BOARD OF DIRECTORS OF DRUGLESS THERAPY – NATUROPATHY

PANEL:	Patricia Rennie	Panel Chair
	Sean Armstrong	
	Sheila Jaggard	

BETWEEN:

BOARD OF DIRECTORS OF DRUGLESS THERAPY – NATUROPATHY	)	Marco Mendicino, for the Board of Directors of Drugless Therapy - Naturopathy
- and -	)	
MAUREEN HORNE-PAUL, (#0789)	)	
	)	Gary Srebrolow, for the Registrant
	)	Luisa Ritacca, Independent Legal Counsel
	)	Heard: June 22, 2015

DECISION AND REASONS

This matter came on for hearing before a panel of the Board of Drugless Therapy – Naturopathy (the "Board") on June 22, 2015 at the Board office in Toronto.

Specified Allegations

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 1 of the definition of Professional Misconduct/Incompetence established by the Board of Directors of Drugless Therapy-Naturopathy in that, you violated s.7 of the *Drugless Practitioners Act*; to wit, by administering drugs for use internally.

2. *Withdrawn*.

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(w) of the definition of Professional Misconduct/Incompetence established by the Board of Directors of Drugless Therapy-Naturopathy in that, you failed to perform a relevant and complete physical examination, contrary to s.4.2(b) of the *Standards of Practice*.

4. *Withdrawn*.

5. *Withdrawn*.

6. *Withdrawn*.

7. *Withdrawn*.

8. *Withdrawn*.

9. *Withdrawn*.

10. *Withdrawn*.

11. *Withdrawn*.

12. *Withdrawn*.

13. *Withdrawn*.

14. *Withdrawn*

15. *Withdrawn*.

16. *Withdrawn*.

Registrant's Plea

The Registrant admitted the allegations set out in paragraphs 1 and 3, of the Notice of Hearing (Exhibit #1). The panel also conducted an oral plea inquiry and was satisfied that the Registrant's admission was voluntary, informed and unequivocal. The parties sought the premises of the panel to withdraw the remaining allegations. The panel agreed to withdraw allegations 2 and 4 through 16 of the Notice of Hearing.

Agreed Statement of Facts

Counsel for the Board and the Registrant advised the panel that an agreement had been reached on the facts and introduced an Agreed Statement of Facts (Exhibit #2), which reads as follows.

The Letter of Complaint to the Board

1. On August 14, 2011, KM ("the Complainant") filed a letter of complaint with the Secretary Treasurer of the Board of Directors of Drugless Therapy – Naturopathy ("the Board"). The complaint was filed against Saraswati Cancer and Naturopathic Care Centre ("Saraswati") and Maureen Horne-Paul ("the Registrant").

2. The particulars of the complaint and the ensuing investigation commenced by the Board are set out below.

Complainant's Medical History and Original Consultation with the Registrant

3. The Complainant has a complicated medical history. In 2008, she was diagnosed with series of health issues, including a 7mm cystic tumor on her brain. She suffered, and continues to suffer from a myriad of symptoms, including daily migraines, chronic fatigue, depression, numbing of the limbs, and fainting. Since her original diagnosis, the Complainant has been monitored under a "wait and watch" protocol to determine whether there has been any growth or change in the nature of the cystic tumor.

4. In the hopes of improving her health, the Complainant conducted research and discovered the Registrant's website for Saraswati. The Complainant noted that Saraswati advertised IV amino acid therapy and other treatments, which she believed, at the time, would address many of her adverse symptoms.

5. The Complainant subsequently booked a consultation with the Registrant on March 12, 2011. During this appointment, the Complainant was asked by the Registrant to provide blood and urine samples, and to explain her medical and personal history.

6. The Complainant provided the Registrant a detailed medical history, along with information regarding her prescription drug regimen. Among other things, she informed the Registrant at the outset that she was "interested in reducing the need for pharmaceutical drugs", but the Complainant cautioned that one of the many prescribed

medications she was taking "would have to be weaned very slowly due to the risk of seizure."

7. At the time of the original consultation, the Registrant made the following entries in her clinical notes with respect to the Complainant's active prescribed medications and respective doses:

    - Fiorinal: 6-8 per day now is trying to wean down slowly from 20/day can't get off; This is the main issue for her wrt weaning
    - Endocet: 12-15/day-had been able to stop before; feels that she can wean off this
    - Immovane: 7.5mg ½-1½ / night since 2 years d t menopause <<< can't get off
    - Zomig: not for a few months but off and on now since the past few weeks
    - Cortef: 10mg 2-3/day off and on for lethargy for energy then cx her ST d/c and goes off; Takes it inconsistently
    - Nexxium 40mg; at least od daily occ bid since a year or more
    - Dulcolax d t pain meds.i

8. There is also an entry in the Registrant's notes from the original appointment which specifically states that the Complainant's Fiorinal dependency had increased over the last two years. The shorthand entry reads goes on to read as follows: "MD sugg that if she weans off too fast [there is] incr risk of stroke etc."ii

9. Following the presentation of the medical history, the Registrant took the Complainant on as a patient. The Registrant assured that her treatment would work "in conjunction" with the Complainant's prescribed medication. The Registrant further assured the Complainant that she would be "in charge" of her own medication.

10. The Registrant did not have a "specific treatment plan" to wean the Complainant off her medication. The Registrant's treatment goal was to "decrease the amount of Fiorinal and Endocet" the Complainant was taking.

11. Although there was considerable discussion of the Complainant's medical history, the Registrant did not conduct a relevant and complete physical examination. The Complainant's intake form did not indicate that she needed a physical examination.

12. However, the records reflect that the Complainant did not provide permission for the Registrant to communicate with or obtain records from any other practitioner. Also, on the Intake Form, the Complainant did not list a family doctor.

13. The Registrant also acknowledged that the she did not obtain a full report from a referring practitioner in lieu of a physical examination.

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[i] The Exhibits have not been included in the panel's reasons.

Complainant's Treatment at Saraswati

14. The Complainant arrived at Saraswati with her husband, HM, on April 1, 2011. Mr. M. left shortly after.

15. The Complainant's treatment began the next day on April 2, 2011. The Registrant documented in her clinical notes that the Complainant had taken the following prescribed medication:

    - Fiorinal: 2 pills at 5:00am, 1 pill at 10:20am
    - Endocet: 3 pills at 5:00am, 1 at 10:20am
    - Zomig: 1 pill at 10:20amii

16. The above records were made based on what the Complainant "reported" taking.

17. The Registrant's clinical notes from that day further state: "physical Xm this morning not done today".iii

18. The Complainant's first IV treatment commenced at 10:25am on April 2, 2011. Within a couple of hours of her first dosage, the Complainant stated she experienced a series of adverse reactions, including:

    - "a heavy, drowsy, nauseating feeling, and it was triggering a bad migraine";
    - "getting really sick";
    - "shaking so bad" she could not get onto the bed;
    - "vomiting so hard [she] was dizzy and seeing stars…more violent than [she] had ever experienced in her life";
    - an "intense, crippling lower back pain"; and
    - "wetting [her] pants".

19. The Registrant's clinical notes record the onset of the first adverse reaction as follows:

    - 1:30pm onset of H/A sx
        - Went upstairs to lie down took Fiorinal x2
        - Vomiting <<< x3 occ
        - Reduce IV rate to 3ml/min
        - Apply ice and heat to neck and forehead
        - Phoenixx assisting with keeping her calm and focused on her breathing

[ii] The Exhibits have not been included in the panel's reasons.

[iii] The Exhibits have not been included in the panel's reasons.

- H/A bec // within 1 hour, pt rested until 330pm then up again to LRiv

20. The clinical notes above reflect that the Complainant did not complain of a headache until 1:30pm (after lunch) and with the administration of the IV Mg and rescue remedy she had improved after 1 hour.

21. Once the symptoms subsided, the Complainant informed the Registrant that she wanted to leave the clinic. However, the Registrant impressed upon the Complainant that she should undergo further treatment. The Complainant subsequently stayed to carry on with the treatment.

22. Thereafter, the Registrant recorded the following entries in her clinical notes:

    - Negotiated a different meds scheme for the next 24 hours with KM and she agreed to this regime
        - Fiorinal, Endocet t b given 1 q3h x 24h with Zomig prn
        - To take Gravol or Cocculine as needed (she will have the Cocculine with her) for nausea
    - Wanted to quit and go home
    - D n like the fact that I changed my mind and took her meds but explained that I need to be able to monitor her dosing to ensure she is on a regular schedule
        - She agreed to this
        - Wanted to call H but changed her mind
    - Afraid that she will only be treated for her addictions and nothing else
        - Reiterated to her that this was not the case that the migraine and possible hormonal issues would be dealt with but that the first priority was getting her drug use discontinued
        - She understands this after several repeats of the same information […]
    - Re meds
        - KM has agreed to a schedule of q3h Fiorinal x 2, Endocet x 2 and Zomig od at least for the next 24 hoursv

[iv] The Exhibits have not been included in the panel's reasons.

[v] The Exhibits have not been included in the panel's reasons.

23. As reflected in the excerpts from the clinical notes above, the Registrant assumed a degree of control over the prescribed medication the Complainant was taking. The Complainant was in a vulnerable state. The Registrant had removed all of the prescribed medication from the drawer beside the Complainant's bed.

24. At 10:00pm on April 2, 2011, the Registrant went to the Complainant's room to give her the "meds" she had taken possession of. Instead of returning with all of the prescribed medication, the Registrant came back with only those doses of pain and sleeping pills that she had planned to give to the Complainant.

25. What followed was a dispute over the dose of the prescribed medication to be taken. The Registrant modified the dosages of both sleeping pills and pain killers as prescribed by her treating physician. The Registrant indicated that she wanted to establish "a baseline" instead of taking them on an as needed basis.

26. The Registrant's evidence if she were to testify, as well as the evidence in the records, would be that she initially set out the medications that the Complainant agreed to take based on her reported "prescribed amounts".

27. On the morning of April 3, 2011, the Registrant administered a second IV treatment. The Registrant's clinical notes of April 3, 2011 reflect that the Complainant awoke and did not report any headache at that time and did not report a head at all until that afternoon. Further, the treatment on April 3, 2011 was divided into two treatments and the Complainant did not complain of any symptoms in the morning, other than some drowsiness.

28. The clinical records of April 3, 2011 further reflect that when the Complainant complained of a headache around 3:45pm, as noted above, she requested that the Registrant provide her with Zomig (zoliptotran) prior to the full onset of a migraine. The Registrant returned instead with a vitamin supplement she identified as 5 HTP (5-hydroxytryptophan), and told the Complainant that would have the same impact as Zomig. The clinical notes for the remainder of April 3, 2011 reflect that at 4:00pm the Complainant was experiencing stomach upset and that at 5:00pm she was resting comfortably with the IV still running.

29. The Complainant had not slept well when she awoke on the morning of April 4, 2011. Over the next two to three hours, the Complainant's condition worsened. She did not ask for a Zomig pill, because she did not believe that the Registrant would provide her one.

30. The Registrant documented the following entries with respect to her administration of the Complainant's prescribed medication, her on-going symptoms, and the decision to depart:

    - In to see her at 700 am to give her her meds
    - <u>She did not sleep after taking Zopiclone 1 at 10pm</u>
    - Reported that she woke up at 1045 and was awake until 3am

- At 3am she took her nighttime dose of Fiorinal 1 pill and Endocet 1 pill and fell asleep

31. On April 4, 2011, the Complainant confirmed her decision to terminate treatment and leave Saraswati. Her husband, HM, was called and arrived to pick up the Complainant. The Complainant was billed for the treatment, which was paid. They then departed.

Decision

The panel finds that the Registrant committed acts of professional misconduct as alleged in paragraphs1 and 3 of the Notice of Hearing.

Reasons for Decision

The panel considered the Agreed Statement of Facts and the Registrant's plea and finds that this evidence supports findings of professional misconduct as alleged in paragraphs 1 and 3 of the Notice of Hearing. The facts in this case support that Ms. Horne-Paul is guilty of Professional Misconduct. In particular she:

- administered Schedule 1 drugs for use internally, and
- failed to perform a relevant and complete physical examination contrary to the standards of practice of the profession.

Penalty Order

Counsel for the Board and the Registrant advised the panel that a Joint Submission on Penalty had been agreed upon. The Joint Submission, appeared in the body of the Board's submissions, which were marked as Exhibit #3. The parties jointly requested that this panel make the following order:

1. The Registrant will appear before a Panel of the Discipline to receive an oral reprimand.
2. The Registrant's certificate of registration will be suspended for a period of three (3) months during which time she will:
    a) not engage in the practice of naturopathy;
    b) not use the title ND (or any variation or abbreviation);
    c) not hold out as an ND or as somebody who is entitled to practice naturopathic medicine;
    d) advise staff that her certificate of registration is under suspension and shall ensure staff are instructed not to do anything that would suggest to patients that she is entitled to engage in the practice of naturopathy during her suspension;
    e) not supervise any students or graduates of naturopathic medicine; and

f) the commencement of the suspension will be deferred until July 15, 2015.

The parties also advised the panel that the Registrant had entered into an undertaking, which was signed and marked as Exhibit #5. The undertaking provides, as follows:

Following the three (3) month suspension, the Registrant will be bound by a one (1) year undertaking which will include the following terms:

a) Continuing Professional Development: The Registrant shall complete successfully and unconditionally, at the Registrant's own expense, and within twelve (12) months of the date of this Undertaking, an educational and/or jurisprudence course that is to be approved of by the Board. Such educational course will include a review and testing of knowledge of the Board's policies regarding the standards of practice.

b) Monitoring: No later than three (3) months prior to the commencement of the Undertaking, the Executive Director shall appoint a Monitor who will monitor the Registrant's practice. The Monitor shall be

   i. a properly registered Naturopath in good standing with the Board, OR another regulated healthcare practitioner approved by the Executive Director;

   ii. aware of the Registrant's discipline history;

   iii. aware of the terms of this Sanction and Undertaking;

   iv. agree to meet with and supervise the Registrant in person no less than once every two (2) weeks for the first six (6) months of the Undertaking, and no less than once every four (4) weeks for the last six (6) months of the Undertaking;

   v. agree that, in the event the Monitor suspects that the Registrant has committed misconduct, has acted with incompetence, or has become incapacitated, that s/he shall immediately:

      1. take all reasonable steps to ensure that the Registrant does not perform any further naturopathic services;

      2. notify the Executive Director;

      3. advise the Registrant of any specific concerns regarding the Registrant's conduct, competence or capacity;

      4. document specific concerns regarding the Registrant's conduct, competence or capacity;

c) The restrictions of this paragraph may be removed or varied with the written agreement of the Executive Director, or alternatively, by an Order of the Board.

d) The Registrant shall fully acknowledge and understand the terms of this Undertaking.

e) The Registrant shall acknowledge that the Undertaking was signed voluntarily and without compulsion or duress.

The parties also agreed that the Registrant shall be bound by the terms of the proposed order and the signed undertaking on the date that s. 5 of the *Naturopathy Act*, 2007, S.O. 2007, c. 10 comes into force and, to this end, any reference to the Board, Executive Director etc., in the order and undertaking is deemed to include a reference to the College, Registrar etc.

Penalty Decision

The panel accepts the Joint Submission as to Order and accordingly orders:

1. The Registrant will appear before a Panel of the Discipline to receive an oral reprimand.

2. The Registrant's certificate of registration will be suspended for a period of three (3) months during which time she will:

    a) not engage in the practice of naturopathy;

    b) not use the title ND (or any variation or abbreviation);

    c) not hold out as an ND or as somebody who is entitled to practice naturopathic medicine;

    d) advise staff that her certificate of registration is under suspension and shall ensure staff are instructed not to do anything that would suggest to patients that she is entitled to engage in the practice of naturopathy during her suspension;

    e) not supervise any students or graduates of naturopathic medicine; and

    f) the commencement of the suspension will be deferred until July 15, 2015.

Reasons for Penalty Decision

The panel understands that the penalty ordered should protect the public and enhance public confidence in the ability of the Board to regulate its registrants. 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 should not be interfered with lightly.

The panel concluded that the proposed penalty is reasonable and in the public interest. The Registrant has co-operated with the Board 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.

As mentioned in the proposed order, the parties advised the panel that Ms. Horne-Paul had agreed to be bound by a one year Undertaking with the Board (and the College of Naturopaths upon proclamation) whereby she would, among other things:

- complete successfully and unconditionally, at her own expense, an educational and/or jurisprudence course approved by the Board which reviews and tests her knowledge of Board policies and standards of practice
- meet with a monitor at least once every two weeks in the first six months of the Undertaking and at least once every four weeks for the last six months of the Undertaking to monitor her practice,

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

- the conduct involved a breach of the DPA,
- the misconduct carried a significant risk to the Complainant's health,
- the Registrant has a previous complaints history with the Board,
- the Registrant is an experienced member of the profession who should have known better.

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

- the Registrant saved the Board considerable time and resources by admitting to her conduct,
- the Registrant has undertaken to commit to significant remediation through on-going education at her own expense,
- the Registrant has agreed to submit to monitoring of her practice to address potential on-going risk to the public.

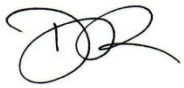
The proposed penalty provides for general deterrence through publication of the details of this hearing.

The proposed penalty provides for specific deterrence through;

- The general deterrent above will also be a specific deterrent, particularly having her name published with the details of the case. In addition, Ms. Horne-Paul has signed an undertaking with the Board which requires that she complete remedial activities including meeting with a monitor and completing an approved educational and/or jurisprudence course. She also agreed to receive an oral reprimand from the discipline panel which was delivered by the panel chair.

The penalty is in line with what has been ordered in previous cases.

I, Patricia Rennie, 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:



August 10, 2015
Chairperson Date

Sean Armstrong

Sheila Jaggard

Oral Reprimand MHP

Ms. Horne Paul the panel appreciates that you have come before us today with an Agreed Statement of Facts. We are well aware that as a contested hearing this case would have consumer considerable resources - yours and the Board's including the personal and professional time of board members, staff, legal counsel and witnesses. We understand that by coming before us as you have today that you have saved all of us that trouble.

However, we are disturbed by the facts that led to the findings in this case which you have admitted to today. We are concerned that such unprofessional behavior erodes the profile of this profession in the minds of the public and other regulated health care providers. For that reason we hope that your case will serve as a caution to you and the others in the profession.

Your role as a naturopathic doctor is to provide safe, ethical competent care within the bounds of the scope of practice and your knowledge, skills and judgment. You have admitted to knowingly engaging in activities that were a risk to the public by stepping outside your scope of practice as a naturopath. These activities could have resulted in a significantly more serious outcome for the patient, yourself and the profession. Further, the panel has serious concerns regarding your failure to perform a relevant and complete physical exam in particular on a patient for whom you were performing intravenous therapy.

On behalf of the panel I would like to state that we are extremely disappointed in your conduct. We recognize that you have been in practice for some time and this is your first time before a discipline panel but it is not your first encounter with the complaints process of the BDDT-N.

While the penalty imposed today was reasonable we expect that should you come before a discipline panel of this profession again the penalty will likely be much more severe.

It is our desire that a strong message is sent to the public and other Registrants that we consider this conduct to be unprofessional. We sincerely hope that the lessons of this experience will remain with you as long as you are a member of this profession.