DISCIPLINE COMMITTEE
OF THE COLLEGE OF NATUROPATHS OF ONTARIO

PANEL:	Danielle O'Connor , Chair Dianne Delany, public member R. Gail Goodman, public member	
		Jenna McNamee
BETWEEN:		
COLLEGE OF NATUROPATHS OF ONTARIO	)	BONNI ELLIS for the College of Naturopaths of Ontario
- and -	)	
	)	MICHAEL MANDARINO for ROBERT ALLAN PRICE
ROBERT ALLAN PRICE Reg. No. 0934	)	
	)	LUISA RITACCA Independent Legal Counsel
	)	Heard: December 14, 2016

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee on December 14, 2016 at the College of Naturopaths of Ontario ("the College") at Toronto.

Publication Ban

At the outset of the hearing, the College sought an order for a partial publication and broadcasting ban prohibiting the publication or disclosure of the name of the patient referred to during the hearing or in documents filed at the hearing, or any information that would disclose the identity of the patient.

The Member did not oppose the request. The panel agreed that a partial publication and broadcasting ban was appropriate in the circumstances and made the order accordingly.

This Decision and Reasons is subject to the publication ban order which continues to remain in force.

The Allegations

The allegations against Robert Allan Price (the "Member") as stated in the Notice of Hearing dated May 10, 2016 are as follows:

1. You have committed an act or acts of misconduct as provided by subsection 30(1) of Ontario Regulation 278, R.R.O. 1990, as amended, and as defined in paragraph 2(w) of the definition of Professional Misconduct/Incompetence established by the Board of Directors of Drugless Therapy-Naturopathy in that, you contravened standards of practice or guidelines of practice set by the Board of Directors of Drugless Therapy-Naturopathy, and, in particular:

    a. in or about April 2013, you recommended that M.L. commence the HCG diet program and knew or ought to have known that M.L. followed that recommendation without having first (i) consulted with a physician, (ii) obtained the necessary blood work, (iii) obtained a prescription for HCG from a physician and/or (iv) received sufficient information from you regarding the relevant potential risks and/or side effects;

    b. [withdrawn]

    c. on or about May 6 and/or May 7, 2013, you failed to provide an appropriate assessment, care and/or treatment to M.L. when she presented to your office with jaundice and/or other symptoms;

    d. on or about May 7, 8 or 9, 2013, you recommended to M.L. that she undergo UVB treatments to address her symptoms, including jaundice, without knowing the underlying cause of those symptoms; and/or

    e. [withdrawn]

2. You have committed an act or acts of misconduct as provided by subsection 30(1) of Ontario Regulation 278, R.R.O. 1990, as amended, and as defined in paragraph 2(d) of the definition of Professional Misconduct/Incompetence established by the Board of Directors of Drugless Therapy-Naturopathy in that, on or about May 6 and/or May 7, 2013, you failed to refer M.L. to an appropriate healthcare practitioner when indicated.

3. You have committed an act or acts of misconduct as provided by subsection 30(1) of Ontario Regulation 278, R.R.O. 1990, as amended, and as defined in paragraph 2(u) of the definition of Professional Misconduct/Incompetence established by the Board of Directors of Drugless Therapy-Naturopathy in that, in or around April 2013, you failed to obtain informed consent from M.L. with respect to the HCG diet program before allowing her to start that program.

4. You have committed an act or acts of misconduct as provided by subsection 30(1) of Ontario Regulation 278, R.R.O. 1990, as amended, and as defined in paragraph 2(i) of the definition of Professional Misconduct/Incompetence established by the Board of Directors of Drugless Therapy-Naturopathy, in particular:

a. in or around April 2013 you issued or allowed to be issued to M.L. an account or accounts that were false, misleading or otherwise improper, including but not limited to invoices #4101, 4102, 4106 and/or 4107, which identified naturopathic services, products and/or treatments that had already been billed and/or that were never provided; and/or

b. [withdrawn]

5. You have committed an act of misconduct as provided by subsection 30(1) of Ontario Regulation 278, R.R.O. 1990, as amended, and as defined in paragraph 2(r) of the definition of Professional Misconduct/Incompetence established by the Board of Directors of Drugless Therapy-Naturopathy ("the Board") in that, you committed conduct or an act relevant to the practice of naturopathic medicine that, having regard to all the circumstances, would reasonably be regarded by naturopathic doctors as unprofessional or incompetent and, in particular:

a. in or about April 2013, you recommended that M.L. commence the HCG diet program and knew or ought to have known that M.L. followed that recommendation without having first (i) consulted with a physician, (ii) obtained the necessary blood work, (iii) obtained a prescription for HCG from a physician and/or (iv) received sufficient information from you regarding the relevant potential risks and/or side effects;

b. [withdrawn];

c. on or about May 6 and/or May 7, 2013, you failed to provide an appropriate assessment, care and/or treatment to M.L. when she presented to your office with jaundice and/or other symptoms;

d. on or about May 7, 8 or 9, 2013, you recommended to M.L. that she undergo UVB treatments to address her symptoms, including jaundice, without knowing the underlying cause of those symptoms;

e. [withdrawn]

f. in or about April 2013 you knew or ought to have known that M.L. intended to submit to her insurance company for reimbursement the false invoices that you issued or allowed to be issued, including but not limited to invoices #4101, 4102, 4106 and/or 4107, which identified naturopathic services, products and/or treatments that had already been billed and/or that were never provided, and/or

g. [withdrawn]

Member's Plea

Robert Allan Price admitted the allegations set out in paragraphs numbered 1.a, c, d, 2, 3, 4.a, 5.a, c, d, and f in the Notice of Hearing.

The panel conducted an oral plea inquiry and was satisfied that the Member's admission was voluntary, informed and unequivocal.

The parties sought leave to withdraw the allegations at paragraphs 1. b, e, 4. b, 5. b, e and g. The panel granted the request.

Agreed Statement of Facts (Exhibit #2)

BACKGROUND

The Member

1. Dr. Robert Allan Price, ND ("the Member") registered as a naturopathic doctor with the Board of Directors of Drugless Therapy - Naturopathy ("the Board") in 2000, after graduating from the Canadian College of Naturopathic Medicine earlier that same year. Prior to that, the Member obtained a Bachelor of Science in Life Science from McMaster University in 1995 and studied Nutritional Biochemistry at Laurentian University.

2. In 2011, the Member opened Pure Wellness Group ("the Clinic") in Sudbury, Ontario, a multi-disciplinary naturopathic clinic. The Member continues to practice naturopathy at the Clinic, which is where the conduct at issue in this matter took place.

3. The Member, who practises under the name Allan Price, was registered with the Board or the College of Naturopaths of Ontario ("the College") at all relevant times.

4. As per Section 13(4) of the Naturopathy Act, 2007, S.O. 2007, c. 10, Sched. P, as amended ("the Naturopathy Act'), an investigation or proceedings respecting an allegation of misconduct or incompetence commenced under the Drugless Practitioners Act, R.S.O. 1990, c. D. 18 and its regulations by the Board shall be taken up and continued under the Naturopathy Act. As such the Inquiries, Complaints and Reports Committee of the College continued the investigation and referred the matter on December 3, 2015.

The Complaint/Initiating Information

5. On August 23, 2013, the Board received a complaint from M.L., a member of the public, regarding the care she had received from the Member between April 3 and May 7, 2013. Specifically, M.L. expressed concern with the weight loss program the Member recommended to her and how the Member dealt with her subsequent symptoms of jaundice.

M.L.'s Appointments with the Member

(i) The Initial Appointment on April 3, 2013

6. M.L. initially attended the Member's practice at the Clinic on April 3, 2013 seeking bio identical hormone therapy to address her menopause. According to M.L., she and the Member agreed that he would also treat her for a damaged esophagus, lower back pain and weight loss.

7. With respect to the latter concern, M.L. advised the Board that the Member recommended the HCG (human chorionic gonadotrop) weight loss program to her during that first appointment on April 3, 2013. The Member explained to M.L. that the program involved daily injections of the hormone HCG into her stomach or thigh, together with a restricted diet of 500 calories per day. The Member further explained that the diet would last for four to eight weeks, during which time she would record her weight at home, daily, and attend the Clinic for weekly weigh-ins. The Member, according to M.L., did not advise her of any side-effects or contra-indications of the HCG program. According to M.L., the Member was also present when the front desk staff provided her with a package of pre-filled HCG syringes.

8. The Member also recommended to M.L. that she undergo a female saliva hormone panel test, which she agreed to, and suggested that she commence taking Pure Adrenal Support, Pure Restart, Pure Clear, Gastromycin, Flora Syntropy and R59 and Drainage Tox, all of which she purchased from the front desk at the Clinic on April 3, 2013 (except for the R59, which she purchased form a health food store), together with a 20-day HCG diet program.

9. According to the Member, M.L.'s April 3, 2013 visit lasted approximately 60-90 minutes. During this time, the Member conducted a physical examination, recorded M.L.'s weight, took her temperature, heart rate and blood pressure and checked her reflexes. The Member agrees that he also discussed the HCG diet with M.L. during this visit, but would testify that he understood their discussion around the HCG program was framed as a future consideration.

10. If the Member were to testify, he would also say that patients to whom he recommends HCG are subject to a protocol before they start the program. Specifically, the Member normally ensures that patients:

- are provided with information, through discussion, regarding various weight loss options;

- receive a HCG manual; and

- attend a pre-screening visit so that objective and subjective data can be collected including, a comprehensive metabolic panel, a thyroid panel and a salivary hormone panel.

11. Patients are also normally required to have the necessary blood work and a discussion with their family physician to confirm that they are a suitable candidate for the HCG program. Once these steps have been completed, the HCG is prescribed by a physician, following which, Clinic staff provide the patient with pre-filled syringes and show the patient how to self-administer the drug by injection.

12. According to the Member, he did not discuss with M.L. the potential benefits, risks and side-effects of the HCG program at her April 3, 2013 appointment because the pre-requisites, described above, had not yet been met.

13. If the Member were to testify, the Member would also say that he was unaware the pre-filled syringes were inadvertently provided to M.L. by his staff on April 3, 2013 and that the Clinic has since implemented procedures and safeguards to ensure this does not occur in the future.

(ii) The April 8, 15 and 23, 2013 Appointments

14. M.L. next attended the Clinic on April 8 and 15, 2013. On both of these days she "weighed in" and, according to M.L., met with the Member for a brief consult. If the Member were to testify, he would say that M.L. met with his Clinical Staff, and the weigh-ins were performed by the Clinical Assistant.

15. M.L.'s second full visit with the Member occurred on April 23rd, when she reported to him that she felt better, having lost weight in the 20 days since her first visit.

16. According to the Member he was unaware that M.L. had attended the Clinic for a weekly "weigh-in" between April 8 and 23, 2013 and did not see M.L. when she attended the Clinic on April 8 and 15, 2013.

17. With respect to M.L.'s April 23, 2013 visit, the Member states that they discussed life changes and anti-aging strategies like bioidentical hormone therapy (BHT). According to the Member, he discussed with M.L. the pros, cons and side-effects of this therapy and suggested books for her to read. He also sent a prescription recommendation for M.L. to receive BHT to a physician so that the physician could "sign off" on the prescription, as NDs are not able to prescribe (BHT).

18. M.L.'s health record includes a weekly weigh-in sheet for her attendances on April 3, 8, 15 and 23, 2013 as well as a daily weight log, which she recorded at home and then brought to the Clinic. There is no other documentation in the Member's clinical record for M.L. relating to the April 8 and 15, 2013 appointments. The Member's clinical record for M.L.'s April 23, 2013 visit lists the HCG program under the heading of "Consider/Provide info brochure" The

Member's clinical record for April 23 also includes the following notation "↓ 18 lbs → ↓ 20 lbs!!".

19. According to the Member, he only became aware that M.L. had started the HCG program due to the rapid weight loss noted in the April 23, 2013 appointment. However, the Member admits that he should have been aware that M.L. had started the HCG program before (i) she had consulted with a physician, (ii) he obtained the necessary blood work, (iii) a prescription for HCG from a physician had been obtained and (iv) she received sufficient information from the Member regarding the relevant potential risks and/or side effects.

(iii) The May 6 and 7, 2013 Appointment

20. In early May, M.L. was advised by a colleague that she looked "yellow". M.L. did not think much of the comment, however, because she had recently been ill and had been lying out in the sun. When another colleague told her that her eyes were yellow on May 6, 2013, M.L. called the Clinic and was advised to come in to see the Member right away, which she did.

21. When M.L. attended the Clinic, the Member took a urine sample which showed that her that her bilirubin levels were quite high at +2. The Member did not perform or requisition any further tests that day. Instead, the Member engaged M.L. in a list of subjective symptom questioning and then advised M.L. to stop taking her medications and supplements (with the exception of Restart), consume only apple and pear juice, and return to the Clinic for another urine test the following day. The Member did not advise M.L. to attend the ER or to contact her family physician, which he now recognizes was what the standards of practice would require of an ND faced with M.L.'s presentation.

22. When M.L. attended the Clinic the following day, May 7, 2013, she provided another urine sample, which showed that her bilirubin levels remained elevated at +1. According to M.L., the Member told her to drink pear, apple and beet juice for three days and provided her with a requisition for blood work, which she had done at the hospital later that day. The Member also suggested to M.L. that she contact her physician to schedule an ultrasound. When M.L. attempted to contact her physician, she was told he was away until May 13, 2013. If M.L. were to testify she would say that she did not understand from her discussion with the Member that her symptoms warranted an immediate attendance with a physician.

23. If the Member were to testify he we would state that he advised M.L. during her May 7, 2013 attendance at this office to attend the Emergency Department or contact her physician to obtain an ultrasound. The Member would also state that he advised ML to go to the hospital to get the blood work done in the hope she would seek further medical attention. The Member, nevertheless, acknowledges that he did not stress to M.L. the importance of an immediate assessment by a physician as he was required to do pursuant to the standards of practice.

24. M.L. then received a call from the Member's receptionist at some point between May 7 and May 9, 2013. According to M.L., she was advised by the Member's receptionist during that call that the Member was recommending she undergo five UVB treatments, at a cost of $155 each, to address her jaundice. If the Member were to testify, he would state that the recommendation was intended to be for future treatment, as the Member could not have prescribed these treatments without a physician's approval.

25. M.L. did not follow that recommendation. Instead, she made the decision to attend the Emergency Department on May 9, 2013 because she was getting progressively more jaundiced and fatigued. If M.L. were to testify she would state that the Member did not advise her to attend the Emergency Department at any point during May 7, 2013 appointment.

26. If the Member were to testify he would acknowledge that M.L.'s symptoms and test results were significant and that he was unable to diagnose the underlying cause of her jaundice.

27. The Member would further acknowledge that, in hindsight, the treatments he recommended to M.L. on May 6 and 7, 2013 were inappropriate given her presentation, which warranted a referral to a physician and/or the Emergency Department so that the underlying cause of her jaundice could be diagnosed. Although the Member recalls having advised M.L. to report to the Emergency Department on May 7, 2013, he agrees that he failed to both impress upon M.L. the gravity of her symptoms and to advise her to attend her family physician and/or the Emergency Department without delay.

M.L.'s May 9, 2013 ER Attendance and Subsequent Care

28. M.L. attended the Emergency Department on May 9, 2013 due to worsening symptoms of jaundice. She was ultimately diagnosed with Vanishing Bile Duct Syndrome (VBDS) in early 2014, the cause of which was not clear. Due to the significance of her diagnosis, M.L. required weekly blood work to monitor her liver, a liver biopsy and an MRI. She also missed work and experienced significant stress as a result of these events.

The Invoices

29. The total cost of M.L.'s initial appointment was $1,894.62. This is reflected on invoice #3584, which is dated April 3, 2013 and attached as Exhibit "A", together with the rest of the invoices referred to below. Invoice #3584 includes a $300 charge for her first naturopathic visit, a charge of $845 for the HCG 20 Day Program, a $250 charge for a Female Hormone Saliva Panel (11 hormones) and $281.66 for various supplements, plus $217.96 in HST.

30. M.L. was quite concerned by this amount as her total budget for naturopathic treatments for the year was $2,000. According to M.L., she asked the Clinic staff whether this amount would be covered by her insurance and was told that it would. According to M.L. she was further advised that they could "change the format of the billing" in the event that the entire amount was not covered.

31. M.L. submitted invoice #3584 to her insurance company but was reimbursed only $522.50 on or around April 15, 2013. The reimbursement relates to her visit with the Member and her saliva panel. M.L. was not reimbursed for either the HCG program or the supplements.

32. The next invoice that M.L. received from the Clinic was in relation to her April 23, 2013 appointment. That invoice, #3970, purports to be for her appointment that day in the amount of $453.09. The charges include $200 for "second visit".

33. M.L. then received four invoices from the Clinic dated April 29, 2013. These invoices purported to relate to appointments M.L. had on April 3, 8, 15, 23, and 29, 2013. All of these invoices included a $200 or $245 charge for "naturopathic consultation", despite the fact that M.L. had already received invoices which included a consultation charge for her April 3 and 23, 2013 appointments and despite the fact the Member's clinic notes contain no records in relation to her visits on April 8 and 15, 2013 other than a chart recording her weight and measurements.

34. The invoices that M.L. received from the Clinic on April 29, 2013 for the April 3 and 8, 2013 visits are sequentially numbered at 4101 and 4102. The same observation applies to invoices 4106, 4107 and 4108, which state they relate to visits on April 15, 23 and 29, 2013.

35. The following table sets out the invoices that M.L. provided to the Board in relation to the products and services she received from the Member:

Inv #	Date of visit	Date of invoice	Invoice ttl	Amount reimbursed	Insurance stmnt date
3584	Apr 3/13	Apr 3/13	$1,894.62	$522.50	Apr 15/13
4101	Apr 3/13	Apr 29/13	$226.00	$180	May 13/13
4102	Apr 8/13	Apr 29/13	$226.00	$180	May 13/13
4106	Apr 15/13	Apr 29/13	$226.00	$180	May 13/13
3812	Apr 15/13	Sept 12/13	$35.93	N/A	N/A
4107	Apr 23/13	Apr 29/13	$276.85	$180	May 13/13
3970	Apr 23/13	Apr 23/13	$453.09	$0	May 13/13
4108	Apr 29/13	Apr 29/13	$77.97	$0	May 13/13

36. Based on the invoices and the Member's clinical records, the Clinic issued four invoices (#4101, #4102, #4106, and #4107) to M.L. totalling $954.85

(inclusive of HST), knowing that these would be submitted to her insurance company. The charges on invoices # 4101 and #4107 were for services that had already been billed. The charges on invoices #4102 # 4106 were for services that had never been provided. M.L. was reimbursed $720 by her insurance company in relation to these invoices.

37. The Member admits and acknowledges that he was ultimately responsible for the invoices issued to M.L. by the Clinic and that the four invoices in question were false and/or misleading, in that they identified naturopathic services that had already been billed and/or that were never provided. However, if the Member were to testify, he would state that he had asked his staff to re-issue the invoices in a manner that would reflect and separate the distinct components of the HCG program (e.g., initial consultation, injection demonstration, weigh-ins, syringes and product, etc.) to replace the bulk fee invoice that had been provided to M.L. on April 3, 2013. The Member would further state that he expected staff would provide him with the re-issued invoices for review before they were released to M.L., however, this did not happen.

THE BOARD'S STANDARDS, POLICIES AND GUIDELINES

38. The Member acknowledges and agrees that the following Board standards and guidelines were in place at the time of the conduct described above and reflect the standards expected of a naturopathic doctor at that time:

- Guide to Ethical Conduct of Naturopathic Doctors ("the Guide to Ethical Conduct"), which is attached as Appendix "B";
- Standards of Practice ("the Board Standards"), which is attached as Appendix "C"; and
- Standards of Practice and Performance Expectations for Consent ("the Consent Standard), which is attached as Appendix "D".

Appropriate Recommendations/Treatment/Referrals

39. The Board's Guide to Ethical Conduct identifies various duties that are owed by the naturopathic doctor to the patient, including, the requirement for naturopathic doctors to "recognize his/her professional limitations and when indicated recommend to the patient that additional options and/or services be obtained" (p. 2 of 3).

40. The requirements set out in the Board Standards are confirmed to be "the criteria that guide the day to day actions of naturopathic doctors in the delivery of care and service to the patient and the community. They also serve as the basis for the evaluation of behaviour of practitioners by disciplinary and judicial functions" (p. 2 of 5).

41. According to 2.3 of the basic standards of practice, each naturopathic doctor is required to "actively consult and/or refer as appropriate to other health professionals when the patient's condition so warrants" (p. 2 of 5).

42. Specifically, referrals are deemed warranted when, as here:

a) a life-threatening situation occurs or is suspected;

b) the diagnosis or the treatment of a patient or of a specific condition is not within the scope of naturopathic practice;

c) the diagnosis or treatment of a patient or a specific treatment requires expertise or technology that is not available to the naturopathic doctor;

d) a diagnosis is required but cannot be confirmed with the training and technology that is available to the naturopathic doctor (p. 2 of 5).

Billing

43. The Guide to Ethical Conduct also sets out various responsibilities owed by each member to the profession at large, including the requirement for naturopathic doctors to "recognize that the profession demands integrity and dedication from all its members" (p. 3 of 3).

44. Section 2.6 of the Board Standards sets out a similar requirement with the expectation that naturopathic doctors shall "deal honestly with all patients, colleagues, public institutions and legal bodies and refrain from giving any false, incomplete or misleading information" (p. 3 of 5).

Consent

45. Section 1.0 of the Consent Standard makes it clear that "consent is required for all interventions", subject to limited exceptions that would not apply here (p. 2 of 16).

46. Further, the Consent Standard requires that, in order for consent to be valid, it must (i) relate to the proposed intervention, (ii) be informed, (iii) be voluntary, and (iv) not be obtained through fear, misrepresentation or fraud (p. 2 of 16).

47. Section 2.0 of the Consent Standard clarifies that, in order for consent to be informed, "[p]atients need to understand and appreciate the reasonable foreseeable consequences of their decisions" and goes on to clarify the Member's responsibility to ensure that the patient understands the following:

- *the nature of the intervention,*
- *its expected benefits,*
- *the material risks and side effects,*
- *available reasonable alternatives, and*
- *the likely consequences of not receiving the intervention (p. 2 of 16).*

48. The Member acknowledges that he failed to obtain informed consent from M.L. when he failed to discuss with her the potential benefits, risks, side-effects and/or contra-indications of the HCG program before she started it.

THE MEMBER'S ADMISSIONS

49. The Member admits that he engaged in acts of misconduct as set out in paragraphs 1(a), (c), and (d) of the Notice of Hearing and, specifically, that he contravened standards of practice or guidelines of practice set by the Board of Directors of Drugless Therapy-Naturopathy when:

- in or about April 2013, he recommended to patient M.L. that she commence the HCG diet program in circumstances where he ought to have known that M.L. followed that recommendation without having first (i) consulted with a physician, (ii) obtained the necessary blood work, (iii) obtained a prescription for HCG from a physician and/or (iv) received sufficient information from the Member regarding the relevant potential risks and/or side effects;
- on or about May 6 and/or May 7, 2013, he failed to provide an appropriate assessment, care and/or treatment to patient M.L. when she presented to his office with jaundice; and
- on or about May 7, 8 or 9, 2013, he recommended to patient M.L. that she undergo UVB treatments to address her symptoms, including jaundice, without knowing the underlying cause of those symptoms.

50. The Member admits that he engaged in an act or acts of misconduct as set out in paragraph 2 of the Notice of Hearing and specifically, on or about May 6 and/or May 7, 2013, he failed to refer patient M.L. to an appropriate healthcare practitioner when indicated.

51. The Member admits that he engaged in an act or acts of misconduct as set out in paragraph 3 of the Notice of Hearing and specifically, in or around April 2013, he failed to obtain informed consent from patient M.L. with respect to the HCG diet program in circumstances where he ought to have known that she had started that program.

52. The Member admits that he engaged in an act or acts of misconduct as set out in paragraph 4(a) of the Notice of Hearing and specifically:

- in or around April 2013 he issued or allowed to be issued to patient M.L. invoices #4101, 4102, 4106 and/or 4107, which accounts were false and misleading because they identified naturopathic services, products and/or treatments that had already been billed and/or that were never provided.

53. The Member admits that he engaged in an act or acts of misconduct as set out in paragraphs 5 (a), (c), (d), and (f) of the Notice of Hearing and specifically, that he committed an act of misconduct as provided by subsection 30(1) of Ontario Regulation 278, R.R.O. 1990, as amended, and as defined in paragraph 2(r) of the

definition of Professional Misconduct/Incompetence established by the Board of Directors of Drugless Therapy-Naturopathy ("the Board") in that, he committed conduct or an act relevant to the practice of naturopathic medicine that, having regard to all the circumstances, would reasonably be regarded by naturopathic doctors as unprofessional and, in particular:

- in or about April 2013, he recommended that M.L. commence the HCG diet program and knew or ought to have known that M.L. followed that recommendation without having first (i) consulted with a physician, (ii) obtained the necessary blood work, (iii) obtained a prescription for HCG from a physician and/or (iv) received sufficient information from him regarding the relevant potential risks and/or side effects;

- on or about May 6 and/or May 7, 2013, he failed to provide an appropriate assessment, care and/or treatment to M.L. when she presented to his office with jaundice and/or other symptoms;

- on or about May 7, 8 or 9, 2013, he recommended to M.L. that she undergo UVB treatments to address her symptoms, including jaundice, without knowing the underlying cause of those symptoms; and

- in or about April 2013 he knew or ought to have known that M.L. intended to submit to her insurance company for reimbursement invoices #4101, 4102, 4106 and 4107, which were false and misleading because they identified naturopathic services and/or treatments that had already been billed and/or that were never provided.

Decision

The panel considered the Agreed Statement of Facts and finds that the facts support a finding of professional misconduct and, in particular, finds that the Member committed acts of professional misconduct as alleged in paragraphs numbered 1.a, c, d, 2, 3, 4.a, 5.a, c, d and f of the Notice of Hearing.

Reasons for Decision

The panel considered the Agreed Statement of Facts and the Member's plea and finds that the facts of this case support findings of professional misconduct as alleged in the Notice of Hearing. The facts in this case support the allegations that Dr. Price is guilty of professional misconduct under a number of headings. In particular he:

- recommended that a patient commence a HCG diet program without having first consulted with a physician, obtained the necessary blood work, obtained a prescription

for HCG from a physician and/or received sufficient information from him regarding the relevant potential risks and/or side effects;

- failed to provide an appropriate assessment, care and/or treatment to a patient when she presented to his office with jaundice and/or other symptoms;
- failed to refer the patient to an appropriate healthcare practitioner when indicated;
- recommended to the patient that she undergo UVB treatments to address her symptoms, including jaundice, without knowing the underlying cause of those symptoms;
- failed to obtain informed consent from a patient with respect to the HCG diet program before allowing her to start that program; and
- knew or ought to have know that the patient intended to submit to her insurance company for reimbursement invoices that were false, misleading or otherwise improper which identified naturopathic services, products and/or treatments that had already been billed and/or that were never provided.

Penalty

Counsel for the College advised the panel that a Joint Submission on Order and Costs had been agreed upon (Exhibit #3). The Joint Submission provides as follows:

> 1. Directing the Registrar to suspend the Member's Certificate of Registration for a period of five (5) months, with two (2) months of the suspension remitted on condition that the Member successfully completes the remedial components set out in paragraphs four (4) to eleven (11) of the Undertaking. The suspension shall be served as follows:
>
> - the first month of the suspension shall commence on December 14, 2016 and shall continue, uninterrupted, until 11:59 pm on January 13, 2016;
> - the second month of the suspension shall commence at 12:01 am on February 14 and shall continue, uninterrupted, until 11:59 pm on March 13, 2016;
> - the third month of the suspension shall commence at 12:01 am on April 14, 2016 and shall continue, uninterrupted, until 11:59 pm on May 13, 2016; and

- if the remaining two months of the suspension are required to be served by the Member because he fails to complete any of the remedial components of the Undertaking, as described above, that portion of the suspension shall commence at 12:01 am on December 15, 2017 and run, uninterrupted, until 11:59 pm on February 14, 2018.

2. Directing the Member to pay a portion of the College's costs, in the amount of $7,500, payable by cheque, money order or credit card using the College's on-line system, as follows:

- $1,500 on or before May 1, 2019;
- $1,500 on or before November 1, 2019;
- $1,500 on or before May 1, 2020;
- $1,500 on or before November 1, 2020; and
- $1,500 on or before May 1, 2021.

3. Clarity Note: The requirement for the Member to complete the remedial components set out in paragraphs four (4) to eleven (11) of the Undertaking, cannot be relieved by serving the remitted portion of the suspension referred to in paragraph 1, above.

Penalty Submissions

Submissions were made by the College Counsel and the Member's Counsel.

The parties agreed that the mitigating factors in this case were:

- The Agreed Statement of Facts outlines the Member's acts of misconduct, demonstrating his insight into his conduct;
- The Undertaking contains significant remedial activities to be completed at the Member's expense and indicates a willingness to remediate deficiencies in his practice, in particular, Dr. Price has put into place procedures with respect to staff, distribution of HCG and the preparation and issuing of invoices;
- The admissions made alleviates the College's obligation to prove the allegations and saves the College considerable resources which would have been expended if this matter went to a contested hearing; and,
- The Member has already participated in continuing education programs.

The proposed penalty and costs order provides for general deterrence through:

- The $7,500 reimbursement to the College, which, while not part of the "penalty, represents a significant burden for the Member; and

- The publication of the details of the case.

The proposed penalty provides for specific deterrence through:

- The publication of the Member's name and details of the case;
- The payment for and participation in meetings with the experts;
- The payment for and participation in an inspection; and,
- The oral reprimand which was delivered by the panel at the end of the oral hearing.

Finally, the parties' submitted that the public is protected because Dr. Price has admitted to his wrongdoings and has agreed to an appropriate and significant penalty which includes remedial and rehabilitative activities to ensure his behavior henceforth is appropriate and that he complies with all College standards, policies and guidelines. Publication of the outcome of this hearing will send a strong message to other members of the profession and the public that the College takes this kind of behavior very seriously.

Penalty Decision

The panel recognizes that it could not reject the Joint Submission of the College and the Member unless to accept the submission would be contrary to the public interest and bring the administration of the discipline process into disrepute.

The panel therefore accepts the Joint Submission and accordingly orders:

1. That the Registrar to suspend the Member's Certificate of Registration for a period of five (5) months, with two (2) months of the suspension remitted on condition that the Member successfully completes the remedial components set out in paragraphs four (4) to eleven (11) of the Undertaking. The suspension shall be served as follows:

- the first month of the suspension shall commence on December 14, 2016 and shall continue, uninterrupted, until 11:59 pm on January 13, 2016;

- the second month of the suspension shall commence at 12:01 am on February 14 and shall continue, uninterrupted, until 11:59 pm on March 13, 2016;

- the third month of the suspension shall commence at 12:01 am on April 14, 2016 and shall continue, uninterrupted, until 11:59 pm on May 13, 2016; and

- if the remaining two months of the suspension are required to be served by the Member because he fails to complete any of the remedial components of the Undertaking, as described above, that portion of the suspension shall commence at 12:01 am on December 15, 2017 and run, uninterrupted, until 11:59 pm on February 14, 2018.

2. That the Member to pay a portion of the College's costs, in the amount of $7,500, payable by cheque, money order or credit card using the College's on-line system, as follows:

- $1,500 on or before May 1, 2019;
- $1,500 on or before November 1, 2019;
- $1,500 on or before May 1, 2020;
- $1,500 on or before November 1, 2020; and
- $1,500 on or before May 1, 2021.

3. Clarity Note: The requirement for the Member to complete the remedial components set out in paragraphs four (4) to eleven (11) of the Undertaking, cannot be relieved by serving the remitted portion of the suspension referred to in paragraph 1, above.

Reasons for Penalty Decision

The panel understands that the penalty ordered will protect the public and enhance public confidence in the ability of the College to regulate its members. This is achieved through a penalty order that addresses specific deterrence, general deterrence and, where appropriate, rehabilitation and remediation. The panel also considered the penalty in light of the principle that joint submissions will be accepted unless to do so would be contrary to public interest or bring the administration of the discipline process into disrepute.

The panel agreed that these criteria have been met via the Member's agreement to a rigorous Undertaking in addition to the proposed order itself. The Undertaking which Dr. Price has agreed to provides multiple avenues for remediation and rehabilitation. In particular, Dr. Price has agreed to meet with an expert in professional regulation to discuss his understanding of publications recommended by the expert and what it means to be a member of a self-regulated profession. Further, Dr. Price has agreed to meet with an expert in naturopathic medicine to discuss his understanding of College publications as set out in the Undertaking; the impact of the misconduct for which he was found to have committed on his patients, colleagues, the public, the profession and himself; and skills and strategies to prevent the misconduct from recurring. Dr. Price has agreed to pay the fees incurred for these meetings. Finally, Dr. Price has agreed to receive an oral reprimand from the Discipline Committee, which was delivered by the panel chair at the close of the hearing. A copy of the reprimand is attached below.

The panel concluded that the proposed penalty is reasonable and in the public interest. The Member has co-operated with the College and, by agreeing to the facts and a proposed penalty has accepted responsibility. The panel finds that the penalty satisfies the principles of specific and general deterrence, rehabilitation and remediation, and public protection.

I, Danielle O'Connor, sign this decision and reasons for the decision as Chairperson of this Discipline panel and on behalf of the members of the Discipline panel as listed below:

Danielle O'Connor — Jan. 12/17

Chairperson — Date

Names of panel members

Danielle O'Connor
Dianne Delany, public member
R. Gail Goodman, public member
Jenna McNamee

Oral Reprimand- Robert Price

As you know, Dr. Price, as part of your penalty, you have agreed to attend before this panel to receive an oral reprimand. You agreed to this term of order as part of your joint submission on penalty filed during the course of the hearing.

The panel appreciates that you have come before us with an Agreed Statement of Fact. We are well aware that as a contested hearing, this case would have consumed considerable resources- both yours and the College's including the personal and professional time of College members, staff and legal counsel. We understand that by coming before us you have saved all of us that trouble.

The fact that you have received this reprimand will be part of the public portion of the Register and, as such, part of your record with the College.

The panel has found that you have engaged in professional misconduct, including, recommending commencement of a HCG diet program without a physician consult, without the necessary blood work, without obtaining a prescription for HCG from a physician, and without providing sufficient information to the patient regarding the potential risks and side effects; providing an inappropriate assessment; recommending treatment without knowing the underlying cause; not obtaining informed consent; and improper billing.

It is a matter of profound concern to this panel that you have engaged in these forms of professional misconduct. By doing so, you have brought discredit to the profession and to yourself. Public confidence in this profession has been put in jeopardy. Moreover, the result of your misconduct is that you have let down the public, insurers, the profession, and yourself.

We need to make it clear to you that your conduct is unacceptable.

Of special concern to us is the fact that the professional misconduct in which you have engaged has involved putting patients at risk and threatening the integrity of the naturopathic profession. Consequently, it is necessary for us to take steps to impress upon you the seriousness of the misconduct in which you have engaged.

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

This is not an opportunity for you to review the decision, or debate the correctness of the decision, which in any event, was agreed to by you and your counsel.

We sincerely hope that the lessons of this experience will remain with you as long as you are a member of this profession. It is our expectation that you will learn from these events and from the remediation program that you have agreed to undertake and that your future conduct will reflect this learning.