

ONTARIO CHIROPDISTS AND PODIATRISTS DISCIPLINE TRIBUNAL

B E T W E E N:

COLLEGE OF CHIROPDISTS OF ONTARIO

(the “**College**”)

-and-

BILL BITAXIS

(the “**Registrant**”)

NOTICE OF HEARING

On July 21, 2026, a panel of the Inquiries, Complaints and Reports Committee of the College referred specified allegations of the Registrant’s professional misconduct to the Tribunal.

In this proceeding, the term “Registrant” means a “member” as set out in the *Regulated Health Professions Act, 1991*, the *Health Professions Procedural Code* (“Code”), the applicable health profession Act, and the regulations thereto.

The allegation(s) are that the Registrant:

1. Has committed an act of professional misconduct under:
 - a. Subsection 51(1)(c) of the Code, which is Schedule 2 of the *Regulated Health Professions Act, 1991*, and as defined in one or more of the following paragraphs of section 1 of the *Professional Misconduct Regulation* (O. Reg. 750/93) under the *Chiropody Act, 1991*:

- (i) paragraph 2 – failing to meet or contravening a standard of practice of the profession) and, in particular, the College’s written standards pertaining to:
 - a. Competence;
 - b. Assessment and Management
 - c. Patient Relations;
 - d. Records; and/or
 - e. Advertising.
- (ii) paragraph 14 – providing treatment to a patient where the member knows or ought to know that the provision of the treatment is ineffective, unnecessary or deleterious to the patient or is inappropriate to meet the needs of the patient.
- (iii) paragraph 17 – failing to keep records as required by the regulations
- (v) paragraph 30 – contravening the *Chiropody Act, 1991*, the *Regulated Health Professions Act, 1991*, and/or the regulations under either of those Acts, including, but not limited to, Ontario Regulation 203/94, Part II (Advertising) and Part III (Records); and/or
- (vi) paragraph 33 – engaging in conduct or performing an act, in the course of practising the profession that, having regard to all the

circumstances, would reasonably be regarded by members as disgraceful, dishonourable, or unprofessional.

Further information about these allegations is set out below:

1. The Registrant was first registered with the College on July 12, 2006. At all times material to the allegations, the Registrant was registered with the College in the chiropodist classification to practise chiropody in Ontario.
2. During the relevant period, from approximately February 2025 to October 2025, the Registrant practised at several clinics in the Toronto area, including at Flemingdon Health Centre in Toronto (the “**Clinic**”).
3. On or about October 21, 2025, the College received a complaint from a patient (“**Patient A**”) about inappropriate treatment he had received from the Registrant at the Clinic. In particular, the Complaint raised concerns that the Registrant had administered numerous corticosteroid injections into Patient A’s heels and ankles in May and June 2025, which had caused injury to his Achilles tendons (the “**Complaint**”).
4. The Registrant had advised Patient A, in or about May 2025, that corticosteroid injections would address the pain and inflammation from his heel spurs.
5. Following the injections administered by the Registrant into Patient A’s ankles and heels, Patient A suffered a ruptured Achilles tendon in his left foot in July 2025 while on vacation outside the country. In seeking treatment for his left foot, Patient A was informed that the Achilles tendon in his right foot was also compromised.
6. In providing treatment to Patient A during the relevant period, the Registrant failed to maintain the standards of the profession, including but not limited to the following:
 - (i) The Registrant failed to obtain, document, and/or consider Patient A’s history before recommending and/or proceeding with the treatment plan;

- (ii) The Registrant failed to consider if the treatment plan was appropriate or clinically indicated for Patient A before recommending and/or proceeding with the treatment plan;
- (iii) The Registrant failed to obtain and/or document in the patient record informed consent from Patient A before proceeding with the corticosteroid injections;
- (iv) The Registrant failed to clearly explain to Patient A and/or document in the patient record the material risks associated with administering corticosteroid injections in the area of the Achilles tendon;
- (v) The Registrant failed to take reasonable steps to explain and/or ensure that Patient A fully understood the risks with the corticosteroid injections, the expected outcomes of the treatment plan, and/or the alternative treatments that were available;
- (vi) The Registrant administered the corticosteroid injections to Patient A where the Registrant knew or ought to know that the provision of the treatment was ineffective, unnecessary and/or deleterious to Patient A or inappropriate to meet the needs of Patient A;
- (vii) The Registrant administered the corticosteroid injections to Patient A in a manner, dosage and/or frequency that was inappropriate for Patient A and/or failed to meet the standards of the profession;
- (viii) The Registrant failed to provide adequate follow-up, including but not limited to failure to communicate with Patient A and/or his family and/or his treatment providers with respect to the rupture of Patient A's Achilles tendon;
- (ix) the Registrant failed to fully and clearly communicate with Patient A about the Registrant's credentials;

- (x) the Registrant advertised his practice in manner that was false or misleading and/or failed to accurately and clearly identify his credentials as a chiroprapist;
- (xi) Any further information and disclosure about the allegations against the Registrant will be provided in advance of the hearing.

The Tribunal will hold a hearing under sections 38 to 56 of the Code, the *Statutory Powers Procedure Act*, and the *Hearings in Tribunal Proceedings (Temporary Measures) Act, 2020*, on a date or dates to be set at a case management conference, to decide whether the Registrant has committed an act or acts of professional misconduct and/or is incompetent.

The College will file this Notice with the Tribunal. The Tribunal will then set a date for the first case management conference and send it to the parties with more information about the Tribunal's process.

If the Registrant or their representative does not attend the case management conference or the hearing, the Tribunal may proceed in the Registrant's absence and the Registrant is not entitled to any further notice in the proceeding.

If the Tribunal finds the Registrant committed an act or acts of professional misconduct, it may make one or more of the following orders under subsections 51(2) of the Code.

- direct the Registrar to revoke the Registrant's certificate of registration.
- direct the Registrar to suspend the Registrant's certificate of registration for a specified period of time.
- direct the Registrar to impose specified terms, conditions and limitations on the Registrant's certificate of registration for a specified or indefinite period of time.
- require the Registrant to appear before the Tribunal to be reprimanded.
- require the Registrant to pay a fine of not more than \$35,000 to the Minister of Finance.

- if the act of professional misconduct was the sexual abuse of a patient, require the Registrant to reimburse the College for funding provided for that patient under the program and/or require the Registrant to post security acceptable to the College to guarantee this payment.

The Tribunal may, under subsection 53.1 of the Code, require the Registrant to pay all or part of the College's costs and expenses. The Tribunal's website includes the Tribunal's Rules of Procedure, Practice Directions and guides to the process.

Date: July 21, 2026

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On behalf of the College:

Nicole Zwiers, Registrar and CEO

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