IN THE MATTER OF
THE COLLEGE OF OPTOMETRISTS OF BRITISH COLUMBIA
AND A CITATION ISSUED UNDER THE *HEALTH PROFESSIONS ACT*

BETWEEN:

The College of Optometrists of British Columbia

(the "College")

AND:

Dr. Jerry Mackenzie

(the "Respondent")

Date and Place of Hearing:

Date: August 19 and 20, 2013
Place: 1650 – 885 West Georgia St, Vancouver, BC,

Counsel for the College:

Angela R. Westmacott

Counsel for the Respondent:

Susan Sangha

Thea Hoogstraten

The Discipline Committee (the "Panel"):

David MacPherson (Chair)
Dr. Mark Bourdeau
Dr. Anisa Nurani

Court Reporter:

Day: August 19 and 20, 2013 – Barbara Neuberger

DECISION ON VERDICT

1. The Discipline Committee of the College (the "Panel") met on August 19 and 20, 2013 at 1650 – 885 West Georgia Street, Vancouver, BC, to inquire into allegations that

the Respondent contravened sections 130 and 131 and Schedule "A" of the College bylaws and Parts 2, 4, 5 and 6 of the Standards of Practice for Optometry ("Standards of Practice"), and engaged in professional misconduct as defined in section 26 of the *Health Professions Act* (the "Act").

2. The hearing came to order at 9:07 a.m. on August 19, 2013 at which time the court reporter, Barbara Neuberger, was sworn in.

1.0 CITATION

3. The Panel accepted the Citation (Exhibit #3, tab 1) was properly served based on the testimony of the process server that the Respondent was personally served with the Citation on July 11, 2013. The Respondent did not dispute the testimony of the process server that he was served with the Citation.

4. The attached Citation and its schedule form a part of this Decision of the Panel.

2.0 ISSUE

5. The issue before the Panel is whether the Respondent has contravened Parts 2, 4, 5 or 6 of the Standards of Practice, or contravened paragraphs 2 or 4 of the terms of the Consent Order made under section 36(1) of the Act. A contravention of any one of these requirements constitutes professional misconduct as defined in section 26 of the Act. Under Bylaw section 135, registrants must in all cases appraise the oculo-visual status of their patients and record the results in accordance with the policies of the College. The policies include the Standards of Practice, which consist of six parts.

6. In relation to the allegation that the Respondent falsely altered his clinical records, the College also alleged that the Respondent has breached sections 130 and 131, and Schedule A of the College's bylaws:

> *Code of Ethics*
>
> 130 Registrants must adhere at all times to the Code of Ethics set out in Schedule A.
>
> *Honour, integrity and reputation*
>
> 131 (1) Registrants must, in all matters pertaining to the profession of optometry, maintain and uphold the honour, integrity and reputation of the profession, the college, its registrants and themselves.
>
> (2) Registrants must refrain from conduct which brings, appears to bring, or tends to bring the profession or themselves into disrepute.
>
> *Schedule A – Code of Ethics*

It is the ideal, resolve, and duty of registrants of the College of Optometrists of British Columbia:

- to maintain at all times the dignity, honour and integrity of the profession and to conduct themselves as exemplary citizens.

7. Specifically, the College alleges that:

"9. The Respondent contravened paragraph 2 of the Consent Order and Part 4 (Patient Examination) and Part 5 (Specific Assessments) of the Standards of Practice for optometry by failing to perform a complete or adequate eye examination with dilation for the Complainant on September 16, 2010 that would have confirmed the existence of significant cataracts in her left eye";

"10. The Respondent failed to meet Part 4 (Patient Examination) and Part 6 (Other Matters) of the Standards of Practice for optometry on September 16, 2010 by failing to refer the Complainant to an appropriate health specialist in a timely manner or at all";

"11. The Respondent contravened paragraph 4 of the Consent Order and Part 2 of the Standards of Practice (Patient Records) by failing to maintain accurate and complete clinical records, specifically by maintaining that he saw the Complainant on September 16, 2011 rather than September 16, 2010 and by claiming that he referred the Complainant to Dr. [redacted] at the time of his initial examination";

"12. The Respondent contravened Part 2 of the Standards of Practice (Patient Records) and engaged in unethical conduct in contravention of sections 130 and 131 and Schedule "A" of the College bylaws by falsely altering his clinical records by: (a) adding a sticky note to the September 16, 2010 clinical record entry indicating that he had referred the Complainant to Dr. [redacted] when no such referral had been made at the time of that examination; (b) changing the date on his handwritten referral note from September 16, 2010 to September 16, 2011; and (c) faxing a handwritten referral note to Dr. [redacted] on August 26, 2011 which was one month after the Complainant filed a complaint with the College and approximately two months after she had received cataract surgery from Dr. [redacted]; and

"13. The Respondent's contravention of paragraphs 2 and 4 of the Consent Order and Parts 2, 4, 5 and 6 of the Standards of Practice for optometry constitutes professional misconduct."

8. The first allegation at Citation paragraph 11 that the Respondent maintains he saw the Complainant on September 16, 2011, rather than September 16, 2010 is not an

issue, as the Respondent testified that his referring to "2011" in his response to the Inquiry Committee was a typographical error.

9. The allegation at Citation paragraph 12(b) that the Respondent changed the date on a handwritten referral note from September 16, 2010 to September 16, 2011 appears to be an error. At the hearing, the College consistently argued that the Respondent generated a referral note dated September 16, 2011, and changed it to September 16, 2010 (College's submission at page 21, first full paragraph). The Respondent responded to the allegation that the Respondent changed "2011" to "2010". For example, in closing submissions, the Respondent's counsel argued that it would make no sense for the Respondent to alter a referral note date from 2011 to 2010.

3.0 PRELIMINARY MATTER

10. The Respondent applied for a stay of proceedings, and related relief, which was opposed by the College.

11. Specifically, the Respondent sought a stay of proceedings on the basis the Respondent would be prejudiced by a disciplinary hearing proceeding to address allegations of an improper eye examination and an inadequate record, where the citation alleges a breach of a Consent Order that includes an admission of misconduct of a similar nature.

12. On March 9, 2010, the Respondent signed an Undertaking and Consent Order under section 36 of the Act (the "Consent Order"). Only a redacted version of the Consent Order on which the College intends to rely has come before the Panel. The Consent Order contains two undertakings of the Respondent:

> "2. The Registrant undertakes not to repeat the conduct of performing incomplete or inadequate eye examinations;
>
> ...
>
> "4. The Registrant undertakes not to repeat the conduct of completing inaccurate clinical records; ...."

13. These undertakings, which speak to the Registrant not repeating conduct, amount to the Respondent admitting past misconduct of the nature specified. However, the Consent Order before the Panel has been redacted so that the Panel is unaware of the specifics of the past conduct underlying the Consent Order.

14. The Consent Order includes, at paragraph 9, an acknowledgment of the Respondent that "a contravention of any term of this Consent Order constitutes professional misconduct and will lead to the issuance of a citation."

15. The Consent Order states, at paragraph 12, that "This Consent Order will be disclosed to the Inquiry Committee or to the Discipline Committee in any future

proceedings following consideration by those committees of the merits of any future complaint."

16. The Respondent applied for an order that the Panel direct the Registrar to:

1) Stay the discipline proceedings;

2) Sever the allegations related to the breach of the March 9, 2010 Consent Order from the matters which are the subject of the [redacted] Complaint (Bylaw 78(3);

3) Amend the current citation to remove all reference to the Consent Order (Bylaw 78(4); and

4) Convene a new hearing before a new panel of the Discipline Committee to consider the [redacted] Complaint.

17. The Respondent essentially objected to the Citation addressing, and the Panel knowing of, the Consent Order. The Respondent did not however, suggest the College had to prove the facts of a breach of the Consent Order in a separate hearing. The Respondent submitted that if the Complainant's allegations are proven, a breach of the Consent Order would be established, and the Panel could consider the Consent Order as part of a determination of penalty.

18. The Panel considered each of the Respondent's arguments in turn:

Statutory Requirement

19. The Registrant argued that section 39.2 of the Act, Consideration of Past Action, requires that the Consent Order not be admitted until the completion of the hearing on the verdict of a matter, and intends that past actions be used only to assist with determination of penalty.

20. It is the opinion of the Panel that this section of the Act does not expressly limit a discipline committee in this regard. While the Consent Order is evidence of past action taken by the Inquiry Committee, and of past conduct by the Respondent, it is also evidence of current obligations which are alleged to be breached. Section 39.2 has no application to evidence of current obligations. Further, section 39.2 is permissive, not restrictive. It does not prevent the Discipline Committee from considering past conduct in an appropriate case, although the College has advised that it does not rely on similar past conduct to show that he committed misconduct relating to the Complainant.

21. Contractual Requirement of the Consent Order

22. The Registrant claimed that the Consent Order was entered into with the explicit understanding that it would not be disclosed to either the Inquiry Committee or the Discipline Committee, and that disclosing the order to the Panel is a violation of a contractual agreement.

23. While paragraph 12 of the Consent Order states that it will be available to the Inquiry Committee or the Discipline Committee following their deliberations on the merits of any future complaint, it does not say it is only available for that purpose. The Panel cannot reasonably interpret paragraph 12 to mean that the College could never allege and proceed to a discipline proceeding for a breach of the Consent Order.

High Standard of Fairness and Prejudice

24. The Registrant argued that knowledge of the Consent Order would prejudice the Panel and prevent him from receiving a fair hearing.

25. The Respondent submitted the only possible relevance of the Consent Order to the [redacted] Complaint is as similar fact evidence. The Panel does not accept this.

26. The College has alleged acts that contravene Standards of Practice, and contravene undertakings. The Consent Order is evidence of the Respondent's undertakings. The College may prove the undertakings which are alleged to be breached by tendering the Consent Order.

27. The prejudice the Respondent asserts arises from the extent the undertakings show past misconduct, and the risk of the evidence playing an improper role in the Panel's deliberations on the allegations relating to the [redacted] Complaint.

28. The Panel agrees with the College that the prior acts in the Consent Order are not relevant to the Complainant's allegations. The details of the prior acts were voluntarily redacted by the College and therefore not available to the Panel in any event. The Panel does not make any comment about the need for redaction. The Panel would not consider the Consent Order as proof of past conduct relevant to the Complainant's allegations. The Panel considers it as proof of the undertakings allegedly breached. The Panel is of the opinion that the probative value of knowledge of the Consent Order as a whole outweighs any potential prejudice from the Panel being exposed to the admissions that remained after redactions. This is consistent with the decision that the inquiry committee made to include the breach of the terms of the Consent Order when issuing the citation in relation to this complaint.

29. With respect to the College's submissions, the Panel agrees with the College that the role of the Discipline Committee is not to direct the College as to what it can or cannot allege in a citation. The Panel can hear and determine the result of a citation pursuant to sections 38 and 39 of the Act.

30. The Panel concluded that appropriate steps have been taken in order to ensure that the proceeding is conducted in a fair manner, that it would not be prejudiced by its knowledge of the Consent Order, and that it could conduct a fair hearing with this knowledge. The Panel was unanimous in denying the application for a stay, and for related relief, and therefore decided to proceed.

4.0 BACKGROUND

31. The Respondent has practiced optometry for over 40 years.

32. The Respondent was granted a Full B registration on March 2, 2009 under registration no. 353.

33. The Respondent practiced optometry at all times material to this matter at his clinic at 3235 West Broadway, Vancouver, BC.

34. On March 9, 2010, the Respondent executed a Consent Order under section 36 of the Act in which he undertook to complete adequate eye examinations and accurate clinical records.

5.0 DOCUMENTARY EVIDENCE

35. The College adduced the following exhibits, including a Book of Documents with 16 tabbed documents, all of which were identified and entered into evidence:

Exhibit 1: Affidavit of Service of Hamid Heidar Alizadeh sworn July 16, 2013;

Exhibit 2: Standards of Practice, Parts 2 to 6;

Exhibit 3: Book of Documents

Tab 1: Citation to Appear dated July 9, 2013 with Schedule

Tab 2: Certificate of Registration of Dr. Jerry Mackenzie issued March 2, 2009;

Tab 3: Consent Order dated March 9, 2010 [redacted]

Tab 4: Complaint dated July 20, 2011 and received July 26, 2011

Tab 5: Respondent's response, with

-Letter from Dr. [redacted] to Dr. [redacted] dated April 7, 2003

-Letter from Dr. [redacted] to Ms [redacted] dated May 16, 2011

-Procedure Report dated June 17, 2011

Tab 6: Complainant's reply dated October 3, 2011 and received October 11, 2011

Tab 7: Internal email re: discussion with Dr. [redacted] office dated April 5, 2012, with

-Copy of referral note dated "Sept 16, 2011" with fax receipt line dated August 26, 2011

-Fax cover page from Dr [redacted] office dated April 5, 2012

Tab 8: Respondent's further response dated April 26, 2012, with

-Copy of Referral note dated "Sept 16, 2010" and received by the College April 24, 2012

-Copy of record dated September 16, 2010 (3 pages)

-Letter from Dr. [redacted] to Dr. [redacted] dated May 25, 2007

Tab 9: MSP History Report dated May 8, 2012

Tab 10: Notes of interview of Respondent taken by Registrar

Tab 11: Email and letter from Complainant dated May 28, 2012

Tab 12: Letter from Respondent received June 18, 2012

Tab 13: Letter from Complainant dated June 28, 2012

Tab 14: Copy of Respondent's clinical records for Complainant

Tab 15: Clinical records from Dr. [redacted]

Tab 16: Clinical records from Dr. [redacted], including

- Copy of referral note dated "Sept 16, 2011" with fax receipt line dated August 26, 2011 (page 82)

Exhibit 4: Original Respondent's clinical records for Complainant

Exhibit 5A: Letter from the College dated September 2, 2011 with

-Consent to Release of Information signed by Complainant

-Canada Post tracking records for registered mail accepted September 23, 2011

Exhibit 5B: Letter from the College dated October 24, 2011 with Canada Post tracking records for registered mail accepted October 25, 2011

36. The Panel reviewed all of these documents.

6.0 STATEMENTS TO THE INQUIRY COMMITTEE

37. On July 20, 2011, the Complainant submitted a complaint to the College concerning an eye examination which the Respondent performed on her on September 16, 2010 with a presenting problem of deteriorating vision in her left eye.

38. The Complainant alleged that the Respondent failed to respond when she stated that she could not see the letters on the wall.

39. The Complaint alleged that the Respondent provided a contact lens prescription which did not address her vision.

40. The Complainant alleged that she subsequently attended her general practitioner, Dr[redacted], who referred her to ophthalmologist, Dr. [redacted]. The Complainant stated that Dr[redacted] immediately diagnosed that she had significant cataracts in her left eye, and performed surgery on June 17, 2011, which restored her vision.

41. In her complaint, the Complainant alleges that the Registrant failed to perform a proper eye examination by failing to recognize that she had a significant cataract in her left eye at the time of the examination with him.

42. As a result of the complaint, the Inquiry Committee of the College initiated an investigation under section 33(1) of the Act and forwarded the complaint to the Registrant for a response.

43. On September 6, 2011, the College received a response from the Respondent, the highlights of which are as follows:

a) First visit by the Complainant to the Respondent's clinic was September 16, **2011** (emphasis added)

b) Presenting problem was red itchy eyes

c) "No complaints about visual acuity at all"

d) Complainant had some trouble with reading but does not have reading glasses

e) Complainant had muscle surgery on eye as a child

f) Family physician is 'Dr. Ma'

g) Complainant has seen Dr. [redacted] since 2006

h) Some "frosting" showing in lenses of both eyes, but particularly in left eye

i) Respondent offered to refer her back to Dr. [redacted] "to evaluate her poor visual acuity"

j) Complainant indicated she would initiate the referral herself

k) Respondent offered to write a referral letter which the Complainant could pick up at subsequent visit

l) Complainant had follow up visit on 'Aug 22' which was changed by hand on the letter to 'Sep' 22.

m) At the follow up visit, the Respondent inquired about the appointment with Dr. [redacted]

n) Subsequently, the Respondent attempted to contact all of the Dr. Ma's listed in the phone book

o) Respondent phoned Dr [redacted] office for report regarding treatment for cataracts

44. By letter dated October 3, 2011, the Complainant responded that her recollection of events differed significantly from the Respondent's, specifically, the date of her first visit to the Respondent, her need for reading glasses, the inaccurate information regarding the name of her general practitioner, when she had eye surgery for a wandering eye, and the incorrect date of her follow up visit. In addition, she disputed the fact that the Respondent offered a referral to Dr. [redacted] or that the Respondent mentioned frosting of the lens to her.

45. On April 5, 2012, Dr. [redacted] office provided the Registrar with a copy of a referral note sent by the Respondent to Dr. [redacted] via facsimile transmission. The referral note was dated September 16, 20**11** (emphasis added), but the facsimile header shows Dr [redacted] office receiving the transmission dated on August 26, 2011. (Ex. 3, Tab 7)

46. On April 24, 2012, the Respondent hand-delivered an original referral note. The original referral note appears identical to the facsimile received by Dr [redacted] office except for its date, which may be September 16, 2010 *or* 2011. (Ex. 3, Tab 8)

47. Between April 26, 2012, and June 28, 2012, there was a series of written responses to the College from the Respondent and the Complainant regarding the facts of the complaint, particularly the nature of the presenting problem at the September 16, 2010 visit to the Respondent's clinic, the adequacy of the eye exam at the September 16, 2010, office visit, accuracy of case history information gathered, accuracy of information regarding vision status and vision needs (ie., glasses and contact lenses), name of Complainant's family physician, and referral to Dr [redacted].

48. After considering all the material submitted by the parties and the information gathered by the Registrar of the College, including the clinical records of the Respondent, Dr[redacted] and Dr. [redacted] the Inquiry Committee directed the issuance of a citation under section 33(6)(d) of the Act.

7.0 TESTIMONY OF WITNESSES

Dr. Robin Simpson

49. Dr. Robin Simpson testified. He is the Registrar of the College.

50. His testimony was directed in large measure to identifying a number of documents in the Book of Documents tendered as Exhibit #3 by the College.

51. Dr. Simpson also testified that the College had difficulty getting the records requested of the Respondent by the Inquiry Committee. In letters dated September 2, 2011, and October 24, 2011, Dr. Simpson directed the Respondent to provide the clinical records requested by the Inquiry Committee.

52. Subsequently, the Inquiry Committee requested that Dr. Brad McDougall, an optometrist designated as an inspector for the Inquiry Committee, attend the Respondent's clinic in order to obtain the Complainant's clinical records. The inspection took place on November 15, 2011.

53. Dr. Simpson noted that the Inquiry Committee met with the Respondent on April 24, 2012, to review with him information that they had received prior to rendering a decision.

54. Finally, Dr. Simpson testified that he interviewed the Complainant on May 26, 2012.

55. The Inquiry Committee decided under s. 33(6)(d) the Act to direct the Registrar to issue a citation under section 37 alleging that the Respondent engaged in professional misconduct, and this was communicated to the Respondent by letter dated July 9, 2013.

Ms. [redacted] (the "Complainant")

56. The Complainant testified that she first saw the Respondent as a patient at his clinic on September 16, 2010, at the recommendation of her husband who was a patient of the Respondent.

57. She stated that she regularly got bi-annual eye examinations but in particular she was concerned with the vision in her left eye.

58. She further stated that she has been wearing glasses since age 7, has had contact lenses since age 18, and has had a 'wandering eye' virtually all of her life.

59. She testified that she did not feel that the Respondent responded to her needs. She claimed that he ignored her when she told him she couldn't see the letters on the wall with her left eye.

60. She testified that the Respondent only gave her a new contact lens prescription.

61. She further testified that she does not recall receiving any drops for her eyes. She felt the exam was rather brief and cursory, although she could not recall how long the exam took.

62. She claimed that she did not receive any warning about safe driving due to her eyesight. Nor does she recall any mention of 'frosting' of her eyes.

63. She claimed that the prescribed contact lenses did not improve her vision. She further claimed that she had experienced soreness and redness of her eyes and that the diminished vision in her left eye was creating problems seeing the computer at work and led to her no longer being able to knit.

64. She did not recall the Respondent suggesting that she see ophthalmologist, Dr. [redacted], whom she had seen on previous occasions.

65. She stated that she subsequently went to her general practitioner for a referral to a neurologist, concerned that she had a neurological disease, and to Dr. [redacted], as her vision problems persisted.

66. She claimed that the delay in following up with her family doctor regarding her vision problems was due to fear that she may have a serious neurological condition.

67. She testified that at her appointment with Dr. [redacted] on May 16, 2011, he immediately diagnosed a significant cataract in her left eye, and the beginning of a cataract in her right eye. In reply to cross examination, the Complainant testified that Dr. [redacted] indicated that the cataracts had been developing for some time.

68. Dr. [redacted] performed surgery to remove the cataract in her left eye on June 17, 2011, and on the right eye on June 28, 2011. The Complainant testified that the removal of the cataracts was "like a miracle" in restoring her vision. She claims that she has had no further eye problems.

69. On July 20, 2011, the Complainant filed a complaint with the College alleging that the Respondent had performed an inadequate eye examination on her on September 16, 2010, by failing to diagnose that she had significant cataracts, particularly in her left eye.

70. The Complainant stated that she filed the complaint as a result of the anger she felt with the cataracts not being diagnosed and treated sooner, but also to protect others from a similar experience.

Dr. Jerry Mackenzie (the "Respondent")

71. The Respondent testified that he has been practicing optometry since 1970, and that he specializes in children's vision and contact lenses.

72. He testified that he saw the Complainant for the first time on September 16, 2010, at which time he completed a case history and eye exam. He stated that the presenting problem was that Complainant's eyes became tired in the afternoon.

73. He further stated that he did not dilate the Complainant's pupils as it was not necessary due to her large pupils.

74. The Respondent denied that the Complainant told him that she was experiencing poor vision, particularly in her left eye, or that she wore reading glasses.

75. The Respondent testified that he prescribed a change in the Complainant's contact lens prescription. He also claimed that he did caution her not to drive until her new contact lenses were fitted.

76. The Respondent stated that he was aware that the Complainant had been a patient of Dr. [redacted] since 2006. He claims that he did mention cataracts to the Complainant and that he recommended a referral to Dr [redacted]. His recollection is that the Complainant said she would make her own referral to Dr. [redacted].

77. The Respondent claimed that he completed a referral form for his clinical records even though he acknowledged that the form wasn't necessary since the Complainant had indicated she was going to refer herself to Dr. [redacted].

78. The Respondent claimed that he could not recall when the referral form was completed, and denied faxing the referral form to Dr. [redacted].

79. He further testified that the Complainant returned for a routine follow up appointment on September 22, 2010, to check the fitting of the contact lenses. He stated that there were no other complaints from the Complainant at that time.

80. The Respondent also testified that that some time after the September 22, 2010 visit that he attempted to contact the Complainant's general practitioner to check on the status of the referral to Dr [redacted]. He claimed that the Complainant gave him an incorrect name of her general practitioner, as "Dr [redacted] rather than Dr. [redacted] As a result, he was not able to contact her physician.

81. Finally, the Respondent confirmed that the date of the first visit to his clinic by the Complainant was '2010' not 2011, as the latter date appears in one copy of the referral form as well as in a written note to the College on September 6, 2011, in response to Ms [redacted] complaint.

82. When asked about these discrepant dates, the Respondent remarked that it could have been a photocopy error, and then also stated that the date '2011' on one of the copies of the referral form submitted to the College was the result of his tendency to

write his zeros in a rapid up and down motion which tend to look like ones. He went on to explain that the reference to 2011 in his written response of September 6, 2011 was a "typo".

8.0 CREDIBILITY

8.1 The Respondent's credibility

83. The Panel found overall the Respondent lacked credibility.

84. The Panel found contradictions in the Respondent's account of the Complainant's presenting problems. For example, in a written response, dated September 6, 2011, to the College in response to the Complainant's complaint, the Respondent writes that the Complainant "had no complaints about her visual acuity at all" but then notes that he "would refer her back to Dr. [redacted] to evaluate her poor visual acuity". Similarly, the Panel found contradictions in his account of his advice to her. In his initial response of September 6, 2011 he wrote that he suggested no change in the Complainant's distance glasses, but in another response dated April 26, 2012 he said he advised her to change her glasses to "the new prescription," and in cross-examination he confirmed he was referring to a prescription change for the Complainant's distance glasses.

85. The Panel also found inconsistencies in the Respondent's account of his clinical observations. For example, under direct examination, he testified that he observed frosting of either the lens or the cornea and stated it could be either amblyopia or cataracts. He confirmed under cross-examination that he did not know which one, and so he referred the Complainant to Dr. [redacted] When presented with his referral note that set out that the left cataract was getting worse, he then testified that there was the beginning of cataracts, and that he diagnosed the beginning of cataracts.

86. The Panel found the Respondent evasive in a many of his responses, further calling into question his credibility. For example, he testified that he had not received written notification from the College of the complaint or the request for his clinical records. Even when shown his signature confirming that he had received them by registered mail, he asserted he must have been out of town when the requests came in, despite his signature. Under direct examination he asserted he gave the Complainant a drop of Fluress on September 16, 2010; but under cross-examination he said he might have given her that drop on September 22, 2010. When further challenged that he was changing his story, he said that he was just saying what is reasonable to assume.

87. The Respondent asserted with respect to the Consent Order that two men showed up and told him to sign it. When advised that the Consent Order was sent by registered mail, he said he did not recall how he obtained it.

88. The Respondent declined to admit to having been served with the citation in this matter. To prove service, the College called the process server as a witness who then testified to having served the Respondent with the citation in this matter. The

Respondent despite refusing to admit to service did not challenge the process server's testimony.

89. The Panel found that the Respondent blamed all errors on the Complainant, and appeared to lack any ability to consider that he might have done something wrong or been mistaken. The Panel found that this tendency, combined with other issues relating to his testimony, indicated a degree of carelessness or disregard for the truth.

90. As explained below, the Panel decided the Respondent had no persuasive explanation for why his records contained two different versions of a referral letter to Dr. [redacted], one dated in "2011" and one where the "2011" appeared altered to look more like "2010". The Respondent suggested a photocopier error, and also suggested that his "1"s look like "0"s, even though an examination of his records show distinct "1"s and "0"s.

8.2 The Complainant's credibility

91. The Panel did not find the Complainant's credibility wholly free of doubt. The Panel noted the oddity of the Complainant visiting Dr. [redacted] three times after her appointment with the Respondent before seeking a referral to Dr. [redacted]. However, the Panel concluded the Complainant was credible overall, and that overall credibility was not diminished by her errors, or possible errors, about details such as when she stopped knitting due to her loss of vision.

92. In his testimony, the Respondent portrayed the Complainant as someone who did not listen, and was not careful. However, after observing the Complainant, the Panel drew an opposite conclusion about her character, having concluded that the Complainant is someone who does listen and is a careful person.

9.0 FINDINGS OF FACT

9.1 Allegations of Failure to Conduct Proper Eye Examination with Dilation [Citation paragraphs 9 and 13]

93. The Complainant testified, and the Panel accepted, that she had had issues with her eyes from an early age and that she was quite aware of typical eye examination procedures, having undergone such examinations for many years.

94. She had been a patient of ophthalmologist, Dr. [redacted] since 2003, because of her ongoing eye health issues.

95. A medical report from 2007 by Dr [redacted] indicated, and the Panel accepted, that the Complainant had 20/20 vision. There was no mention of any other problems with her eyes.

96. The Complainant testified that the Respondent did not ask her about family history, or details about her current and past vision, nor did he perform procedures that

she was familiar with in previous eye examinations such as puff of air in her eyes, shining of a bright line in her eyes and dilation.

97. **The presence of cataracts.** On May 16, 2011, Dr. [redacted] reported to the Complainant's family physician, Dr. [redacted], that the Complainant had "very significant cataracts in her left eye" which he subsequently operated on, restoring her vision in that eye.

98. Although no expert evidence was submitted to demonstrate that dilation would have revealed the presence of a cataract in the Complainant's left eye, given that her vision in her left eye was 20/200 when she saw the Respondent, was 20/400 when she saw Dr. [redacted] eight months later, and became 20/20 after cataract surgery, the panel inferred that an examination with dilation on September 16, 2010 would have revealed a significant cataract.

99. The Panel accepts the Complainant's evidence that she had significant visual acuity problems at the time the Respondent examined her on September 16, 2010, and inferred that these problems were the result of the presence of cataracts. The Panel accepts that the Complainant reported her acuity problems to the Respondent. The Panel found the Complainant to be a credible witness and accepted her testimony over the testimony of the Respondent.

100. However, this finding does not resolve the whole of the allegation. In order to prove the whole of the allegation, the Respondent must also have failed to perform a complete or adequate eye examination with dilation. The Respondent testified to dilation being unnecessary due to her large pupils.

101. **If a dilated examination was indicated.** The Standards state, in Part 4, paragraph 3(1)(f)(3), that an initial comprehensive eye examination must include an examination of ocular health and function, and in relation to the posterior segment, a "dilated examination must be performed where indicated...."

102. Whether a dilated examination is "indicated" depends on Part 5, paragraph 4(1), which states that a registrant must dilate a patient's eyes "unless the registrant, exercising sound professional judgment, determines that dilation is contraindicated or unnecessary to be performed in the circumstances."

103. **The absence of expert evidence of standards.** The College did not provide expert evidence of professional standards relating to dilation in these circumstances. Counsel for the Respondent properly argued that the Panel cannot add its own expert knowledge of optometry as evidence in these proceedings. That would be a fundamental breach of procedural fairness.

104. The Panel could not decide, based on the evidence on the record, that the Respondent's decision against dilation because the Complainant's pupils were large enough was unsound professional judgment. The Panel therefore could not conclude

the examination was incomplete or inadequate based on the Respondent failing to dilate the Complainant's eyes.

105. Similarly the Panel could not infer that the Respondent failed to perform a complete or adequate eye examination by failing to diagnose a cataract (as the Panel concludes below), without expert evidence of the professional standards that apply in the circumstances.

106. Accordingly, the Panel decided the College did not prove the alleged combined breach of paragraph 2 of the Consent Order, and of Parts 4 and 5 of the Standards of Practice.

9.2 Allegations of Failure to Make Referral to Appropriate Health Specialist [Citation paragraphs 10 and 13]

107. The Respondent testified he did mention cataracts to the Complainant, and recommended a referral to Dr. [redacted]. However, the Panel concluded that the Respondent failed to diagnose the presence of a cataract in the Complainant's left eye at the time of the eye examination on September 16, 2010.

108. There was no mention in [redacted] clinical notes, dated March 29, 2011, that the reason for the referral to Dr. [redacted] at that time was the presence of a cataract in the Complainant's left eye. The Panel accepts that the Complainant did not inform Dr[redacted] of a cataract because she did not know of the cataract, and she did not know because the Respondent did not convey information about a cataract to the Complainant at the September 16, 2010, eye examination.

109. Given the Respondent's position that he recommended a referral to Dr. [redacted], and given the Respondent identifying the Complainant's vision in her left eye as 20/200, no issue exists that the Complainant either required or might benefit from treatment by an ophthalmologist such as Dr. [redacted], and that Part 6 of the Standards required the Respondent to refer the Complainant.

110. The Complainant did not recall the Respondent suggesting she see Dr. [redacted].

111. A review of MSP records indicated that the Respondent did not bill MSP for a referral to Dr. [redacted] which is customary practice.

112. Clinical records from Dr[redacted] ndicated that she initiated a referral to Dr. [redacted] on March 29, 2011. Her clinical notes indicated that the request for the referral came from the Complainant.

113. Further, there was no reference on the clinical records of either Dr. [redacted] or Dr. [redacted] that the Respondent had identified the existence of cataracts or that he had requested a referral to Dr. [redacted].

114. The Complainant testified that the time delay between her September 16, 2010, eye examination with the Respondent and her subsequent request for a referral to Dr. [redacted] was due to her belief that her visual acuity problems were the result of a serious neurological medical condition, hence the request for a neurological evaluation.

115. The Respondent's account is that he recommended a referral to Dr. [redacted] but the Complainant indicated she wanted to refer herself to Dr. [redacted]. He testified that he wanted to know more about her condition, and attempted to call the Complainant's physician, "Dr[redacted]" by calling each of five doctors listed in a directory with a '[redacted]' surname, but he did not call the Complainant for her physician's number, or call Dr. [redacted]r. The Respondent claimed that he completed a referral note for his clinical records even though he acknowledged that (on his own account of events) the note was not necessary since the Complainant had indicated she was going to refer herself to Dr. [redacted]

116. The Panel found no genuine record of a referral by the Respondent to Dr. [redacted]r. As set out below, the Panel concluded that the Respondent did not create the referral note in 2010, did not communicate a referral in 2010 to his staff using a post-it note, and did not record references to Dr. [redacted] in 2010.

117. In these circumstances, the Panel preferred the Complainant's testimony over the Respondent's testimony. The Panel found the Respondent's credibility to suffer from inconsistencies in his account which demonstrated a carelessness or disregard for the truth. His fabricating a referral form also undermines his evidence that he recommended a referral. The Panel concluded that despite his finding "lens frosting", the Respondent did not refer or attempt to refer the Complainant to Dr. [redacted], as required under Part 6 of the Standards of Practice.

9.3 Allegations of Failure to Maintain Proper Clinical Records [Citation paragraphs 11 and 13]

118. Apart from the issue of whether the Respondent added false entries or documents to his clinical records to show a referral to Dr. [redacted] (Citation paragraphs 11, 12 and 13), the College submitted that the Respondent's records contravened Parts 2, 4, and 5 of the Standards of Practice, and the Panel identified a number of deficiencies:

a. The clinical records, dated September 16, 2010, relating to Ms[redacted] were in many places illegible, inconsistent with Part 2, paragraph 1 of the Standards of Practice.

b. The Panel found that changes or additions to the records were not dated or initialled, inconsistent with Part 2, paragraph 3(2) of the Standards of Practice.

c. The Panel further found that there were mistakes in case history information in the records, for example, the Respondent's name (which is

missing from the record), aspects of the patient's case history such as when the surgery for a wandering eye occurred, the patient's need for reading glasses, the correct name of the patient's family physician, the examination and/or assessment procedures used and results obtained, the counselling provided, and the treatments administered, inconsistent with Part 2, paragraph 2 of the Standards of Practice.

d. The Panel found that the Respondent failed to include as part of the patient's case history "general medical history including any allergies and use of medications" inconsistent with Part 4, paragraph 2(1) of the Standards of Practice.

e. Most significantly, the Panel found that the Respondent failed to document the reasons for not performing dilation on the Complainant, inconsistent with Part 5, paragraph 4(2) of the Standards of Practice. When cross-examined, the Respondent testified that he did not know he had to document his reasons for not performing dilation.

119. However, while Citation paragraph 11 refers to the Respondent failing to maintain accurate and complete records, it specifies the issue of the Respondent falsely claiming that he referred the Complainant to Dr. [redacted] As the Citation does not allege that the Respondent contravened Parts 2, 4, and 5 of the Standards of Practice apart from alleged fraud, the Panel will not determine if the deficiencies noted above in paragraphs 118 (a)-(e) contravene the Standards of Practice, the Consent Order, or constitute professional misconduct in this hearing.

9.4 Allegations of Falsely Altering Clinical Records [Citation paragraphs 11, 12 and 13]

120. The College alleged that the Respondent falsely altered his clinical records, which it says was unethical conduct, and contravened Part 2 of the Standards of Practice (Citation paragraph 12). It refers to a "sticky note" indicating a referral, a change to the date of a referral note, and the faxing of a referral note to Dr. [redacted] (Citation para. 12). The College also alleged that the Respondent failed to maintain accurate and complete clinical records by claiming he referred the Complainant to Dr. [redacted] at the time of his initial examination (Citation paragraph 11). The College alleged that contraventions of the Consent Order and Parts 2, 4, 5 and 6 of the Standards of Practice also constitute professional misconduct (Citation paragraph 13).

121. In essence, the College alleges the Respondent created a false referral note, changed its date during the investigation, and wrote a false entry to indicate a referral that he did not make. At the hearing, however, the Panel requested the original record, and the Panel found that there were a number of additions to the Complainant's clinical records, some with a different colour or weight of ink, leading to concerns by the Panel that the Respondent also added the notations "Discused [sic] OS caterat [sic]" and what appears to be "Dr. [redacted] last saw her Aug 2006" after the Complainant filed her complaint. The Respondent testified that he uses two different examination rooms which

have different pens in them; when he goes from one room to the other, he sometimes switches pens.

122. The allegation in Citation paragraph 12 to a sticky note as a false entry addresses writing on the Respondent's record for the Complainant, surrounded on two sides by straight lines, which appears to say "Refer Dr. [redacted] She Make Apt." The Respondent's position is that the Respondent put a sticky note on the Complainant's file with those words in 2010, to advise his staff. The sticky note was later thrown out, but the words were added to the record so that the College could see it.

123. Counsel for the Respondent argued that a referral is not part of a clinical record for the purposes of Part 2 of the Standards. However the Panel does not accept this, as Part 2, section 2 of the Standards of Practice stipulates that a "patient record" must contain "(i) the referral made, if any".

124. A sticky note would seem an inappropriate way to record a referral in a patient record. The Respondent's position is presumably that the sticky note he used was replaced by the referral note he says he created in 2010. Both the content of the purported sticky note and the referral note are at least misleading, as the Respondent's own testimony is that he did not make a referral, and that the Complainant would refer herself. However, the larger issue is if the Respondent did not recommend a referral at all, making the contents of the purported sticky note, and the referral note, false entries.

125. Of further concern for the Panel was the existence of two identical copies of the purported referral note to Dr. [redacted], one with the date "2011" and the other with the date "2010", the latter appearing to have had the numeral '1' altered to appear as a zero. The Panel's had two concerns.

126. First, the referral notes included details it should not contain if the Respondent had created it in 2010. One referral note was dated "Sept 16, 2011". That note was faxed to Dr. [redacted] office from the Respondent's clinic on August 26, 2011, two months after the Complainant had received cataract surgery by Dr. [redacted]. The Respondent also testified that he observed frosting of either the lens or the cornea and stated it could be either amblyopia or cataracts, but he stated in the referral note that "OS neuclear [sic] cataract is getting worse". On September 6, 2012, the Respondent wrote a response to the College in which he referred to an examination on September 16, 2011.

127. Secondly, the circumstances in which the Respondent provided a referral note apparently dated 2010 is consistent with his having changed the note. On April 24, 2012, after the Complainant wrote to clarify that their first meeting had been in 2010, the Respondent provided a referral note to the College with a date that could be read as 2010.

128. The Respondent's counsel submitted that it would make no sense for the Respondent to have modified the referral note date from 2011 to 2010 as the College already had a copy of the referral note obtained through its inspection. While it is

correct that the College already had a copy of the referral note from its inspection, the Respondent has amply demonstrated his disregard for consistency.

129. When asked about the discrepancy between the referral note he had provided to the College and the note faxed to Dr. [redacted] the Respondent suggested that "2011" may appear as "2010" due to either a photocopying error, or because his "1"s sometimes look like "0"s.

130. The Respondent's counsel argued that the College failed to submit expert evidence of handwriting analysis and the Panel could not use their own judgement to determine whether the handwriting was the same between the two referral notes. The College submitted and the Panel agrees that it could use its own common sense judgement to review the two referral notes to determine if they are different.

131. Upon reviewing the referral notes, including the original note, and the Respondent's handwriting in his records, the Panel found that the Respondent's "1"s and "0"s are clear. Further, the "2010" date on the College's copy of the referral note was not the result of a photocopy error, as the mark changing "2011" to "2010" on the original referral note appeared to be done with a different type of pen given the apparent different black ink.

132. The Panel concluded that the Respondent did not create the referral note in 2010, and instead wrote the referral note after the complaint, but mistakenly dated it "Sept 16, 2011". The Respondent faxed the referral note to Dr[redacted], or had it faxed, on August 26, 2011. On September 6, 2011, the Respondent wrote a response to the Inquiry Committee referring to an eye examination on September 16, 2011. After realizing the date on the referral note had the wrong year, the Respondent altered "2011" in the referral note to "2010".

133. While the Respondent purported that the words in the records, "Refer t[redacted] she make Apt." repeat a sticky note from 2010, the Panel concluded he did not create such a sticky note in 2010.

134. The Panel also concluded the Respondent altered the records to falsely show he discussed a cataract with the Complaint, and to add words that may say "Dr. [redacted] last saw her Aug 2006" to support his assertion that he had referred the Complainant to Dr. [redacted]

135. The College established a combined breach of paragraph 4 of the Consent Order and Part 2 of the Standards of Practice based on the Respondent adding an inaccurate notation and referral note to a patient record. The College also established a breach of Part 2 of the Standards of Practice and Bylaw sections 130 and 131 based on the Respondent making false entries, and his creating, distributing and providing to the College a false referral form to hide his failure to refer the Complainant as required by Part 6 of the Standards of Practice.

10.0 VERDICT

136. The Panel unanimously finds that the Respondent contravened Standards of Conduct, the Consent Order, and the Bylaws as the College, as the College alleged in paragraph 10, a part of paragraph 11 (relating to the Respondent claiming he referred the Complainant to Dr. [redacted] and paragraph 12 of the Schedule to the Citation. The Panel finds that these contraventions are also professional misconduct.

137. The Panel unanimously dismisses the allegation the Respondent contravened the Standards of Conduct, or the Consent Order, as the College alleged in paragraph 9 of the Schedule to the Citation.

11.0 PENALTY, PUBLICATION AND COSTS

138. Submission regarding penalty, publication and costs will be forthcoming from the College and may be forthcoming from the Respondent. The Panel will arrive at a decision on these issues in due course and its further Reasons will form part of this Decision.

12.0 NOTICE

139. Under section 40(1) of the Act, a respondent or registrant aggrieved or adversely affected by an order of the Discipline Committee may appeal the order to the Supreme Court.

REASONS FOR DECISION of the Panel:

M L	SIDNEY, BC	Oct 3, 2013
Name	Place	Date
Name	Place	Date
Name	Place	Date