Records re : IVIT and Ultraviolet Irradiation	4
Patient Records re: Cancer Care	5
Appointments of Investigators dated March 9, 2021	6
Audio Recording of Undercover Investigation Appointment	7
Patient Record (PB) noting "5x IVIT" for next appointment – Redacted	8
Appointments of Investigators dated June 10, 2021	9
Certificate of Non-Attendance for the Registrant dated July 29, 2021	10
Public Register Profile of Richard Dodd as of November 21, 2022	11
Correspondence to the Registrant dated December 30, 2015 *re: registrant not authorized to administer IVIT*	12
Ontario Emergency Order, Directive #2 for Health Care Providers	13
Notice to Registrants re: Emergency Order	14
College Resources and Notices to Registrants re: COVID policies and vaccinations	15
Standard of Practice: Scope of Practice	16
Professional Practice Policies re: Vaccinations	17
Ministry of Health Notice re: COVID medical exemption letters from health professionals	18
Standard of Practice: Injection	19
Standard of Practice: Performing Authorized Acts	20
Correspondence to Registrant *re: cease and desist performing and/or advertising IVIT and Ultraviolet Irradiation*	21
Correspondence from the Registrant *re: conditional acceptance of cease and desist*	22
Correspondence to the Registrant *re: response to conditional acceptance of cease and desist*	23
Correspondence with the Registrant *re: investigator's attempts to schedule meeting*	24
Correspondence to the Registrant enclosing Decisions of the ICRC and Interim Order	25
Standard of Practice: Advertising	26
Screenshots of the Natural Path Care Integrated Health Care Website	27
Correspondence to the Registrant enclosing Investigation Reports re 20-033R	28

Correspondence to the Registrant enclosing Investigation Reports re 21-005R	29
Correspondence to the Registrant enclosing Investigation Reports re 21-015R	30
Correspondence to the Registrant enclosing Investigation Reports re 21-039	31
Registrant's *Notice of Objection and Writ*	32
Correspondence to the Registrant *re: Ms. Durcan's response to document provided to the College*	33
Correspondence from March 15, 2021 to February 3, 2022	34
Excerpt from the website of The Natural Path Integrated Health Care Centre	35
LinkedIn Website for Registrant	36
Correspondence from February 9, 2021 to February 18, 2021	37
CONO Website: Inspection Program re: IVIT	38
Letter from Registrant to Patient 1 providing vaccination exemption – Redacted	39
Letter from Registrant to Patient 2 providing vaccination exemption – Redacted	40
Prescribing Therapeutics Program & Examination Policy	41
Standard of Practice: Intravenous Infusion Therapy	42
Standard of Practice: Prescribing	43
Patient PB Appointment Note re: 5 IV Drip – Redacted	44
Photograph of sign in clinic re: restrictions	45
Search Warrant Dated December 14, 2021	46
Patient 1 – CW Record – Redacted	47
Patient 2 – NG Record – Redacted	48

The College's witnesses included three investigators, three College staff members, and one complainant. The evidence of these witnesses is summarized below.

EVIDENCE OF THE WITNESSES

Ziggy Bardel

Mr. Bardel is a private investigator with Benard and Associates. Mr. Bardel was appointed as an investigator by the CEO to investigate several concerns (Exhibits ("Ex") 3, 6, and 9). Mr. Bardel gave evidence regarding these investigations, and advised the Panel of the following:

Mr. Bardel attended the Clinic as an undercover patient on or about December 9, 2020. During that attendance, the Registrant admitted to providing ultraviolet blood irradiation therapy, and recommended an "IV Protocol" for Mr. Bardel. The Registrant provided Mr. Bardel with a list of various nutrients in the IV drip and informed him that the IV protocol is the best option out of

the two treatment plans. Mr. Bardel recorded his conversation with the Registrant, and the College filed this recording as Exhibit 7.

Five to ten minutes after conducting this visit, Mr. Bardel returned to the Clinic in order to obtain certain patient records, including records with respect to IVIT, Cancer treatment and Ultraviolet Irradiation. The records obtained by Mr. Bardel were reviewed with the Panel, and entered into evidence as Exhibits 4 (for IVIT and Ultraviolet Irradiation treatment) and 5 (for cancer treatment).

Mr. Bardel attempted to serve a summons on the Registrant and attended the Registrant's place of residence on several occasions. However, he was unable to serve the summons despite several attempts, as well as telephoning the Registrant and contacting the Registrant's legal counsel (Ex 24)**.** Mr. Bardel attempted to secure an interview with the Registrant, but had great difficulty doing so. He eventually served the Registrant with a summons to attend an interview, but the Registrant never attended (Ex 10).

Mr. Bardel also gave evidence regarding an investigation undertaken by Lindsay MacDonald. Ms MacDonald could not attend the hearing as she no longer was employed by Benard. Mr. Bardel had reviewed Ms. MacDonald's investigation file and authored a report which included reference to compliance checks carried out by Ms. MacDonald. Mr. Bardel confirmed that Ms. MacDonald was the lead investigator for an investigation in respect of a complaint against the Registrant relating to the Registrant's issuance of COVID exemption letters. Mr. Bardel testified that Ms. MacDonald attended at the Clinic on November 16, 2021 and served the complaint on the Registrant. While there, she attempted to collect the two relevant patient files. He refused. Subsequently, Ms. MacDonald served a summons on the Registrant to obtain the patient files. The Registrant did not comply with the summons served upon him. As a result of the Registrant's refusal to provide the patient records, Ms. MacDonald obtained a search warrant (Ex 46) on December 14, 2021 and executed it on December 21, 2021 to obtain the patient files for Patient 1 (Ex 47) and Patient 2 (Ex 48).

Jeremy Quesnelle

Mr. Quesnelle is the Deputy CEO of the College. Mr. Quesnelle testified as to: the Registrant's registration history with the College; the circumstances under which registrants are permitted to perform certain controlled acts; the facts that the Registrant was not authorized to administer IVIT as of January 1, 2016 and that the Registrant's clinic, The Natural Path, was not identified as a premise that could provide IVIT; the College's investigations of the Registrant; the terms, conditions and limitations placed on the Registrant's certificate of registration; the impact of Ontario's Emergency Order and the Registrant's treatment of patients contrary to the Emergency Order; the Registrant's failure to cooperate with the College; the Registrant's website advertising; the prohibition on registrants performing blood therapy treatment; and the prohibition on registrants providing vaccine exemptions.

The following is a summary of Mr. Quesnelle's evidence:

Registration History
The Registrant has been a naturopath since 1994. He became a registrant of the College on July 1, 2015.

IVIT Authorization
Prior to his registration with the College, the Registrant was authorized to administer IVIT. However, upon registration with the College, in order to continue administering IVIT, the Registrant was required to be in compliance with the General Regulation as well as written standards, including:

a. Standard of Practice: Intravenous Infusion Therapy (Ex 42)
b. Standard of Practice: Injection (Ex 19)
c. Standard of Practice: Performing Authorized Acts (Ex 20)
d. Standard of Practice: Prescribing (Ex 43)

These required the Registrant to complete coursework and pass an exam by December 31, 2015. The Registrant failed to complete these steps and accordingly, he was no longer authorized to do so as of January 1, 2016. The College sent the Registrant a letter confirming this on December 30, 2015.

Cease and Desist
In 2020, the College had information to reasonably believe that the Registrant had been performing/advertising IVIT and UV Blood irradiation. On December 11, 2020, the College issued the Registrant a Cease and Desist letter (Ex 21), reminding the Registrant that he was not authorized to provide IVIT or ultraviolet blood irradiation treatments, and that his place of employment was not a registered premises for performing IVIT. On December 14, 2020, the Registrant responded to the Cease and Desist letter. He agreed to cease and desist only if the CEO of the College could provide proof that the Registrant was performing IVIT, injections and ultraviolet blood irradiation. The Registrant asserted that he was authorized to perform IVIT and injections and demanded remuneration ($10,000,000) for the CEO's "unfounded accusations and unjust enrichment" (Ex 22). Mr. Quesnelle responded to the Registrant on December 15, 2020 and reiterated that the Registrant was not legally authorized to provide these services. Mr. Quesnelle was concerned that the Registrant was not aware of this, and that the Registrant would demand money from the College (Ex 23).

On December 15, 2020 a panel of the ICRC imposed an interim order on the Registrant that forbade him from performing, delegating or accepting the delegation of IVIT. Further, he could not advertise IVIT, advertise or administer vaccinations, or advertise or administer Ultraviolet blood irradiation treatment. The Registrant was also required to post a sign that he was not authorized to perform IVIT and/or injections or compounding. He was also required to ensure all patients sign a form that they understood he was not able to perform the procedures.

Emergency Order

The Chief Medical Officer of Health issued an Emergency Order, specifically, *Directive #2 for Health Care Providers (Regulated Health Professionals or Persons who operate a Group Practice of Regulated Health Professionals)* issued under Section 77.7 of the *Health Protection and Promotion Act* (HPPA), R.S.O. 1990, c. H.7, came into effect on March 19, 2020 and required that all health care practitioners who were not providing essential services cease practicing. As a result, between March 24 and May 29, 2020, registrants were not permitted to provide services to patients. On May 26, 2020, the order was amended to allow health care practitioners who were providing non-essential services to resume their practices, while ensuring they were following COVID-19 protocols. The College informed all registrants of the order and its amendment, advising them not to provide treatment that was not essential or necessary, unless it was necessary to avert/avoid negative patient outcome.

Despite the order, the patient records that were collected during the investigation indicate that the Registrant provided non-emergent services during the periods in question, as outlined below:

Patient	**Dates**
KA	March 24, 2020
OP	April 8, 2020, April 22, 2020, May 6, 2020, May 20, 2020
FK	April 2, 2020, April 25, 2020, May 21, 2020

Cooperation with Investigation

During the course of the College's investigation, the College asked the Registrant to provide his lawyer's first name and relevant contact information (as there was concern that the Registrant's lawyer was not licensed to practise in Ontario). The Registrant never provided the requested information (Ex 24). Nor did the Registrant respond to summonses issued by the College's investigators. The College's legal counsel wrote to the Registrant's legal counsel Mr. Richards and informed him that section 33 of the *Public Inquiries Act* stipulated that if the Registrant failed to comply with a summons, the investigator could make an application to the Divisional Court for contempt and his failure was also in contravention of section 76 (3.1) of the Code (Ex 33).

Following the investigations of the Registrant, the Registrant was served with Registrar Reports and asked by the College to provide his response (Ex 28, 29, 30 and 31). The Registrant never did so.

The Registrant was eventually served with Notices of Hearing for these proceedings. By way of response, the Registrant sent a document titled *Notice of Objection Writ of Quo Warranto* (Ex 32), advising that the Registrant did not consent to, and objected "to the proce[e]ding(s) scheduled for 30 July, 2021, or at anytime thereafter, regarding the matters identified in your Notice by your file #20-033R and #21-005R."

Mr. Quesnelle identified and confirmed that several pieces of correspondence had been sent to the Registrant and/or his lawyer, asking for information. The Registrant, in response, asked the College to provide irrelevant information (such as the CEO's contract) as a precondition to complying with the College's requests. (Ex 24, 34 and 37). The College reminded the Registrant that failing to co-operate could amount to professional misconduct.

Interim Order

On December 8, 2021, a panel of the ICRC made an interim order directing the Chief Executive Officer to immediately suspend the Registrant's certificate of registration. The ICRC directed that the interim suspension would continue until it is varied by the ICRC, or until the matter is disposed of by a panel of the ICRC or the Discipline Committee. Although invited to do so, the Registrant did not provided submissions in respect of the interim order.

Website

Mr. Quesnelle had viewed the Registrant's website (Ex 27 and 35) and that it claimed:

a. The naturopaths at the clinic provide treatment … including cancer care and "treatment processes"

b. The Registrant was the only naturopath at the clinic

c. The Registrant's "special area of expertise and passion is Cancer prevention and treatment."

d. Tests, such as "standard lab tests and tumor testing", are available at the clinic.

Mr. Quesnelle confirmed that registrants are not authorized to treat cancer as it is outside the scope of practice of naturopaths in Ontario. This fact was communicated by the College to all registrants through an Advisory to the profession advising that both the diagnosis and treatment of cancer does not fall within the scope of the practice of the profession.

The Standard of Practice for Scope of Practice (Ex 16) provides that registrants are restricted from treating or advising of items outside of the naturopathic scope of practice and that they should advise patients seeking such procedures that these are outside their scope, and refer them to a person authorized to perform the procedure.

Registrants are not authorized to offer or provide ultraviolet blood irradiation therapy. Section 5(1) of the General Regulation made under the Act states that registrants authorized to administer a substance by injection can only administer the substances listed in Table 2 of the regulation, via the authorized route of administration and in accordance with any limitations. Blood is not a substance listed in the regulation as something that NDs are authorized to inject. Registrants are authorized to take blood from a patient in office only for the purposes of performing one or more of the 7 listed naturopathic examinations, pursuant to section 8(1) of the General Regulation. Blood Irradiation is not one of the 7 authorized naturopathic examinations for which NDs can take blood. All of the foregoing is listed on the College website. Further, the Registrant would not have been authorized to inject any substance, as he had not met the requirements of the standard of practice for prescribing or the injection standard (Ex 19).

A website would be considered a form of advertising. The College expects registrants to advertise in an accurate, verifiable, comprehensible and truthful manner. The College had published a standard on Advertising to assist registrants (Ex 26).

Vaccines

Mr. Quesnelle confirmed that vaccines were outside the scope of practice of naturopaths and that registrants are aware of that, as the College has published a Vaccination policy speaking to this issue (Ex 17). The December 15, 2020, ICRC interim order addressed this issue, stating that the Registrant could not advertise or administer vaccinations.

On September 14, 2021, the Ontario Ministry of Health advised the province that documentation of a COVID medical exemption must be provided by either a physician or nurse practitioner (Ex 18). This document was made available on the College website. The College advised all registrants on September 21 that they are not permitted to discuss COVID-19 vaccinations (or any other vaccinations) with patients, nor could they suggest alternatives to vaccinations, and that as a result, COVID-19 is outside of the scope of practice of the profession. In keeping with the Standard of Practice on Scope of Practice, patients who have questions about COVID-19 and the vaccinations must be referred to a regulated health care provider (Ex 15). The College also posted a blog on September 22, 2022, advising that registrants are not authorized to provide patient with vaccine exemption letters (Ex 15).

Dr. Mary-Ellen McKenna, ND (Inactive)

Dr. McKenna, ND (Inactive) is the Manager, Professional Practice of the College. Dr. McKenna, ND (Inactive) gave evidence regarding the College's Inspection Program. As is explained on the College's website, the Inspection Program ensures that when a registrant intends to compound drugs or administer a therapeutic product by IVIT, it occurs in a safe environment. The College will perform a thorough inspection before such services can occur. These controlled acts cannot occur unless the premises is registered by the College. (Ex 38). Dr. McKenna, ND (Inactive) confirmed that the Registrant's clinic, The Natural Path, was never registered as an IVIT premises with the College. Further, Dr. McKenna ND (Inactive) advised that the College never received an application from the Registrant for registration of The Natural Path, and that The Natural Path had never been inspected by the College. The Registrant was never identified as a designated member of a premises. As a result, IVIT could not be performed at The Natural Path by any naturopath.

Alison Bailey

Ms. Bailey testified that she is a human resources professional for a real estate company who received letters which purported to exempt employees from vaccine mandates. Ms. Bailey alerted the College that the Registrant was signing COVID-19 exemption letters and ultimately filed a complaint against the Registrant. Ms. Bailey advised the Panel that she received a letter from Patient 1, dated October 19, 2021 signed by the Registrant on his clinic letterhead. The letter purported to be an exemption for Patient 1 to obtain the COVID-19 vaccination (Ex 39). Ms. Bailey also advised that she received a letter from Patient 2, dated October 28, 2021 signed by the Registrant on his clinic letterhead. By this letter (Ex 40), the Registrant was providing an exemption for Patient 2 to obtain the COVID-19 vaccination. Ms. Bailey was aware that only nurse

practitioners and physicians were authorized to sign such letters. Ms. Bailey therefore filed a complaint with the College against the Registrant.

Valerie Henderson

Ms. Henderson was an investigator who attended at the Clinic in December 2020 to ascertain if the Registrant was complying with the interim order. Ms. Henderson advised the Panel that, contrary to the terms of the interim order, the Clinic did not have any signs posted in the waiting room or clinic rooms. Additionally, and also contrary to the terms of the interim order, none of the patient files included the form advising patients of the interim order. Ms. Henderson gave evidence that she noted that a patient chart indicated that IVIT was to be provided at the next appointment (Ex 44) and asked the Registrant about this. The Registrant said that this was an error but Ms. Henderson did not notice any correction in the chart advising that the Registrant had alerted the patient of the error.

Erica Laugalys

Ms. Laugalys was the Director of Registration and Examinations of the College. Ms. Laugalys gave evidence regarding the requirements for registrants to meet the standard of practice (SOP) for prescribing. Ms. Laugalys explained that the College has a Therapeutics Program and Examination Policy that sets out how registrants can meet the Standard of Practice for Prescribing. This Policy states that if a registrant wants to prescribe, compound, sell or dispense a drug, or administer a drug by injection, the registrant must have successfully completed a training course in therapeutic prescribing, and a Prescribing and Therapeutics examination (Prescribing exam) (Ex 41). Ms. Laugalys confirmed that the Registrant did not meet the SOP for Prescribing or the SOP for IVIT and confirmed that the Registrant did not pass the prescribing exam in November 2015, attempt the prescribing exam after November 2015, or ever attempt the IVIT exam.

Lauren DeVriese

Ms. DeVriese was an investigator who attended at the Registrant's clinic in January 2021 to ascertain if the Registrant was complying with the interim order. Ms. DeVriese advised the Panel that she noted that some signs were posted (Ex 45) but, contrary to the terms of the interim order, none of the patient files included the form advising patients of the interim order. Ms. DeVriese asked the Registrant about this, and the Registrant said he only asked patients who had previously received IVIT to sign the form. Ms. DeVriese noted that a patient had received IVIT on December 17, 2020 but that no patient form was included in the patient's chart. Ms. DeVriese asked the Registrant about this, and the Registrant advised her that they just called patients to advise of the prohibition of IVIT.

SUBMISSIONS OF THE COLLEGE ON LIABILITY

The College submitted that all of its witnesses were credible. All testified to matters within their observation, none had an interest in the outcome, and none had any bias against the Registrant. The College submitted that much of the witnesses' testimony was corroborated by documents that were entered into evidence and was consistent with the testimony of other witnesses and documents.

With respect to the documentary evidence, the College submitted that section 35 of the *Evidence Act* permits the admission of any writing or record that is made in the usual and ordinary course of business, including patient records, and that the Panel could rely on these as evidence of the treatment provided by the Registrant to patients.

The College further submitted that it had proven all of the allegations on a balance of probabilities, as follows:

Contravening, by act or omission, a standard of practice of the profession or failing to maintain the standard of practice of the profession (Paragraph 1)

The College alleged that the Registrant contravened several standards of practice of the profession; these include written and statutory standards. The College submitted that it does not need to provide an expert to speak to the statutory standards of practice, as they are set out in legislation. With respect to other standards of practice, the College submitted that it would need to provide an expert to speak to the written standards of practice if the written standards were not obvious or notorious. The College submitted, however, that all of the written standards are obvious and essentially align with the statutory standards of practice. As such, expert opinion was not required.

Advertising

The College submitted that the Advertising Standard (Ex 26) simply provides that registrants are expected to advertise their services in a fair, accurate and non-predatory manner. The College submitted that the evidence demonstrates that the Registrant advertised he could treat cancer, provide IVIT and Ultraviolet blood irradiation therapy. These were all false claims, as the Registrant was not permitted to provide any of these treatments. It was the submission of the College that this breaches the standards of the profession.

Intravenous Infusion Therapy

Naturopaths are authorized to administer IVIT but must do so in compliance with the General Regulation. The evidence demonstrates that the Registrant had not met the necessary standards to continue to administer IVIT as of January 1, 2016. He was fully aware of this, as the College wrote to him and reminded him of such. Despite this, he proceeded to administer IVIT to several patients. The Registrant also recommended this treatment to Mr. Bardel when he attended in an undercover capacity.

The Standard relating to IVIT was filed as Exhibit 42. The College submitted that the requirements of this written Standard align with the language of the General Regulation. The College submitted

that the Registrant contravened the General Regulation and the IVIT Standard when delivering IVIT without having passed the required exam, and that this breached the standards of the profession.

Injection

The College submitted that Naturopaths are authorized to inject drugs and substances, but must do so in compliance with the General Regulation as well as the Injection Standard (Ex 19). The General Regulation permits Registrants to inject substances that are set out in Table 2 to the General Regulation. The Standard prohibits registrants from injecting any substances unless they have passed the relevant exam. The College submitted that the evidence demonstrates that the Registrant engaged in ultraviolet blood irradiation, which involves the injection of a substance, namely blood, that is not listed in Table 2, in contravention of the General Regulation. As such, the Registrant contravened the standard of practice relating to injection.

Performing Authorized Acts

The College submitted that Naturopaths are authorized to perform certain controlled acts, but must do so in accordance with the General Regulation as well as the Standard: Performing Authorized Acts (Ex 20). The evidence demonstrates that the Registrant failed to adhere to the statutory standards when performing the controlled acts authorized to naturopaths. This includes: performing IVIT after January 1, 2016 when the Registrant had not passed the exam required to perform IVIT; injecting substances not permitted in accordance with the General Regulation; compounding substances to be injected in the course of IVIT administration without having met the requirements of the Standard of Practice for Compounding; and taking blood samples for purposes not authorized. The College submitted that the Registrant failed to appreciate his responsibility and accountability for performing authorized acts.

Scope of Practice

The College submitted that the Registrant contravened the Scope of Practice Standard (Ex 16) when he exceeded the scope of the profession by offering to treat and treating cancer, and providing UV blood irradiation therapy. The Registrant also exceeded his personal scope by administering IVIT and compounding drugs without having met the College's requirements for doing so, and taking blood samples for improper purposes. The College submitted that naturopaths must remain within their scope of practice, or the public is placed at risk. The scope includes both the professional scope and the personal scope.

Statutory standards of practice

The General Regulation also contains various statutory standards of practice that, the College submitted, were contravened by the Registrant.

Subsection 3(1) prohibits a registrant from performing a controlled act under authority of subsection 4(1) of the *Naturopathy Act* unless they perform it in accordance with the standards

of practice of the profession, including that the registrant ensures that appropriate infection control procedures are in place at all times and that the controlled act is performed in an environment that is clean, safe, private and comfortable for the patient.

Subsection 5(1) of the General Regulation authorizes a registrant to administer a substance to a patient by injection, provided it is specified in Table 2 and in accordance with any limitations that are set out in the Table. Subsection 5(3) of the General Regulation provides that it is a standard of practice that a registrant complies with all of the standards of practice set out in subsection 11(2) of the General Regulation when administering a customized therapeutic product to a patient by injection. These standards of practice include that the registrant must have the knowledge, skill and judgment to engage in the controlled act safely, competently and ethically.

Pursuant to subsection 5(4) of the General Regulation, it is a standard of practice of the profession that a registrant may only perform the controlled act of administering a substance by injection if he or she has successfully completed a course and an examination on prescribing that has been administered or approved by the Council.

Subsection 5(5) of the General Regulation relates to intravenous injection. It provides that where the administration of a substance is by intravenous injection, it is a standard of practice of the profession that a member may only perform the controlled act if he or she has successfully completed a course and an examination on administering a substance by intravenous injection that is administered or approved by the Council, in addition to the requirements outlined above.

The standards of practice relating to blood samples are set out in subsection 8(2) of the General Regulation, and include that a registrant shall only take blood samples for the purpose of performing one or more enumerated naturopathic examinations on a patient's blood sample. Paragraph 5 of that subsection prohibits registrants from taking a blood sample from a patient for any other purpose.

Subsection 9(5) of the General Regulation sets out standards of practice relating to prescribing a drug, including that a registrant may only perform the controlled act of prescribing if they have successfully completed a course and examination on prescribing that is or has been administered or approved by the Council. Likewise, subsection 10(4) provides that it is a further standard of practice of the profession that a registrant may only perform the controlled act of dispensing a drug if they have successfully completed a course and an examination on prescribing that is administered or has been approved by the Council. Subsection 11(3) of the General Regulation provides that it is a standard of practice for compounding a drug that a registrant may only perform this controlled act if they have successfully completed a course and examination on prescribing that is or has been administered or approved by the Council.

The College submitted that the Registrant contravened all of these standards of practice, noting that the Registrant has not successfully completed a course or exam related to prescribing, dispensing or compounding drugs, IVIT or administration of substances by injection, and that the

Registrant took blood samples for blood irradiation therapy, and not for a naturopathic examination.

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 8)

The College submitted that the evidence demonstrates that the Registrant offered and administered IVIT to patients in his clinic, when he was not authorized to administer IVIT and the Clinic was not registered to provide such services. This was demonstrated by the patient records which established that the Registrant administered IVIT, and by the fact that the Registrant told Mr. Bardel that he should receive IVIT as part of his treatment plan.

The College further submitted that the evidence demonstrates that the Registrant administered unauthorized substances by injection, that he provided cancer treatment and that he provided ultraviolet irradiation, all despite not having the knowledge, skill or judgment to do so. The Registrant told Mr. Bardel that he provided ultraviolet blood irradiation therapy (which includes injecting blood into a patient), and patient records established that this was a treatment he provided.

The College submitted that the parameters of what naturopaths in Ontario are permitted to do are set out in the General Regulation and the standards of practice of the profession, but the Registrant repeatedly and extensively ignored these parameters and provided or attempted to provide services or treatments that he could not provide.

Additionally, the Registrant held himself out as a health professional that could provide opinion on the exemption status for the COVID-19 vaccination, despite knowing that this was outside of his scope as a naturopath. In addition, the Registrant had an explicit interim order imposed upon him to refrain from engaging in such discussions.

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 9)

The College submitted that the Registrant knew that he was not authorized to administer IVIT, provide cancer treatment, or provide ultraviolet blood irradiation therapy, and that such services could not be performed at his clinic, but did not advise patients of his limitations. The Registrant was required to advise the patients or their representative that if they wished to obtain these services they ought to consult with another regulated health professional.

The College submitted that the Registrant also engaged in this act of misconduct because he knew that any vaccine matter, including exemption to the COVID-19 vaccination, was outside of his scope, as the College communicated this to all registrants. The Registrant therefore knew that

he ought to refer Patient 1 and Patient 2 to a nurse practitioner or a physician. Additionally, the interim order imposed upon the Registrant explicitly informed him that he could not engage in such discussions or write such letters.

Performing a controlled act that the member is not authorized to perform (Paragraph 10)

The College submitted that this act of misconduct was engaged by the Registrant having:

a. administered a non-prescribed substance by injection;
b. administered substances by IVIT injection without having met the Standards of Practice for Prescribing; and
c. compounded or sold a drug without having met the Standards of Practice for Prescribing.

The College submitted that registrants are authorized to perform these controlled acts as set out in the *Naturopathy Act*, provided they do so in accordance with the General Regulation. This is expressly and clearly set out in subsection 4(2) of the *Naturopathy Act*. Failing to perform a controlled act in accordance with the General Regulation results in the registrant engaging in an unauthorized performance and an act of professional misconduct.

Permitting the advertising of the member or his or her practice in a manner that is false or misleading or that includes statements that are not factual and verifiable (Paragraph 27)

The College alleged that the Registrant advertised in a manner that was false or misleading, in that the Registrant 's clinic website advertised the following, all of which were false:

a) that IVIT could be performed at the clinic;
b) that ultraviolet blood irradiation therapy could be performed at the clinic;
c) that cancer treatment could be obtained at the clinic; and
d) that his "special area of expertise and passion is Cancer prevention and treatment."

As none of these treatments could be provided at the Clinic or by the Registrant, the College submitted that all of the foregoing statements were false or misleading. The College noted that it is not permitted for registrants to have an area of expertise, so the Registrant could not have had an area of expertise or advertised having one. Further, as the Registrant was not authorized to treat cancer, any claims that he could do so would be false, misleading, not factual and not verifiable.

Signing or issuing, in his or her professional capacity, a document that the member knows or ought to know contains a false or misleading statement (Paragraph 24)

The College submitted that the Registrant signed documents that he knew or ought to have known contained a false or misleading statement when he signed two COVID-19 exemption letters (Ex 39 and 40) in his professional capacity. One letter stated that based on the Registrant's assessment and the patient's cardiac condition and adverse reactions, it was not recommended that they receive a COVID vaccine, while the other letter included the Registrant's interpretation

of section 2(a) of the *Charter* as "allow[ing] for religious or conscientious objection to any and all vaccines or medical treatments/procedures".

The College submitted that Patient 1 had no history of adverse reactions to standard immunizations and that their chart contained no reference to heart issues other than a past incident of murmurs/palpitations and a non-specific family history of "cardiovascular." The College also noted that Patient 2 only had one visit with the Registrant, and their chart contained no report of any adverse reactions to the standard immunizations, nor any reference to physical concerns.

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

The College submitted that the Registrant contravened the legislation governing naturopaths. Section 4(2) of the *Naturopathy Act* states that "A member shall not perform a procedure under the authority of subsection (1) unless the member performs the procedure in accordance with the regulations." Section 4(3) also states "In addition to the grounds set out in subsection 51 (1) of the Health Professions Procedural Code, a panel of the Discipline Committee shall find that a member has committed an act of professional misconduct if the member contravenes subsection (2)." The College submitted that the Registrant did not comply with subsections 5(1), 8(1), 9(1), 10(1), 11(1) and 31(1) of the General Regulation, as outlined below:

2(1)	A member shall not perform a controlled act under the authority of subsection 4 (1) of the Act except in accordance with this Part.
5(1)	For the purposes of paragraph 3 of subsection 4 (1) of the Act, a member who meets all of the standards of practice of the profession in this section and section 3 of this Regulation is authorized to perform the following controlled acts: 1. Administering a substance specified in Table 1 by inhalation to a patient, in accordance with any limitations respecting the substance set out in the Table. 2. Administering a substance specified in Table 2 by injection to a patient using the routes of administration respecting the substance that are set out in the Table and in accordance with any limitations respecting the substance that are set out in the Table.
8(1)	For the purposes of paragraph 6 of subsection 4 (1) of the Act, a member who meets all of the standards of practice of the profession in this section and section 3 of this Regulation is authorized to take blood samples from veins or by skin pricking for the purpose of performing one or more of the following naturopathic examinations on a patient's blood sample: 1. BTA Bioterrain Assessment. 2. Glucose. 3. Live blood cell analysis. 4. Hemoglobin – A1C. 5. Mononuclear Heterophile Antibodies (monospot). 6. Fatty acids, free. 7. Blood Group – ABO and RhD.

9(1)	For the purposes of paragraph 7 of subsection 4 (1) of the Act, a member may prescribe a drug designated in Table 3 only if all of the standards of practice of the profession in this section are met.
10(1)	For the purposes of paragraph 7 of subsection 4 (1) of the Act, a member may dispense a drug designated in Table 4 only if all of the standards of practice of the profession in this section are met.
11(1)	For the purposes of paragraph 7 of subsection 4 (1) of the Act, a member may compound a drug designated in Table 5 only if all of the standards of practice of the profession in this section are met.
31(1)	No member shall commence using any premises for the purpose of performing a procedure unless the member has previously given notice in writing to the College in accordance with subsection (5) of the member's intention to do so and the premises pass an inspection or pass an inspection with conditions.

The College submitted that the Registrant also engaged in this act of professional misconduct by not cooperating "fully" with College investigators, as is required by subsection 76(3.1) of the Health Professions Procedural Code. Further, subsection 76(3) states that "no person shall obstruct an investigator or withhold or conceal from him or her or destroy anything that is relevant to the investigation." The College submitted that the evidence demonstrates that the Registrant:

a) failed to respond to numerous requests of Mr. Bardel;
b) failed to co-operate with numerous inquiries of Mr Bardel and Ms. MacDonald;
c) failed to attend an interview on July 29, 2021 with Mr. Bardel despite being served with a summons;
d) sent the College a Notice of Objection Writ Quo Warranto on July 26, 2021 in response to being served with the summons; and
e) failed to produce the patient records of Patient 1 and Patient 2 despite being served with a summons.

Additionally, the College submitted that a search warrant was required in order to obtain the patient records of Patient 1 and Patient 2, demonstrating the Registrant's failure to cooperate fully with College investigators.

Without restricting the generality of paragraph 36, failing, by act or omission, to comply with any duty or requirement under Part IV (Inspection of Premises Where Certain Procedures are Performed) of Ontario Regulation 168/15 (General) made under the Act (Paragraph 36.1)

The College submitted that Part IV of the General Regulation prohibits a registrant from using any premises for the purpose of performing a procedure unless they have previously given notice in writing to the College in accordance with subsection (5) of their intention to do so and the premises pass an inspection or pass an inspection with conditions. The College submitted that it

was established that the Registrant never registered his premise yet proceeded to administer IVIT at his clinic, thereby engaging in this act of misconduct.

Contravening, by act or omission, a law if, the purpose of the law is to protect or promote public health, or the contravention is relevant to the member's suitability to practice (Paragraph 37)

The College submitted that the Registrant contravened Ontario's Emergency Order, the purpose of which was to protect or promote public health, and that this was relevant to his suitability to practise. In March 2020, during the state of emergency in Ontario, an Emergency Order was issued which mandated that health professionals only provide essential services. The College clearly and transparently communicated this to all registrants. Despite this, the Registrant proceed to provide non-essential services to his patients. The College also submitted that the Government advised that COVID-19 exemption letters could be signed by nurse practitioners or physicians, and that the Registrant contravened this requirement.

Contravening, by act or omission, a term, condition or limitation on the member's certificate of registration (Paragraph 38)

The College submitted that the ICRC issued an interim order on December 15, 2020 that imposed various terms, conditions, and limitations on the Registrant's certificate of registration including but not limited to the following:

a. The Registrant was not to:
    i. perform, delegate or accept delegation of controlled acts;
    ii. advertise IVIT;
    iii. advertise or administer vaccinations; and/or
    iv. advertise or administer ultraviolet blood irradiation treatments; and

b. The Registrant was required to:
    i. post a sign in their Clinic and on their professional website that they are not authorized to perform IVIT and/or injections and/or compounding; and
    ii. ensure all patients signed a form indicating they were aware of the terms, conditions and limitations.

The evidence demonstrated that as of December 22, 2020:

a. The Registrant did not have the required signs posted;
b. The Registrant did not have any signed copies of the required patient forms; and
c. The Registrant's appointment book indicated he was going to administer IVIT to a patient on or about December 17, 2020.

The evidence also demonstrated that on or about January 27, 2021:

a. The Registrant had posted the required sign at the Clinic but not on his professional website;
b. The Registrant administered IVIT to a patient on December 17, 2020; and

c. The Registrant did not obtain a signed form from the patient or any patient.

The College submitted further that, despite the term, condition and limitation on his certificate of registration requiring him to refrain from advertising or administering vaccinations, the Registrant wrote two letters setting out his professional opinion as to why Patient 1 and Patient 2 should be exempted from the COVID-19 vaccination. The College submitted that this contravenes the spirit of this term, and that all of the foregoing contraventions of terms, conditions or limitations on his certificate of registration were acts of professional misconduct under paragraph 38 of section 1 of the Misconduct Regulation.

Failing to comply with an order of a panel of the College (Paragraph 41)

The College submitted that the Registrant engaged in this act of professional misconduct by contravening the interim order of the ICRC that was issued on December 15, 2020. For reasons described in paragraphs 61-64, it is the submission of the College that the Registrant failed to comply with this order.

Failing to reply appropriately and within 30 days to a written inquiry or request from the College (Paragraph 44)

The College submitted that the Registrant engaged in professional misconduct by failing to reply appropriately to two written inquiries or requests from the College: on or about April 26, 2021 the College asked the Registrant to provide his lawyer's first name and relevant contact information (as there was concern that his lawyer was not licensed to practise in Ontario). The Registrant never provided the requested information to the College.

Then, the Registrant was served with two Registrar Reports and asked by the College to provide his response. The Registrant advised that he required proof of the authority of the College before he would provide any response. The Registrant never provided a response to the Registrar Reports.

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 46)

The College submitted that all of the foregoing conduct would reasonably be regarded by members of the profession as disgraceful, dishonourable and unprofessional, and that the Registrant's conduct meets all three of these descriptors.

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

The College submitted that if any of the foregoing conduct was not relevant to the practice of the profession, then such conduct would be found to be conduct unbecoming a member of the profession, and would therefore be an act of professional misconduct under this paragraph.

DECISIONS AND REASONS ON LIABILITY

The College was required to prove the acts of professional misconduct alleged in the Notice of hearing on a balance of probabilities, based on evidence that was clear, cogent, and convincing.

The Panel accepted the uncontroverted and reliable testimony of the witnesses and the documents filed as exhibits, and concluded that the College established the following acts of misconduct set out in the Notice of Hearing.

The following section reviews the allegations under each heading of misconduct set out in the Notice of Hearing. Although the Notice of Hearing contains allegations of misconduct arising from four separate investigations, the Panel will address the allegations of misconduct arising from all four investigations together. For example, the investigation in File 20-033R related to concerns that the Registrant was offering, providing and advertising the provision of IVIT, ultraviolet irradiation therapy and cancer treatment, and gave rise to allegations that the Registrant contravened numerous standards of practice of the profession and engaged in other acts of misconduct, outlined at the outset of these Reasons. The investigation in File 21-005R related to allegations that the Registrant was the subject of an interim order by the ICRC dated December 15, 2020 and that on or about December 22, 2020 and January 27, 2021, the Registrant contravened terms of the interim order. This investigation gave rise to allegations that the Registrant contravened a term, condition or limitation on his certificate of registration and failed to comply with an order of a panel of the College. Both of these investigations gave rise to allegations that the Registrant engaged in conduct or performed 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 as well as conduct that would reasonably be regarded by members as conduct unbecoming a member of the profession. As such, the Panel will assess whether the Registrant engaged in each of the allegations of professional misconduct alleged, by considering all of the evidence presented by the College, without regard to the investigation that gave rise to the allegation.

Review of Misconduct Allegations

Paragraph 1 of section 1 of the Misconduct Regulation makes it an act of professional misconduct for a registrant to contravene, by act or omission, a standard of practice of the profession, or to fail to maintain the standard of practice of the profession.

The College alleged that the Registrant had contravened standards of practice relating to:

i. Core Competencies;
ii. Advertising;

iii. Compounding;
iv. Intravenous infusion therapy;
v. Injection;
vi. Performing authorized acts
vii. Scope of practice;
viii. Statutory Standards of Practice;
ix. Code of Ethics; and
x. Professional Policy: Vaccination.

The Panel was satisfied that each of the standards of practice was sufficiently "notorious" or obvious, such that no expert evidence was required regarding (a) what the standard required and (b) whether the Registrant's conduct contravened that standard. The conduct alleged was not the exercise of judgment or an approach to treatment that could reasonably have been said to have met the standards of practice; rather, the Registrant's breach of each of the standards at issue was based on a failure to meet published requirements for the performance of treatment in question or on the Registrant's contravention of fundamental principles underlying each standard.

Core Competencies

The standard of practice for core competencies sets out the core competencies that a naturopathic doctor must demonstrate: Naturopathic medical knowledge; Inter and Intra-professional Practice and Collaboration; Communication - with patients, but also the regulator; Patient Care and Health Promotion; Practice Management; and Legislation/Ethics, the last of which specifically includes that a registrant complies with all relevant laws and regulations.

This standard of practice is sufficiently notorious and is available to all registrants of the College, and it is the responsibility of every registrant to know and apply them.
The Registrant fell short in this standard of practice, in that he did not comply with the relevant laws and regulations of the profession. The Registrant's numerous contraventions of relevant laws and regulations are outlined in the College's submissions, but one example relates to IVIT. The requirements for performing IVIT include the completion of coursework and a successful examination. As the Registrant did not meet these criteria, he was not permitted to perform IVIT after January 1, 2016, and his public register profile (Ext 11) clearly states that he was not permitted to perform IVIT. The evidence of patient records (Ext 4) demonstrates that the Registrant performed IVIT on patient ML between November 24, 2020 to December 8, 2020, and on patient GB as late as February 1, 2020 (Ex 5). In so doing, the Registrant contravened the standard of practice relating to core competencies.

Advertising

The standard of practice for advertising clearly states that any advertising done by an ND needs to be within their scope of practice, and have no reference to cure of symptoms or diseases, or appealing to public fears. The Panel found that the Registrant contravened the advertising

standard (Ex 26) by advertising on his website and LinkedIn profile (Ex 27), “cancer treatment”. Similarly, the Registrant advertised offering “Stable management of the disease is achievable during early stages of cancer” on his website (Ex 35), suggesting that this was a “special area of expertise”, which is not permitted for naturopathic doctors. The Registrant also advertised “expertise in alternative cancer care”, and “options for treatment if they or someone they care about is dealing with cancer…..” on his LinkedIn page (Ex 36). This was in contravention of the Advertising Standard, as Naturopathic doctors do not have the knowledge, skill and judgment to treat cancer and can therefore not claim expertise in this area.

Compounding

The standard of practice for compounding very clearly states that in order to compound a drug in a premise the registrant needs to be in compliance with the Standard of Practice for Prescribing.

To meet this standard, as is outlined in – the Standard of Practice for Prescribing (Ex 43), a registrant needs to successfully complete a prescribing course and pass an exam.

This standard of practice is sufficiently notorious and is available to all registrants of the profession, and it is the responsibility of every registrant to know and apply this standard. The Registrant did not meet the Standard of Practice for Prescribing because he did not pass the prescribing exam on December 30, 2015. The College communicated this to the Registrant by letter (Ex 12), and on his public register profile (Ex 11), clearly stating that he was not permitted to perform IVIT after January 1, 2016, which would include compounding. Despite this knowledge, the patient record for patient ML (Ex 4) clearly shows that the Registrant performed IVIT on this patient between November 24 and December 8, 2020. Similarly, the patient record for patient GB (Ex 5) demonstrates IV administration being performed in each of 2016, 2017, 2018, 2019 and on February 1, 2020. As there was no evidence in these patient records that the substances injected were compounded by a pharmacy or other premises that is authorized to compound, the Panel concluded that compounding was done by the Registrant at his clinic, in contravention of this standard.

Intravenous infusion therapy

The standard of practice for intravenous therapy very clearly states the registrant needs to be in compliance with the Standard of Practice for Prescribing, which can be found in Exhibit 42.
To meet this standard, as is outlined in Exhibit 43 – Standard of Practice for Prescribing, a registrant needs to successfully complete a prescribing course and pass an exam.

These standards of practice are sufficiently notorious and are available to all registrants of the profession, and it is the responsibility of every registrant to know and apply them.

The Registrant did not meet the Standard of Practice for Prescribing (included in Exhibit 7), on the basis that the Registrant did not pass the prescribing exam. This was communicated to the

Registrant on December 30, 2015 (Ex 12) and through the Registrant's public register profile (Ex 11), which clearly states he was not permitted to provide IVIT after January 1, 2016. As noted above, the Registrant provided IVIT to patient ML and intravenous administration of substances to patient G.B., in contravention of the IVIT standard of practice.

Injection

The Standard of Practice for Injection (Ex 19) provides that to meet this standard, a registrant needs to be in compliance with the Standard of Practice for Prescribing (Ex 43). To meet this standard, as is outlined in Exhibit 43, a registrant needs to successfully complete a prescribing course and pass an exam. The Panel found that these standards of practice are sufficiently notorious and are available to all registrants of the profession, such that expert evidence is not required to establish what the standard requires or that the Registrant failed to comply with it, and it is the responsibility of every registrant to know and apply them.

The Registrant failed to meet the standard of practice for prescribing on the basis that he failed to successfully complete the requisite course and to pass a prescribing exam. The College communicated this to the Registrant by correspondence dated December 30, 2015 (Ex 12), and this restriction was included in the Registrant's public register profile (Ext 11).

There is no evidence from the college that injections were not done by Mr. Dodd.

Performing authorized acts

The Standard of Practice for Performing Authorized Acts (Ex 20) very clearly states that a registrant need to achieve and maintain all prerequisites required for performing any procedure. The Panel accepted the College's submission that this standard of practice is sufficiently notorious and is available to all registrants of the profession, and accordingly, expert evidence was not required for the Panel to find that the Registrant contravened this standard.

The Registrant did not meet the prerequisites required to prescribe, compound and/or administer IV infusion therapy, as outlined above. Those prerequisites are clearly outlined in Exhibit 42, the Standard of Practice for Infusion Therapy and Exhibit 43, the Standard of Practice for Prescribing. As such, the Registrant also contravened the Standard of Practice for Authorized Acts.

Scope of practice

The Standard of Practice for Scope of Practice (Ex 16) sets out expectations for registrants and the acts registrants are authorized to perform. The Panel accepted the College's submission that registrants must only practice within their scope of practice, which includes both the professional scope and the personal scope, and that there is risk to the public in registrants exceeding their scope of practice.

The Registrant contravened this standard of practice in a number of respects. The Registrant exceeded the scope of the profession by offering to treat and treating cancer, and providing UV blood irradiation therapy to patients, which is not within the scope of practice of naturopathic doctors in Ontario. The Registrant also exceeded his personal scope by administering IVIT and compounding drugs without having met the College's requirements for doing so, and taking blood samples for improper purposes. This was proven through the evidence of Ziggy Bardel, including the audio recording of his attendance at the Registrant's Clinic in an undercover capacity (Ex 7), during which he was offered this therapy. In addition, Patient ML's record (Ex 4) demonstrates that the Registrant administered 5 UV therapy treatments from November 24, 2020 - December 8, 2020, which he was not authorized to provide, in contravention of the Scope of Practice Standard.

The Registrant further contravened this standard when he contravened the College's Professional Practice Policy on Vaccinations (Ex 17). This policy clearly states that registrants are not permitted to vaccinate, and that when asked by a patient about vaccinations, registrants are required to inform the patient that vaccinations are outside of the scope of naturopathic practice and that the patient should consult with a health professional who has the ability within his/her scope of practice. The College communicated this to registrants not only through the Vaccination Policy but by posting on the College website the Ontario Ministry of Health's directive that documentation of a COVID medical exemption must be provided by either a physician or nurse practitioner (Ex 18). The College also advised all registrants on September 21, 2021 that they are not permitted to discuss COVID-19 vaccinations (or any other vaccinations) with patients, nor could they suggest alternatives to vaccinations, and that as a result, COVID-19 is outside of the scope of practice of the profession (Ex 15). The College also posted a blog on September 22, 2022, advising that registrants are not authorized to provide patient with vaccine exemption letters (Ex 15). The Registrant contravened these directives and in so doing, contravened the Scope of Practice Standard.

The Panel found that these standards of practice are sufficiently notorious and are available to all registrants of the profession, and it is the responsibility of every registrant to know and apply them.

The Registrant exceeded his scope by writing COVID vaccination exemption letters for 2 patients, both dated October 28, 2021 (Ex 39).

Statutory Standards of Practice

The Panel also found that the Registrant contravened the statutory standards set out in the General Regulation. These included: subsection 3(1) requiring that a controlled act be performed in accordance with the standards of practice of the profession; subsections 5(3) and 5(4) relating to the administration of a substance by injection; subsection 5(5) relating to the administration of a substance by intravenous injection; subsection 8(2) relating to blood samples; subsection 9(5) relating to prescribing a drug; subsection 10(4) relating to dispensing a drug; and subsection

11(3) relating to compounding a drug, for the reasons outlined above including in the College's submissions.

Professional Policy: Vaccination

The College established that the Registrant failed to comply with the standard of practice for vaccination. This standard, set out in Professional Practice Policy PP04.1: Vaccination (Ex 17), clearly states vaccination is outside the scope of practice of registrants, and that "when asked by a patient about vaccinations, members shall inform the patient that vaccinations are outside of the scope of naturopathic practice and that the patient should consult with a health professional who has the ability within his/her scope of practice."

This standard of practice is sufficiently notorious that expert evidence was not required to establish what the standard of practice required or that the Registrant contravened the standard.

The evidence established that the Registrant contravened the Vaccination Policy and standard of practice by writing COVID vaccination exemptions letters, for Patient 1 dated October 19, 2021 (Ex 39) and for Patient 2 dated October 28, 2021 (Ex 40). The patient records for these patients (Ex 47 and 48) confirm that, contrary to the Vaccination Policy and standard of practice, the Registrant did not refer the patients to other health professionals who has the ability to prescribe and administer vaccinations.

Paragraph 8 of the Misconduct Regulation makes it an act of professional misconduct to provide or attempt to provide services or treatment that the registrant knows or ought to know to be beyond his knowledge, skill or judgment.

The Panel found that the College proved that the Registrant issued vaccine exemptions and held himself out as a health professional that could provide an opinion on the exemption status for the COVID-19 vaccination, despite having been informed through communications to the profession generally (Ex 18) and despite the issuance of an interim order (Ex 25) to the Registrant that he refrain from engaging in such discussions. This was established by the evidence of the exemption letters authored by the Registrant for Patient 1 and Patient 2 (Ex 39 and 40).

Additionally, the Registrant engaged in controlled acts he was not authorized to perform: the evidence of Mr. Bardel and Exhibits 4, 5 and 7 establish that the Registrant offered and administered IVIT to patients in his clinic, when he was not authorized to administer IVIT and the Clinic was not registered to provide such services. The Registrant also administered unauthorized substances by injection, in that he provided cancer treatment and he provided ultraviolet irradiation, all despite not having the knowledge, skill or judgment to do so.

The Panel accepted that the Registrant ignored the limitations imposed on his certificate of registration by the General Regulation and the standards of practice of the profession, and performed treatment that he knew or ought to have known was beyond his knowledge, skills and judgment. For example, contrary to the requirements of the Standard of Practice for Intravenous

Infusion Therapy (Ex 42), the Registrant provided IVIT without having successfully completed a prescribing course and passed an exam. As he did not meet these requirements, the Registrant was therefore not permitted to provide IVIT, and was specifically informed of this by letter dated December 2015 (Ex12). Similarly, the Registrant did not meet the standard of practice for prescribing, in that he did not pass the prescribing exam. As such, IVIT and prescribing were beyond the Registrant's knowledge, skills and judgment and he was specifically advised of this by correspondence (Ex 12) and through the posting on the public register (Ex 11) of limitations on his certificate of registration. The Registrant also prescribed and administered UV irradiation therapy to patients. This is not within the scope of practice of naturopathic doctors in Ontario and is therefore an act of misconduct under this paragraph. The Panel found that this act of misconduct was proven by the College.

Paragraph 9 of the Misconduct Regulation makes it an act of professional misconduct to fail 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 registrant knows or ought to know that the patient requires a service that the registrant does not have the knowledge, skill or judgment to offer or is beyond his or her scope of practice.

Although some patients in Ontario consider their naturopathic doctor to be their primary care doctor, ND's do not always have the scope of practice to provide all of the care and treatment a patient requires or to keep a patient safe. Where a patient requires treatment that is beyond a registrant's scope of practice, the registrant is required to advise a patient or the patient's authorized representative to consult another health professional. The Registrant failed to do so on several occasions.

The Registrant provided Patient 1 and Patient 2 with vaccine exemption letters (Ex 39 and 40), despite the Ministry of Health and Long Term Care Notice re: COVID medical exemption letters from health professionals (Ex 18), which clearly states only members of the CPSO and Nurse Practitioners are allowed to write COVID vaccination exemptions. Additionally, the interim order imposed upon the Registrant explicitly informed him that he could not engage in such discussions or write such letters. It was the Registrant's duty to refer those patients to a health care professional whose scope of practice included vaccinations. By failing to do so, the Registrant engaged in this act of professional misconduct. Further, the Panel found as a fact that the Registrant knew that he was not authorized to administer IVIT, provide cancer treatment, or provide ultraviolet blood irradiation therapy, and that such services could not be performed at his clinic, because of communications from the College. Accordingly, the Registrant was required to advise the patients or their representative that if they wished to obtain these services they ought to consult with another regulated health professional. However, the Registrant failed to make the necessary referrals, and provided these services himself, thereby engaging in professional misconduct.

Paragraph 10 of the Misconduct Regulation makes it an act of professional misconduct to perform a controlled act that the member is not authorized to perform.

As outlined above, the Registrant was not authorized to perform the controlled acts of administration of a substance by injection or by intravenous injection and prescribing, dispensing and compounding a drug, because the Registrant did not obtain the necessary qualifications for authorization (i.e., successful completion of coursework and an exam). The Registrant did not achieve the prerequisites required to prescribe, compound and/or administer IV infusion therapy, and was informed that he was not permitted to perform these acts.

The evidence established that the Registrant provided IVIT to many patients, including patient ML between November 24, 2020 and December 8, 2020, and IV administration to patients including patient GB throughout the period 2016 to 2020.

By performing these controlled acts not in accordance with the General Regulation or the standards of practice, the Registrant engaged in an unauthorized performance and an act of professional misconduct under this paragraph.

Paragraph 24 of the Misconduct Regulation makes it an act of professional misconduct to sign or issue, in his professional capacity, a document that the registrant knows or ought to know contains a false or misleading statement.

The College alleged that the Registrant signed or issued COVID exemptions for Patient 1 and Patient 2 (Ex 39 and 40) in his professional capacity, and that he knew or ought to have known that these letters contained a false or misleading statement.

The Panel found that the College proved this allegation. The Registrant, by signing and issuing COVID vaccine exemption letters, asserted that vaccines were within his scope of practice. The Registrant knew, based on the Vaccination Policy (Ex 17) and communications from the College (Ex15) and Ministry of Health (Ex 18), that only members of the CPSO and Nurse Practitioners are permitted to administer and prescribe vaccinations and therefore able to write COVID vaccination exemptions. Further, the letter he wrote for Patient 1 dated October 19, 2021 (Ex 39) contained an additional false or misleading statement: it stated that based on the Registrant's assessment and the patient's cardiac condition and adverse reactions, it was not recommended that the receive a COVID vaccine. Patient 1's chart (Ex 47) did not indicate that they had a history of adverse reactions to standard immunizations or include any reference to heart issues other than a past incident of murmurs/palpitations and a non-specific family history of "cardiovascular."

Paragraph 27 of the Misconduct Regulation makes it an act of professional misconduct to permit the advertising of the registrant or his practice in a manner that is false or misleading or that includes statements that are not factual and verifiable.

The College established that the Registrant advertised in a manner that was false or misleading and that included statements that were not factual, in that:

a) the Registrant advertised on his website and LinkedIn profile, "cancer treatment" (Ex 27);

b) the Registrant offered "Stable management of the disease is achievable during early stages of cancer" and advertised that cancer was a "special area of expertise" (Ex 35);
c) the Registrant offered "expertise in alternative cancer care", and "options for treatment if they or someone they care about is dealing with cancer….." (Ex 36);
d) the Clinic website indicated that IVIT could be performed at the Clinic; and
e) the Clinic website indicated that ultraviolet blood irradiation therapy could be performed at the Clinic.

Naturopathic doctors do not have the knowledge, skill and judgment to treat cancer. Only oncologists – recognized specialists in this field – can make the above statements. As such, these were all false or misleading statements because none of these treatments could be provided at the Clinic or by the Registrant, and advertising in this manner constituted professional misconduct.

Finally, the Panel accepted that it is not permitted for registrants to have an area of expertise, so the advertisement that the Registrant had an area of expertise was misleading and not factual or verifiable.

Paragraph 36 of the Misconduct Regulation makes it an act of professional misconduct to contravene, by act or omission, a provision of the *Naturopathy Act, 2007*, the *Regulated Health Professions Act, 1991* or the regulations under either of those Acts.

Paragraph 36.1 of the Misconduct Regulation makes it an act of professional misconduct to fail, by act or omission, to comply with any duty or requirement under Part IV (Inspection of Premises Where Certain Procedures are Performed) of Ontario Regulation 168/15 (General) made under the Act.

The Panel found that the College proved that the Registrant engaged in both of these acts of professional misconduct. The Registrant provided IVIT from his Clinic to multiple patients, including ML (Exhibit 4). As explained in the evidence of Mr. Quesnelle and Dr. Mary-Ellen McKenna, ND (Inactive) and outlined on the College's website (Ex 38), the College has an - Inspection program for IVIT, and requires that all premises in which IVIT is performed must comply with completing an "inspection of premises". There was no evidence that the Registrant's clinic went through such an inspection and Dr. Mary Ellen McKenna ND (Inactive) confirmed that no inspection had ever been completed at Mr. Dodd's clinic, the NaturalPath. In this regard, the Registrant contravened Part IV of the General Regulation, which prohibits a registrant from using any premises for the purpose of performing a procedure unless they have previously given notice in writing to the College of their intention to do so and the premises pass an inspection. The Registrant never registered his premises, yet administered IVIT at his clinic, thereby engaging in an act of professional misconduct.

The Registrant's public register profile (Ex 11) states that the Registrant was not permitted to provide IVIT after January 1, 2016.

The Panel further found that the Registrant engaged in misconduct by contravening the *Naturopathy Act,* section 4(2) of which prohibits a registrant from performing a controlled act unless they do so in accordance with the regulations. The Panel found that the Registrant did not comply with subsections 5(1), 8(1), 9(1), 10(1), 11(1) and 31(1) of the General Regulation, as outlined in the College's submissions.

Finally, the Panel found, based on the evidence of Mr. Bardel and Exhibits 22 – 24, 32 – 34 and 46, that the Registrant failed to cooperate with the College's investigators in a number of respects, in that the Registrant:

a) failed to respond to numerous requests of Mr. Bardel;
b) failed to co-operate with numerous inquiries of Mr Bardel and Ms. MacDonald;
c) failed to attend an interview on July 29, 2021 with Mr. Bardel despite being served with a summons;
d) sent the College a "Notice of Objection Writ Quo Warranto" on July 26, 2021 in response to being served with the summons; and
e) failed to produce the patient records of Patient 1 and Patient 2 despite being served with a summons and necessitating the investigator obtaining a search warrant in order to obtain the patient records of Patient 1 and Patient 2.

Subsection 76(3.1) of the Health Professions Procedural Code requires that a registrant cooperate fully with College investigators, and subsection 76(3) states that "no person shall obstruct an investigator or withhold or conceal from him or her or destroy anything that is relevant to the investigation." The foregoing established that the Registrant did not cooperate fully with the College investigators, in contravention of the Code. The Panel therefore found that the Registrant engaged in this act of professional misconduct pursuant to paragraph 38.

Paragraph 37 of the Misconduct Regulation makes it an act of professional misconduct to contravene, by act or omission, a law if,

i. the purpose of the law is to protect or promote public health, or
ii. the contravention is relevant to the member's suitability to practice.

The Panel found that the College proved that the Registrant contravened Ontario's Emergency Order (Ex 13), issued in March 2020 during the state of emergency in Ontario, which mandated that health professionals only provide essential services. The requirements of the Emergency Order were communicated to registrants of the College by email dated March 24, 2020 (Ex 14) and by posting on the College website.

Despite this, the Registrant proceeded to provide non-essential services to his patients. Exhibits 4 and 5 include references to the Registrant's provision of treatment to patients KA on March 24, 2020, OP on April 8 and 22, and May 6 and 20, 2020, and FK on April 2, April 25 and May 21, 2020. The Panel also found that the Government advised by letter dated September 14, 2021 that COVID-19 exemption letters could only be signed by nurse practitioners or physicians (Ex 18), and that the Registrant contravened this requirement, by writing COVID vaccination exemption letters he was not authorized to write for Patient 1 and Patient 2 (Ex 39 and 40).

The Panel accepted the College's submission that the purpose of the Emergency Order, which had the force of law, was to protect or promote public health, and that this was relevant to the Registrant's suitability to practise.

The Panel also found, as outlined above, that the Registrant contravened provisions of the *Naturopathy Act, 2007* and the *Regulated Health Professions Act, 1991* with regard to the performance of controlled acts. The purpose of these laws was to protect or promote public health, and the Registrant's contravention of these laws is relevant to his suitability to practice. As such, the contravention of the *Naturopathy Act* and the RHPA constitutes professional misconduct under paragraph 37.

Paragraph 38 of the Misconduct Regulation makes it an act of professional misconduct to contravene, by act or omission, a term, condition or limitation on the member's certificate of registration.

Paragraph 41 of the Misconduct Regulation makes it an act of professional misconduct to fail to comply with an order of a panel of the College.

The College established that the Registrant engaged in these acts of professional misconduct by contravening a term, condition or limitation on his certificate of registration as well as contravening an order of a panel of the College imposing such terms, conditions or limitations.

On or about December 15, 2020 the ICRC issued its Decision and Reasons including an interim order which included terms, conditions and limitations that the Registrant: not perform, delegate or accept delegation of the controlled acts of administering a substance by injection and/or compounding a substance for the purpose of administration by IVIT and/or injection; not administer vaccinations and/or ultraviolet blood irradiation treatments; and not advertise any of the foregoing. The interim order also required the Registrant to post a sign, acceptable to the College, a) in a prominent and visible location in the waiting room and each of the examination/treatment rooms of the Registrant's place(s) of practice, and b) on the Registrant's professional websites stating that the Registrant is not authorized to perform, delegate or accept delegation for the controlled acts referred to above and that the College has issued terms, conditions and limitations to this effect. The interim order included a further term, condition and limitation that the Registrant ensure that every patient he treats or offers to treat, signs a form, acceptable to the College, confirming they are aware that the Registrant is not authorized to perform, delegate or accept delegation of the controlled acts of administering a substance by injection and/or compounding a substance for the purpose of administration by IVIT and/or injection or to administer vaccinations and/or ultraviolet blood irradiation treatments (Ex25).

The evidence established that the Registrant continued to prescribe IV infusion therapy at his clinic after December 15, 2020 including to patient PB, whose patient record indicates that they received a prescription of 5X IV drip on December 17, 2020 (Ex 44). The Registrant also contravened the term, condition or limitation requiring him to have all patients to whom he

offers or provides treatment sign a form stating they are aware of the terms, conditions and limitations on the Registrant's certificate of registration, as the evidence of Valerie Henderson was that on December 22, 2020 none of the Registrant's patient records contained such a form. Additionally, Ms. Henderson testified that the Registrant did not have the required signs posted.

The evidence of Lauren Devriese was that she attended the Registrant's clinic on January 17, 2021 and observed that the Registrant had posted the required sign at the Clinic but not on his professional website, and that he did not obtain a signed form from any patient, in contravention of the terms, conditions and limitations on the Registrant's certificate of registration.

Finally, despite the term, condition and limitation to refrain from advertising or administering vaccinations, Mr. Dodd wrote two letters setting out his professional opinion as to why Patient 1 and Patient 2 should be exempted from the COVID-19 vaccination. The Panel's determination is that this contravenes the term imposed on Mr. Dodd's certificate of registration.

Paragraph 44 of the Misconduct Regulation makes it an act of professional misconduct to fail to reply appropriately and within 30 days to a written inquiry or request from the College.

It is the professional responsibility of all registrants to comply with written inquiries or requests from the College. However, when the College requested on April 26, 2021 that the Registrant provide his lawyer's first name and relevant contact information (as there was concern that the Registrant's lawyer was not licensed to practise in Ontario) (Ex 24), the Registrant never provided the requested information to the College. Additionally, when the College served the Registrant with Registrar's Reports on June 8 and July 30 (Ex 28, 29 and 30) and asked him to provide his response, the Registrant advised that he required proof of the authority of the College before he would provide any response (Ex 32), and never provided a response to the Registrar Reports. The Registrant thereby engaged in this act of professional misconduct.

Paragraph 46 of the Misconduct Regulation makes it an act of professional misconduct to engage in conduct or perform an act relevant to the practice of the profession that, having regard to all the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional.

The Panel found that the Registrant engaged in myriad conduct that members of the profession would reasonably regard as disgraceful, dishonourable and unprofessional. This includes: the Registrant's contravention of laws and regulations; his performance of controlled acts when he was specifically advised that he was not authorized to do so; his failure to comply with orders of the College; his conduct towards the investigators and the investigation (including failing to respond to letters from the College; his proposal to "conditionally accept" the College's demand that he cease and desist from performing controlled acts he was not authorized to perform including IVIT and UV irradiation; and his continued performance of IVIT (including on December 17, 2020, as documented in Exhibit 44) after the ICRC made an interim order on December 15, 2020 (Ex 25) that he not provide IVIT. Conduct that was particularly egregious was the Registrant's response to communications from the College. In response to a request by Mr.

Bardel to schedule an interview with him (Ex 24) after the Registrant repeatedly refused to do so, the Registrant sent the College a document entitled Notice of Objection - Writ of Quo Warranto (Ex 32) purporting to require the College to prove its jurisdiction to proceed with its investigation, when the College previously provided the Registrant with information regarding the regulatory framework through which the College has authority to investigate misconduct (Ex 24).

Subsequently, the Registrant refused to produce patient records and even sent investigator Lindsay Macdonald a demand to cease and desist her investigation (Ex 34). The result of this conduct was that Ms. MacDonald needed to obtain a search warrant (Ex 46) to gain access to the Registrant's premises and patient records.

All of the above would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional.

Paragraph 47 of the Misconduct Regulation makes it an act of professional misconduct to engage in conduct that would reasonably be regarded by members as conduct unbecoming a member of the profession.

This paragraph relates to conduct unbecoming a registrant of the College and is generally reserved for conduct that is outside of the registrant's professional role or duties. The Panel found that this allegation was not established because all of the objectionable conduct is conduct that members would reasonably regard as disgraceful, dishonourable or unprofessional, as described above.

Finally, the College alleges that the Registrant, by engaging in misconduct alleged, also committed professional misconduct pursuant to subsection 4(3) of the *Naturopathy Act, 2007.*

Subsection 4(1) sets out the authorized acts for naturopaths:

4 (1) In the course of engaging in the practice of naturopathy, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to perform the following controlled acts:

- Administering, by injection or inhalation, a prescribed substance.
- Communicating a naturopathic diagnosis identifying, as the cause of an individual's symptoms, a disease, disorder or dysfunction that may be identified through an assessment that uses naturopathic techniques.
- Taking blood samples from veins or by skin pricking for the purpose of prescribed naturopathic examinations on the samples.
- Prescribing, dispensing, compounding or selling a drug designated in the regulations.

Subsection 4(2) limits the performance of these acts to what is set out in the regulations:

> (2) A member shall not perform a procedure under the authority of subsection (1) unless the member performs the procedure in accordance with the regulations.

Subsection 4(3) adds to the misconduct regulation:

> (3) In addition to the grounds set out in subsection 51 (1) of the Health Professions Procedural Code, a panel of the Discipline Committee shall find that a member has committed an act of professional misconduct if the member contravenes subsection (2).

As noted above, the Panel found that the College proved that the Registrant contravened subsection 4(2) of the *Naturopathy Act* by performing IVIT, administering a substance by injection, prescribing, dispensing and compounding a substance contrary to the Standards of Practice and to the requirements of the General Regulation (which include, for example, the successful completion of coursework and an exam). The College also established that the Registrant took blood samples other than for a prescribed purpose. The Registrant therefore committed professional misconduct on this basis as well.

PENALTY AND COSTS

Having found that the Registrant engaged in the acts of professional misconduct outlined above, the Panel proceeded to the penalty phase of the hearing.

POSITION OF THE COLLEGE ON PENALTY AND COSTS

The College submitted that, in view of the Panel of the Discipline Committee's findings of professional misconduct against the Registrant, the Panel should make an Order:

1. Directing the Chief Executive Officer to revoke the Registrant's Certificate of Registration immediately following the hearing; and
2. Requiring the Registrant to pay the College's costs fixed in the amount of $77,283.04, payable within 30 days of the hearing.

The College submitted that revocation was the only appropriate order in this matter given the Registrant's total unwillingness to be governed by the College. The proposed order was necessary in the circumstances, and it was important to accomplish the sentencing principles, to ensure that this Registrant learned that such conduct will not be tolerated but also to send a message to other registrants that a failure to engage with one's regulator and comply with the authority of that regulator will result in the most serious of sanctions. The College submitted that the proposed penalty would achieve the requirement for public protection as well as ensure that the public will have confidence in the ability of the College to regulate its members.

The College provided the Panel with a number of cases where discipline panels had considered similar conduct and where panels had considered the ungovernability of registrants.[1] In

[1] *College of Massage Therapists of Ontario (CMTO) v Demore*, 2022 ONCMTO 7, *College of Opticians v Truong*, 2021; *CMTO v Miller*, 2020 ONCMTO 3 (CanLII); *CMTO v Schneider*, 2020 ONCMTO 28 (CanLII); *Ontario (College of*

particular, the case of *CMTO v Schneider* involved a registrant who, like the Registrant, engaged in serious misconduct, refused to participate in an investigation and discipline hearing, and failed to comply with previous decisions of the ICRC. The panel in that case found the registrant to be ungovernable and ordered revocation of their certificate of registration, on the basis of the factors from previous cases, including:

a) a consistent and repetitive failure to respond to the governing body;
b) an element of neglect of duties and obligations to the governing body;
c) an element of misleading behaviour directed to a client and or the governing body; and
d) a failure or refusal to attend at the discipline hearing.

The College submitted evidence as to the costs incurred in investigating and prosecuting the Registrant, through an Affidavit on Costs, filed as Exhibit 49. The College submitted that the order for reimbursement of the College's costs fixed in the amount of $77,283.04 payable within 30 days of the hearing, was appropriate in the circumstances.

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 discipline committees of health colleges involving similar conduct.

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.

There were no mitigating factors to consider in this matter.

The most important aggravating factor was that the Registrant had proven himself to be ungovernable. The Panel found that the Registrant demonstrated no respect for the standards of practice of the profession or the regulatory requirements for performing controlled acts. When a panel of the ICRC imposed an interim order in an attempt to prevent further contraventions of the *Naturopathy Act* and its regulations, the Registrant did not comply. He showed consistent disrespect towards the rules and regulations governing registrants, and showed contempt for the regulator, refusing to recognize the College's authority.

The Panel accepted that there was no other option but to revoke the Registrant's certificate of registration, as he has demonstrated that he is unwilling to engage with the legislation, the regulations and the standards of practice, or to respect the authority of the governing body of a self-regulated profession and to be held accountable.

Physicians and Surgeons of Ontario) v. Mitchell, 2018 ONCPSD 63 (CanLII); *College of Nurses of Ontario v Szabo*, 2015 CanLII 65597 (ON CNO)

The Panel also found that the costs award sought by the College was appropriate. Section 53.1 of the Code grants authority to the Panel to award costs to compensate the College for the costs of the investigation and hearing of the Registrant's misconduct. The investigation costs exceeded $25,000, because of the Registrant's conduct towards the College and investigators. The College incurred legal costs associated with the prosecution of this matter which exceeded $68,000. This was in part due to the fact that the Registrant initially agreed to resign his certificate of registration and to an Agreed Statement of Facts. He then did not agree to certain provisions of that agreement, and indicated a desire to proceed to a hearing. The College advised the Registrant that if the matter proceeded to a contested hearing, it would seek payment of two-thirds of the actual costs incurred. The cost of the hearing itself was $22,874.75. The College's evidence was that the actual costs associated with the investigation, prosecution and hearing of this matter exceeded $117,095.53. The Panel agreed that two-thirds of the actual costs incurred was appropriately borne by the Registrant, and accordingly ordered that he pay $77,283.04.

ORDER

The Panel stated its findings in its written order of February 14, 2023 (the "Order"), in which the Panel directed as follows on the matter of penalty and costs:

1. Directing the Chief Executive Officer to revoke the Registrant's Certificate of Registration immediately following the hearing.
2. Requiring the Registrant shall pay the College's costs fixed in the amount of $77,283.04, payable within 30 days of the hearing.

Dated in Ontario on May 2, 2023

DISCIPLINE PANEL

Dr. Tara Gignac, ND, professional member, Chair
Dr. Jacob Scheer, ND, professional member
Lisa Fenton, public member
Paul Philion, public member
Samuel Laldin, public representative

Signed: _____
Dr. Tara Gignac, ND, Chair