NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Noémie Adeline Everette Bertha Guindon, this is notice that the Discipline Committee ordered that there shall be a ban on publication of the names or any identifying information of patients whose names are disclosed at the hearing or in the materials filed. under subsection 45(3) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

Subsection 93(1) of the Code, which is concerned with failure to comply with these orders, reads:

> Every person who contravenes an order made under … section 45 or 47… is guilty of an offence and on conviction is liable,
>
> > (a) in the case of an individual to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence; or
> >
> > (b) in the case of a corporation to a fine of not more than $50,000 for a first offence and not more than $200,000 for a second or subsequent offence.

Indexed as: Guindon (Re)

THE DISCIPLINE COMMITTEE OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

IN THE MATTER OF a Hearing directed
by the Inquiries, Complaints and Reports Committee of
the College of Physicians and Surgeons 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:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. NOÉMIE ADELINE EVERETTE BERTHA GUINDON

PANEL MEMBERS:

DR. C. CLAPPERTON (CHAIR)
D. DOHERTY
DR. A. SHARMA
DR. E. ATTIA (Ph.D.)
DR. B. LENT

Hearing Date:	January 30, 2012
Decision Date:	January 30, 2012
Release of Written Reasons:	March 7, 2012

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on January 30, 2012. At the conclusion of the hearing, the Committee stated its finding that the member committed an act of professional misconduct and delivered its penalty and costs order with written reasons to follow.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Noémie Adeline Everette Bertha Guindon committed an act of professional misconduct:

1. under paragraph 1(1)1 of O. Reg. 856/93, in that she contravened a term, condition or limitation on her certificate of registration.

2. under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act*, 1991 ("O. Reg. 856/93"), in that she has failed to maintain the standard of practice of the profession.

3. under paragraph 1(1)33 of O. Reg. 856/93, in that she has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The Notice of Hearing also alleged that Dr. Guindon is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professions Act*, 1991, ("the Code").

RESPONSE TO THE ALLEGATIONS

Dr. Guindon admitted the allegations of professional misconduct in the Notice of Hearing, that she contravened a term, condition or limitation on her certificate of registration, that she has failed to maintain the standard of practice of the profession, and

that she has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional. Counsel for the College withdrew the allegation of incompetence.

FACTS AND EVIDENCE

The following facts were set out in an Agreed Statement of Facts and Admission that was filed as an exhibit and presented to the Committee:

BACKGROUND

1. Dr. Noémie Adeline Everette Bertha Guindon ("Dr. Guindon") was issued a certificate of registration authorizing independent practice on July 8, 1959. She was a member of the College of Physicians and Surgeons [of Ontario] (the "College") until she resigned on January 24, 2012.

2. Dr. Guindon obtained her medical degree from Ottawa University in June 1958. Dr. Guindon then completed eleven months in a rotating internship at Oakwood Hospital, Dearborn, Michigan. For the next three years, Dr. Guindon had a general practice in LaSalle, Ontario. Thereafter, Dr. Guindon took leaves of absence from her practice to undertake some training in dermatology in the US, following each of which she opened a practice limited to skin disease. She never wrote the examinations and was never certified as a specialist in any specialty in the United States or Canada. Since April 1974, she had limited her practice to skin disease and not undertaken any further periods of training.

INVESTIGATION UNDER SECTION 75(1)(b) OF THE CODE

3. In December 2008, the Executive Committee of the College requested the Registrar to conduct an investigation under section 75(b) of the Health Professions Procedural Code, Schedule 2 to the *Regulated Health Professions Act*, 1991, S.O. 1991, c. 18 (the "Code").

4. The College retained Dr. X, a fellow of the Royal College of Physicians and Surgeons of Canada in dermatology, to review 25 office charts from Dr. Guindon's practice. Dr. X opined that Dr. Guindon's care failed to meet the standard of practice in 23 of the 25 patient charts, including, with respect to:

- her use of UV light as treatment for post-operative infections, fungal infections, seborrheic dermatitis, chelitis, and epidermal cysts;
- her use of cryotherapy as a treatment for fungal infections, psoriasis, facial elastosis, lichen planus pruritus, rosacea, striae distensae, melasma and chelitis;
- her use of intralesional steroid injections as a treatment for xerosis and seborrheic dermatitis; and
- her use of Accutane as a treatment for an epidermal cyst.

5. Dr. X opined that:

> There is a clear trend in the charts provided with regard to the use of UV light, cryotherapy and intralesional injections in situations where such treatment is not standard of practice. Based on this, there is either a lack of knowledge of what the current standard of practice is or a lack of judgment based on not exercising the current standard of practice.

A copy of Dr. X's report received by the College on August 24, 2009 is attached at Schedule 1 [to the Agreed Statement of Facts and Admission].

6. Dr. X opined that in cases where cryotherapy was used to treat psoriasis and lichen planus associated with pruritus, there was a potential for harm. In one case, UV light was used to treat facial elastosis and UV light is known to cause facial elastosis with repeated exposure. She also noted concerns with respect to the documentation of the strength and total amount of intralesional steroid injections.

7. Dr. Guindon provided a response to Dr. X's report on October 6, 2009 and Dr. X provided an addendum dated October 28, 2009. A copy of Dr. Guindon's response and a

copy of Dr. X's addendum are attached at Schedule 2 and Schedule 3 [to the Agreed Statement of Facts and Admission], respectively.

8. On April 23, 2010, Dr. X attended at Dr. Guindon's medical practice to conduct a site visit and to observe Dr. Guindon's treatment of her patients. During her day of observation, she agreed with the majority of Dr. Guindon's diagnoses and found her course of investigation and treatments to be reasonable. However, the following issues arose during her visit including:

(a) Dr. Guindon did not wash her hands nor did she use an alcohol-based hand sanitizer during observation of 27 patients;

(b) Dr. Guindon performed a number of injections during her observation and did not use gloves;

(c) Dr. Guindon performed a number of procedures for which she used electro-cautery with a portable device called a Bovie. This device is meant to be for single use, for one patient only.

9. Dr. X opined that Dr. Guindon failed to meet the standard of practice in all 27 patients seen. She opined that she lacked either knowledge or judgment with regard to hand hygiene, personal protection and instrument sterilization/reuse. She opined that she lacked judgment with regard to charting in that she continued to omit the concentration and amount of drug injected. Further, she opined that Dr. Guindon's practices had the potential to cause transmission of infection to Dr. Guindon's patients or herself. A copy of Dr. X's report dated June 3, 2010 and the addendum to that report dated June 27, 2010 are attached as Schedule 4 [to the Agreed Statement of Facts and Admission].

DR. GUINDON'S UNDERTAKING IN LIEU OF A SECTION 37 ORDER

10. In lieu of an order under section 37 of the *Code*, on November 17, 2010, Dr. Guindon entered into an undertaking with the College (the "Undertaking") requiring, among other things that:

(a) Dr. Guindon restrict her use of cryotherapy to the treatment of only: molluscum contagiosum; viral warts; seborrheic keratosis; skin tags; and, actinic and/or solar keratosis;

(b) Dr. Guindon not use UV phototherapy whatsoever;

(c) Dr. Guindon record the strength and dose for each intralesional injection that she performs and restrict the use of intralesional injections to the treatment of keloids and alopecia areata only; and

(d) Dr. Guindon employ sterile procedures and abide by appropriate infection control processes including washing her hands and/or using hand sanitizers, at a minimum, before and after direct contact with each of her patients.

A copy of the Undertaking executed November 17, 2010 is attached as Schedule 5 [to the Agreed Statement of Facts and Admission].

CLINICAL SUPERVISION

11. In addition to the practice restrictions identified above, under the terms of the Undertaking, Dr. Guindon was required to practice under the guidance of a clinical supervisor acceptable to the College. Dr. Guindon agreed that if she was unable to obtain a clinical supervisor acceptable to the College, she would cease practicing medicine until such time as she obtained one. She further agreed that if she was required to cease practising, that requirement will constitute a term, condition and limitation on her certificate of registration.

12. On January 14, 2011, a clinical supervisor acceptable to the College provided an executed undertaking to the College agreeing to provide the supervision required. The clinical supervisor resigned his role as supervisor and the supervisory arrangement was terminated on February 23, 2011.

13. From February 23, 2011 to April 12, 2011, Dr. Guindon did not have a clinical supervisor. In accordance with the terms of her Undertaking (and the terms of her certificate), Dr. Guindon was required to cease to practice effective March 15, 2011.

14. Despite this requirement, Dr. Guindon saw patients on March 21, 22, 24, 25 and 28, 2011 and April 5, 7 and 8, 2011, in breach of her undertaking and in contravention of the terms, conditions and limitations of her certificate.

15. Ultimately, on April 12, 2011, a new clinical supervisor acceptable to the College submitted an executed undertaking to the College agreeing to provide the supervision required.

INVESTIGATION INTO DR. GUINDON'S BREACH OF THE UNDERTAKING

16. On January 3, 2011, the College received information from the Ministry of Health and Long Term Care regarding Dr. Guindon's claims to OHIP for services contravening her practice restrictions set out in the Undertaking.

17. As a result of this information, on February 1, 2011, the ICRC approved the Registrar's request for an appointment of investigators under section 75(1)(a) of the *Code*.

18. While the investigation was ongoing, on May 1, 2011 Dr. Guindon's clinical supervisor reported that Dr. Guindon had failed to wear gloves and wash her hands between patients. Following September 2011, Dr. Guindon's supervisor reported no concerns.

19. In addition, evidence obtained in the investigation established that Dr. Guindon breached her Undertaking and contravened the terms, conditions and limitations on her certificate of registration by:

(a) using cryotherapy on a number of occasions for conditions not permitted under the terms of her Undertaking;

(b) failing to record the strength and dose for each intralesional injection; and,

(c) using intralesional injections for treatments not permitted under the terms of her Undertaking;

20. On May 18, 2011, the ICRC imposed further restrictions on Dr. Guindon's practice by order under section 37 of the *Code*. That order restricts Dr. Guindon from practicing medicine unless she does so in the presence of a monitor(s) who observes all

patient interactions and reports non-compliance with sterile procedure and infection control processes (the "Order"). A copy of the Order is attached as Schedule 6 [to the Agreed Statement of Facts and Admission]. Dr. Guindon's monitors reported compliance with the Order.

UNDERTAKING TO RESIGN HER MEMBERSHIP

21. On or around December 13, 2011, Dr. Guindon closed her office practice. On January 24, 2012, Dr. Guindon resigned her membership with the College. She entered into an undertaking agreeing not to reapply for membership with the College. A copy of this undertaking, executed January 24, 2012 is attached as Schedule 7 [to the Agreed Statement of Facts and Admission].

ADMISSION

22. Dr. Guindon admits the facts set out above and admits that she has committed acts of professional misconduct:

(a) under paragraph 1(1)1 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* ("O. Reg. 856/93"), in that she contravened a term, condition or limitation on her certificate of registration;

(b) under paragraph 1(1)2 of O. Reg. 856/93, in that she has failed to maintain the standard of practice of the profession; and

(c) under paragraph 1(1)33 of O. Reg. 856/93, in that she has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

FINDINGS

The Committee accepted as true all of the facts set out in the Agreed Statement of Facts and Admission. Having regard to these facts, the Committee accepted Dr. Guindon's

admission and found that she committed an act of professional misconduct, in that she contravened a term, condition or limitation on her certificate of registration, in that she has failed to maintain the standard of practice of the profession, and in that she has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

PENALTY AND REASONS FOR PENALTY

Counsel for the College and counsel for the member made a joint submission as to an appropriate penalty and costs order.

The Committee recognizes that a joint submission on penalty should be accepted unless it would bring the administration of justice into disrepute and be contrary to the public interest. The Committee also recognizes that any proposed penalty must fulfill various guiding principles, including protection of the public, expression of the profession's abhorrence of the conduct, maintenance of public confidence in the medical profession and its ability to regulate itself, specific and general deterrence, and where appropriate, remediation and rehabilitation of the physician.

In evaluating the proposed penalty, the Committee reviewed the agreed facts and the documents submitted as part of Exhibit 2, in support of the agreed facts. Dr. Guindon contravened the Undertaking executed on November 17, 2010, and failed to maintain the standard of practice, in that she neglected to follow appropriate infection control procedures and to consistently record the dose and strength of injected medications. She also used cryotherapy and intralesional injections for conditions not permitted under the terms of the Undertaking. In addition, she contravened the Undertaking by seeing patients without a supervisor. By not maintaining proper hygiene and sterile precautions, Dr. Guindon put her patients and herself at risk of transmitted infection.

The Committee took into account various mitigating factors in considering the appropriateness of the proposed penalty. Dr. Guindon had practiced for more than 50 years, with no other appearances before the Discipline Committee. Although numerous breaches

were noted after the signing of the Undertaking in November 2010 and May 2011, the practice monitor noted no further episodes of non-compliance after May 2011. Dr. Guindon accepts that she failed to maintain the standard of care and acknowledges her breach of the terms and conditions previously imposed, thus obviating the need for a lengthy hearing. Her admissions at the hearing indicate she accepts responsibility for her conduct. Dr. Guindon has closed her clinical practice, and has agreed to resign from the College and not to apply for reinstatement in this, or any other, jurisdiction.

The Discipline Committee considers the breach of an agreement with the College to be a very serious matter. Members must respect the authority of the regulatory body and must not flout undertakings. To do so undermines the governing body and its mandate of regulating the profession and protecting the public. The public expects and must be able to proceed on the expectation that members will comply with the terms of any agreement or order to which they are subject.

The Committee concluded that the public reprimand and the recording of the findings in the register would meet the goals of general deterrence. The proposed penalty sends a strong message to the profession with respect to maintaining standards of care and the absolute requirement that agreements with the regulatory body be followed, and demonstrates to the public that the profession takes the issue of self-governance very seriously. The principles of specific deterrence and protection of the public are met in that Dr. Guindon will no longer be practising medicine. The principles of remediation and rehabilitation of the physician are not relevant given Dr. Guindon's resignation and undertaking agreeing not to apply for reinstatement. The proposed penalty is consistent with those imposed in the cases presented by counsel, which involved similar circumstances.

For these reasons the Committee accepted the proposed disposition on penalty and costs as fair and reasonable.

ORDER

Therefore, the Committee ordered and directed that:

1. Dr. Guindon appear before the panel to be reprimanded.

2. Dr. Guindon pay to the College costs in the amount of $3,650 within 60 days of the date of this Order.

At the conclusion of the hearing, Dr. Guindon waived her right to an appeal under subsection 70(1) of the Code and the Committee administered the public reprimand.