DISCIPLINE COMMITTEE
OF THE COLLEGE OF OPTICIANS OF ONTARIO

PANEL: Rob Vezina, RO – Panel Chair
Daniela Celi (Schowalter), RO
Rob Dickinson, RO (***did not take part in the decision***)
Jacalyn Cop-Rasmussen, Public Member
Jack Zwicker, Public Member

BETWEEN:

COLLEGE OF OPTICIANS OF ONTARIO	)	*Rebecca Durcan & Anastasia-Maria Hountalas* College of Opticians of Ontario
- and -	)	*Damien Frost & Rebecca Young* For the Member, Steve Rodney Sanger
STEVE RODNEY SANGER, 3277	)	*Luisa Ritacca* Independent Legal Counsel
	)	Heard: November 25-27, December 17, 2019

DECISION AND REASONS

This matter came for hearing before a panel of the Discipline Committee on November 25, 26, 27, 28, 2019 and December 17, 2019 at the College of Opticians of Ontario (the "College") at Toronto. Prior to the completion of the Panel's deliberation process, Mr. Robin Dickinson became unable to continue as a member of the Panel. The four remaining members of the Panel who constitute a quorum completed the deliberation process and reached the decision as set out below.

The Allegations

The allegations against the Member as stated in the Notice of Hearing dated February 4, 2019 are set out in full at Appendix 'A' attached to the end of these reasons for decision.

In brief, it is alleged that in his dealings with R.L. (the "Patient"), the Member held himself out as an optometrist and/or physician; prescribed contact lenses; dispensed contact lenses without a prescription; engaged in inappropriate billing practices; kept deficient patient records; and failed to provide the patient with his records in a timely manner or at all.

The Member's Plea

The Member denied all of the allegations set out against him in the Notice of Hearing.

Overview

The events at issue took place between approximately January and October 2017. All of the Member's interactions with the Patient took place at the Sanger Eye Clinic, in Hamilton, Ontario (the "Clinic"). In 2017, the Member was associated with three family-run eye clinics. He did not become an owner of the Clinic until sometime in 2018.

There is no dispute that Mr. Sanger was present for all of R.L.'s appointments from January through October 2017. At the time there were two optometrists associated with the Clinic, Dr. Rob Struk and Dr. Farrukh Sheikh. There is significant dispute as to whether either optometrist was present for some or any of R.L.'s appointments. As is set out in detail below, the Panel was able to reach its decision without concluding whether the Patient's recollection of his interactions with the optometrists was entirely reasonable. The Panel's findings are made in large part on its review of the documentary evidence and the Member's own testimony.

The Evidence

At the outset of the hearing, the Panel was provided with a Joint Book of Documents, which was filed on the consent of both the College and the Member. The Panel received a number of additional documents throughout the course of the hearing and heard evidence from eight witnesses, including the Patient and the Member.

Evidence of the Patient, R.L.

R.L. is a 62-year old male, who suffers from keratoconus, a disorder of the eye, which results in progressive thinning of the cornea. This condition often makes glasses or ordinary corrective lens ineffective, necessitating the fitting of a specialty corrective lens. R.L. is originally from New York State. He testified that he received regular treatment for his eye condition in New York. When he and his wife moved to Ontario, he sought help from one local optometrist, prior to seeking out help from the Member. R.L. testified that he only saw the local optometrist once.

R.L. testified that he researched on-online for a keratoconus specialist and that in the course of his research he found the website operated by the Sanger Eye Clinic. He testified that he was looking to locate an eye doctor and was particularly interested in making an appointment with one who had expertise in treating keratoconus. He believed, based upon the Sanger Eye Clinic website, the Clinic had the particular expertise he was seeking.

The Panel received a print-out copy of the current text found on the Clinic website. It refers to keratoconus as a clinic specialty, but it does not identify the Clinic staff with the specialty or even name the Member as part of the staff.

R.L. testified with respect to each of his appointments with Mr. Sanger at the Clinic. He stated that Mr. Sanger was the only health care professional he saw at his appointments. He testified that no other eye care professional examined his eyes or spoke with him about his eye condition. R.L. was shown OHIP Claim summaries which suggest that at the vast majority of his appointments he was seen by either Dr. Sheikh or Dr. Struk. The Patient denied that he ever met with or was examined by either optometrist connected to the Clinic. He was not aware of why OHIP had been billed for his attendances.

R.L.'s first attendance

R.L. testified that he attended the Clinic prior to making an appointment and spoke with one of the women at the front desk. He told that person that he wished to see a doctor who specialized in keratoconus and that he was told that the Member was the 'king of corneas'. On this basis, R.L. said that he booked an appointment for January 23, 2017.

R.L.'s Appointments

The Patient attended at the Clinic on thirteen (13) occasions between January 23 and October 31, 2017.

On either January 21, 2017 when he says he attended the Clinic to book an appointment or on January 23rd when he attended his first appointment, R.L. provided the front desk with his OHIP card. He also partially filled in a patient information form.

At his first appointment, R.L. stated, "nice to meet you Dr. Sanger," as he thought Mr. Sanger was a doctor. R.L. testified that he was not corrected by the Member or his front desk staff. R.L. stated that at this appointment he told the Member that he was bi-polar and also suffered from PTSD. He emphasized that this was the first thing he mentioned to the Member. The details relating to his previous eye care health professional were left blank on the patient information form; although during his cross-examination the Patient confirmed that he had seen another eye care professional in Ontario prior to attending at the Member's Clinic.

R.L. testified that he had been using Kerasoft contact lenses and stated that the Member pushed him to consider soft scleral lenses instead. The Patient was reluctant to change to scleral lenses and was concerned about using a suction cup to insert and remove the lenses, which may be required with the scleral lenses.

R.L. stated that the Member conducted an eye exam and asked him to read letters from a wall chart and later put in eye drops. According to the Patient no one else was in the examining room and the Member alone made notes of the exam. Following the examination, the Member did a lens fitting. While Dr. Sheikh's name appears on the top left of the patient chart for the date of this visit, R.L. stated that he never met nor was treated by Dr. Sheikh. Under cross-examination, the Patient was taken to an email he sent to the College wherein he indicated that there was a "dark coloured male" present at his first appointment. Despite this admission, the Patient denied being examined by anyone other than Mr. Sanger at his first visit.

According to R.L., the Member discussed the cost of scleral lenses which he priced at $3,700.00 plus additional amounts to be billed to OHIP and to Sun Life, the Member's private insurer. R.L. stated his concern that the scleral lenses were twice as expensive as his old Kerasoft lenses. He stated that in a panic he called his wife not knowing whether to proceed and that once she calmed him down he decided to prepay for the scleral lenses by splitting the costs between a credit card and a debit card.

R.L. stated that he saw the Member again on January 26th, 2017 at which time the Member examined him using a pencil-like instrument to examine the corneas. He stated that this device reflected an image of the corneas. The Member provided the Patient with a test pair of lenses. Upon returning home, R.L. testified that he had runny eyes and mucous, and that he could not see and the lenses appeared as though there were particles of snow on them.

The Patient re-attended the Clinic on January 31st, 2017. He had previously emailed to complain about mucous running from his eyes. He testified that he demanded a refund, as he was extremely upset. Given the state of his eyes on that day, his friend and neighbour, R.A. drove him to the Clinic. The Patient testified that at first the Member did not want to speak with him, but eventually did so. The Patient explained that the Member was able to calm him down. Mr. Sanger provided R.L. with a prescription for Maxidex. The prescription was signed by Dr. Struk and was filled at the pharmacy located next door to the Clinic.

R.L. was upset at the time of the attendance and said that he could not recall whether the prescription was handed to him or was faxed to the pharmacy. In later evidence, it was confirmed that the prescription had not been faxed to the pharmacy, but had been handed to the pharmacist by the Patient. R.L. stated that he did not know Dr. Struk and was not attended to by him that or any other day.

R.L. stated that at another visit the Member handed him sodium chloride solution to help him insert and remove the scleral lenses. R.L. stated that the Member told him that a friend of his who worked at a hospital had provided him with the sodium chloride.

R.L. testified that while he did not remember everything about each of his visits with Mr. Sanger, he confirmed that throughout the relevant time period, he continued to experience discomfort and was generally not happy with the lenses he had received. He confirmed that at no time was he treated by anyone other than Mr. Sanger. The Patient attended the Clinic throughout the winter and spring of 2017.

R.L. attended the Clinic on June 9, 2017 with his with spouse, E.C. He was still suffering from mucous in his eyes, which caused him discomfort. The Member advised R.L. that he would need the mucous squeezed from his eyes. R.L. confirmed that only he, his wife and the Member were present in the examination room for the appointment. He denied seeing Dr. Sheikh at the appointment.

On June 20, 2017 R.L. re-attended the Clinic to have a Meibomian gland squeeze. R.L. said that the procedure was performed by the Member and that the only other person in the room was his wife, E.C.

R.L. re-attended on August 2, 2017 but did not recall the details of this appointment. He was shown his patient record, which refreshed his memory. He attended on that day to complain that his lenses were not fitting well. He thought that the lenses needed to be re-fitted and ordered again. The Member ordered new lenses for the Patient.

On September 22, 2017, R.L. tried the new lenses and did not recall a large improvement as noted on his patient record.

On October 31, 2017, R.L. attended the Clinic for the last time. He mentioned suffering excruciating pain, especially in his left eye. He testified that he went with the Member to another examining room and underwent a test using a 'wand like' machine that the Member waved in front of his eyes. According to R.L. the problem was not with the lenses. R.L. recalled being told by Mr. Sanger that his eyeballs had grown. The Patient commented to the Member that this was a ridiculous suggestion. A discussion took place during which the Member suggested using a 3D lens instead of the one he had been using. The Patient testified that this would have been a fourth set of lenses. R.L. was not prepared to pay for another set of lenses, when in his view he was never provided with a satisfactory pair by Mr. Sanger.

Under cross-examination, R.L. acknowledged that he remembered that at this visit there was a Caucasian male present in the examining room with him and the Member, to whom the Member was reporting his findings. The Patient described that male alternatively as an IT guy, a trainee, or a janitor who said hello to him. When challenged on this memory under cross examination, R.L. stated that due to his condition his memory could go up and down at any time.

The Patient was upset by the amount of money he had paid to the Clinic. In his written complaint and in a subsequent email, the Patient suggested that he paid upwards of $5,000.00 to $6,000.00. During his examination, he acknowledged that he may have been wrong with the amounts and that he may have rounded the figure up.

Following his last visit on October 31st, R.L. contacted the Clinic to ask for his file so that he could bring it to a new eye care professional. R.L. testified that the receptionist refused to provide him with his file. Eventually, the Clinic faxed the Patient's new eye care professional at Abbey Eye Care in Oakville an unsigned summary of the Patient's records.

The Patient complained to the College about his treatment by Mr. Sanger. In his initial communications with the College, R.L. sought help in getting a refund from the Clinic. R.L. stated that he was angry about these events and mentioned suing to get his money back. He learned through the investigation process that the College does not have jurisdiction to deal with such claims.

Evidence of the Member- Steven Rodney Sanger

Mr. Sanger testified that in 2017, during the relevant time period, he was associated with three family-owned eye clinics, including the Clinic, where he saw the Patient. Mr. Sanger did not become the owner of the Clinic until sometime in 2018. Mr. Sanger explained that during the relevant time period, he was the only optician working at the Clinic and that Dr. Struk and Dr. Sheikh were the attending optometrists.

Mr. Sanger agreed that he is not permitted to use the title "doctor" and denied ever having done so in his interaction with R.L. He explained that his usual practice is to tell new patients to "call him Steve". If R.L. referred to Mr. Sanger as doctor at their first meeting, Mr. Sanger said he could not recall if he specifically corrected him or if he simply told him "to call me Steve".

Mr. Sanger admitted that he does not always wear his badge specifically identifying him as an optician.

Contrary to R.L.'s evidence, Mr. Sanger testified that either Dr. Struk or Dr. Sheikh were present for many of the Patient's appointments and that if OHIP was billed for the visit, that was done by one or the other optometrist. Mr. Sanger denies that R.L. never met with or was examined by an optometrist. On the contrary, Mr. Sanger testified that one or the other of Dr. Struk or Dr. Sheikh was present for the majority of the appointments.

For example, Mr. Sanger testified that he first saw R.L. on January 23, 2017 at the Clinic, together with Dr. Sheikh. He and Dr. Sheikh spoke with R.L. about him being a good candidate for scleral lenses.

Mr. Sanger stated that he spent 10 to 15 minutes with R.L., following Dr. Sheikh's examination. The Patient was wearing Kerasoft lenses and complained of poor vision and discomfort. Mr. Sanger described hybrid lenses which were less expensive, but R.L. decided on scleral lenses. A fitting could only be done after measurements were sent to the manufacturer who would create a 'fit set', which would take one to two weeks.

Mr. Sanger stated that the words 'scleral contact lens' appearing on the January 23, 2017 patient record are in his handwriting. He agreed that this record was unsigned and there was no way of knowing who authored it. In addition, the Patient's name and contact information do not appear on the patient record. He further acknowledged that there was no written ongoing patient management plan. Mr. Sanger's name and College registration are also missing from the record.

All of R.L.'s patient records include in the upper left corner of the page, the name of Dr. F.A. Sheikh OD. The Member admitted that the record forms were used by him, Dr. Sheikh and Dr. Struk interchangeably.

Mr. Sanger stated that he did not learn of the Patient's mental health issues at the time of the first appointment. He stated that he learned about R.L.'s PTSD and bi-polar condition sometime later.

At the January 26, 2017 appointment, Mr. Sanger stated that the first fitting took between one and three hours. He stated that he used a phoropter and an auto refractor in order to take eye measurements. He explained that these measurements are necessary in order to order the correct pair of scleral lenses. Mr. Sanger indicated that Dr. Sheikh was present during this examination.

Mr. Sanger testified that at the January 30th appointment, R.L. was taught how to insert and remove his fit lenses. Mr. Sanger could not recall whether either Dr. Struk or Dr. Sheikh was present at this appointment.

Mr. Sanger agreed that he dispensed lenses to R.L. based on the manifest over refraction (MOR) of a trial Keratoconus lens.

On January 31, 2017, Mr. Sanger's assistant Ms. Mahood advised that she had received an e-mail from R.L. complaining of white mucous accumulating in his eyes.

Mr. Sanger stated that Dr. Struk was at this appointment and examined the Patient with a slit lamp. Mr. Sanger recalled that Dr. Struk concluded that R.L. was reacting to the preservative in the saline contact solution and told the Patient not to wear the lenses until they obtained a non preservative saline. Mr. Sanger stated that he could not recall whether he was present when Dr. Struk handed the saline to R.L.

Mr. Sanger confirmed that at a later appointment, on February 21, 2017 he provided R.L. with a saline solution that he obtained from a friend working as a physician at St. Joseph`s Hospital. Mr. Sanger agreed on cross-examination that he did not document this in the patient records.

The Member also stated that he made a prescription change to the scleral lenses. This is not documented in the patient records.

Mr. Sanger acknowledged that during an appointment with R.L. on April 3rd, 2017, he recommended that the Patient might want to consider using Dawn detergent to clean his lenses to reduce fogging. Mr. Sanger explained that he had been told by the manufacturer of the lenses that using Dawn as your preliminary cleaner helps with fogging.

Mr. Sanger stated that R.L. attended the May 5, 2017 appointment to obtain replacement drops for a product called Allaway that he had previously used in the United States. Neither Dr. Struk nor Dr. Sheikh was present that day. Mr. Sanger stated that he called Dr. Struk at the Caledonia location concerning Allaway and that Dr. Struk looked it up and wrote a prescription that he then faxed to a pharmacy nearby the Clinic. Dr. Struk did not see the Patient that day.

At a following appointment on June 9, 2017, Mr. Sanger noticed that the Patient`s Meibomian glands appeared compacted and enflamed. He also noted debris in R.L's eyes and suspected that he could benefit from having the glands squeezed. Mr. Sanger did not recall whether Dr. Sheikh was present in the examining room. He mentioned that Dr. Sheikh was not comfortable doing this procedure and that he could do it if it were delegated to him, or if it were done by an optometrist with him in the room. Mr. Sanger decided to wait until a day when Dr. Struk was available.

The Patient returned for a Meibomian gland expression on June 20, 2017. Mr. Sanger recalled that the Patient attended on that day with his wife. Mr. Sanger stated that Dr. Struk was also present in the examining room Mr. Sanger stated that Dr. Struk examined R.L's eyes with a slit lamp and that Dr. Struk determined that an anterior expression was sufficient so as not to dislodge the patient`s punctal plugs. Mr. Sanger could not remember whether Dr. Struk was in the room when he [Sanger] performed the gland expression as Dr. Struk was in and out of the room during the appointment.

The Patient attended at the Clinic on August 2nd, together with his wife. Mr. Sanger stated that another set of scleral lenses was ordered, and that he made an adjustment for an astigmatism to make the landing zone flatter.

During this appointment, Mr. Sanger said that he had a brief conversation with the Patient's wife who had indicated that she was just recovering from cataract surgery. Mr. Sanger stated that he and Dr. Sheikh agreed to take a look at her eyes. He prepared brief notes of the examination and he says that Dr. Sheikh tested her vision with an auto refractor to provide her with a new prescription.

Mr. Sanger recalled that the Patient attended the Clinic on October 31, 2017 for the last time. Both he and Dr. Struk interacted with the Patient.

With respect to the October 31, 2017 appointment, Mr. Sanger recalled that Dr. Struk was called into the examining room to examine the Patient's lenses and retina. Dr. Struk concluded that the scleral lenses were rubbing on the limbus of the Patient's eye and therefore causing him pain. Mr. Sanger was concerned about the fit of the lenses and suggested other styles and

materials including 3D lenses. Mr. Sanger left it up to the Patient to decide whether he wanted to purchase another type of lens.

Release of Patient Records

Mr. Sanger stated that he understood that a patient has a right to access his records. He understood that R.L. had called the Clinic to request his original file. He assumed that R.L. intended to seek out a second opinion. He did not oppose providing R.L. with a copy of his records, but that there was a $75.00 processing fee. He stated that it is usually easier for patients to arrange to have their new eye care provider contact the Clinic to ask for the records.

Mr. Sanger explained that the Clinic ultimately provided R.L.'s new optometrist with a one-page patient summary. He included a disclaimer on the summary, because in his view there was an issue with the fit of R.L.'s lenses and he did not want another clinic to duplicate them.

OHIP Billings

Mr. Sanger stated that he had nothing to do with OHIP billings submitted by Dr. Struk and Dr. Sheikh. He testified that he was completely unfamiliar with the billing process and that there would be no reason for him to look into how OHIP billings were processed by the optometrists.

Evidence of Ms. Aronne

At the hearing evidence was heard from Ms. Aronne and it was uncontroversial. She was a friend and neighbour of the Patient, who drove him to one appointment at the Clinic.

She testified that she saw a short white man at the Clinic and that she overheard an argument between the Patient and that man.

Evidence of Dr. Tong

Dr. Tong is a registered Ontario optometrist. She operates an eye clinic known as Abbey Eye Care in Oakville, Ontario. She took over the Patient's care after he stopped seeing the Member.

Dr. Tong testified that she received a one page unsigned summary of R.L.'s patient records from the Sanger Eye Clinic indicating "sag height, diameter and refractive power" of the Patient's lenses. According to Dr. Tong, this was the minimum information she expected to receive. She did not receive information with respect to how the lenses were fitting, the health of the Patient's eyes, and the names of those providing care and the name of the person who authored this summary. Dr. Tong states that she did receive the complete patient information at a later date by which time she had already fitted R.L. with new lenses.

On cross-examination Dr. Tong stated that she refitted the Patient with a toric contact lens with which she was more comfortable and she did not comment with respect to the appropriateness of the treatment R.L. received at the Sanger Eye Clinic.

Evidence of E.C.

E.C. is the Patient's wife. She testified that she is a retired banker who worked for Bank of Montreal for 17 years and lives with R.L. in Burlington, Ontario. She stated that R.L. suffers from keratoconus and that he discovered the Clinic in the course of doing research. E.C. could not recall the exact dates when she attended at the Sanger Eye Clinic with her husband.

E.C. accompanied the Patient to his June 9, 2017 appointment. She testified that Mr. Sanger performed an eye examination in an examination room using a machine and that he commented on some mucous buildup that would have to be removed at another appointment.

Mr. Sanger pinched one of R.L.'s eyes and described the procedure required. She stated that no one else was present in the examination room.

E.C. attended with R.L. on August 2, 2017. Again, she stated that only she and her husband were present in the room with Mr. Sanger. E.C. mentioned to the Member that she was a post cataract patient and that she was experiencing blurred vision in one eye. She stated that Mr. Sanger had her read a letter chart on the wall and told her that her eye looked fine. She stated that she did not sign a consent form and did not receive any information relating to informed consent.

After she returned to the reception area she was handed a form to complete. She said she did so because she was considering becoming a patient.

E.C. admitted that she did not mention this interaction with the Member to the College when she was first interviewed because she did not think it was relevant to her husband's complaint.

E.C. was shown her patient record, which she said she did not know had been created. The record included what appeared to be a notation from Dr. Sheikh and a note made by Mr. Sanger.

E.C. stated that no other health professional was present in the examining room and that she did not recall anyone using a refractor or printing a refractor slip. She stated that she was unaware that OHIP had been billed and learned of this in April 2018 when she went to her optometrist for an eye exam. She said that she was shocked to learn of this and was told OHIP would not cover her April 2018 exam since she had already been examined in August 2017.

Evidence of Ms. Mahood

Ms. Mahood has been the receptionist at the Clinic for over three years. She testified that her duties include greeting patients, checking them in, ordering supplies and arranging referrals to specialists. She also books appointments for new and returning patients. She testified that she is aware of the difference between opticians and optometrists, but conceded that she does not always correct patients who addressed Mr. Sanger as Dr. Sanger. Ms. Mahood stated that she could recall most of R.L.'s appointments.

Ms. Mahood recalled being in contact with the Patient to book his first appointment. She was able to identify her handwriting on the appointment book. She did not tell the Patient that there were two optometrists connected with the Clinic. She conceded that she did not tell the Patient that Mr. Sanger was not an optometrist and agreed that R.L. had no way of knowing this otherwise. She stated that his patient information form would have been filled in at the first appointment and that Dr. Sheikh treated him as his patient.

Mr. Sanger worked Monday to Thursday and Friday mornings at the Clinic, while Dr. Struk worked at the Clinic on Tuesdays and at the Sanger clinics in Hagersville and Caledonia as well. Dr. Sheikh worked at the Clinic Monday, Wednesday, Thursday and Friday. She denied that she referred to Mr. Sanger as the 'king of corneas" when speaking with the Patient. She did confirm that she spoke to the Patient about his insurance coverage. She also confirmed that she recalled the Patient attending the Clinic with two different women at two or three different appointments, but could not remember the dates of those appointments.

Ms. Mahood testified that at his first appointment, R.L. was seen by both Dr. Sheikh and Mr. Sanger. She testified that her handwriting appeared on the bottom of the patient record, wherein she set out the price calculations. The reference to 'scleral contact lenses' was Mr.

Sanger's writing and the other writing was Dr. Sheikh's. She also identified a contact lens order and an invoice as having been prepared on that day.

Ms. Mahood recalled the Patient's appointment on January 30, 2017. She identified Mr. Sanger's handwriting in the "present Rx box', and Dr. Sheikh's OHIP notation. She stated that Mr. Sanger and Dr. Sheikh would have been present that day.

Ms. Mahood stated that at R.L.'s February 21, 2017 appointment, Mr. Sanger and Dr. Struk would have seen the Patient and that both would have attended to him since they always worked in tandem. Mr. Sanger's handwriting was identified on that day's patient record.

Ms. Mahood stated regarding the June 9, 2017 appointment that Mr. Sanger and Dr. Sheikh attended the Patient and Mr. Sanger's handwriting was identified on the patient record. Ms. Mahood stated that the OHIP billing information on this form was in her handwriting. She explained that Dr. Sheikh would "holler" out the OHIP codes to her from the examination room. She would then record them on the patient record.

E.C.'s patient record

Ms. Mahood stated that E.C. never made an appointment, but that she was attended to during one of her husband's appointments. E.C. completed a patient information form possibly after being examined and that either she [Mahood] or Mr. Sanger asked E.C. for her OHIP card and that the OHIP billing code was dictated by Dr. Sheikh and recorded in Mr. Sanger's handwriting.

Request for patient file

Ms. Mahood stated that she was unclear as to whether R.L. requested the original file or a copy of it and that Dr. Struk instructed her not to release it. After receiving a request from Abbey Eye Clinic, she sent the summary as instructed.

Evidence of Dr. John Struk OD

Dr. Struk is an optometrist registered with the Ontario College of Optometrists since 2002. He stated that he is an independent contractor at the Clinic and that in 2017 he divided his time between the Caledonia and Hagersville Sanger clinic locations. He was generally present at the Clinic on Tuesdays. He stated that he assisted Mr. Sanger in managing contact lens fitting if Mr. Sanger encountered difficult pathology. He explained that the Clinic provided fluid care as between the optician and the optometrists. He acknowledged that there was no specific or signed agreement with Mr. Sanger regarding patient charting or with respect to their respective roles. There was no specific agreement in place as to how to ensure patients were aware of the distinction between opticians and optometrists. He stated that he was in and out of patient meetings with Mr. Sanger 95% of the time.

Dr. Struk testified that he met the Patient on January 31, 2017. He stated that while he did not specifically recall the Patient, he did remember his eyes and his particular eye condition. Dr. Struk recalled that the Patient was "agitated, emotional and colourful" and that he was clearly experiencing discomfort. The care he provided included writing a prescription for Maxidex to clear some eye inflammation and stated that he handed this prescription to the Patient directly. He did not note this on the patient record referred to earlier. Dr. Struk also examined R.L's eyes with a slit lamp. No notation was made of this examination in the January 31, 2017 patient record. He also stated that did not remember whether Mr. Sanger was present and said that he probably was.

Dr. Struk confirmed that he was present on June 20, 2017, when R.L. attended for the "Meibomiam gland squeeze". Dr. Struk stated that upon examining the Patient he observed that he had dry skin in his eye lashes, large punctal plugs and a Meibomian gland malfunction. He then stated that it was not as invasive as suspected and in fact that R.L. could do it himself. Because he was at the clinic attending to another patient in another examining room he was not present when Mr. Sanger performed this particular gland squeeze.

Dr. Struk stated that he had little recollection of the October 31, 2017 appointment which he described as uneventful. He agreed that there was no notation on the patient record to support his assertion that he was present in the examination room.

Dr. Struk stated that he would correct any patient who referred to Mr. Sanger as Dr. Sanger by saying "he is an optician. I am a doctor."

OHIP billing practice

Dr. Struk explained that on occasion he would use Dr. Sheikh's OHIP billing number rather than his own while operating out the Clinic in 2017. He conceded that he had his own OHIP billing number that he could have used and that his practice of using Dr. Sheikh's OHIP number caused confusion and could be seen as misleading. Dr. Struk stated that he was paid a daily fee by the Clinic and that he used Dr. Sheikh's OHIP billing number. He stated that the received payment of his OHIP billings and a percentage of clinic profits. Dr. Struk denied sharing any of his OHIP billings with Mr. Sanger.

Evidence of Dr. Sheik OD

Dr. Sheikh is an optometrist registered with the College of Optometrists of Ontario. He has been employed with Sanger family eye clinics since 2012. At present he is a co-owner of the Clinic. He confirmed that in 2017, he worked Mondays, Wednesdays, Thursdays and Friday mornings to allow him to go to mosque services on Friday afternoons.

Dr. Sheikh explained that patients would generally book an appointment with the receptionist. He would see the patient first, before involving Mr. Sanger. He said that Mr. Sanger would typically introduce himself as "Steve Sanger" or "Steve". Dr. Sheikh testified that patients were told that Mr. Sanger was a "contact lens fitter" or "specialist".

Dr. Sheikh stated that he met R.L. on January 23rd , 2017. He made a hand-written notation on the patient record during this appointment. He confirmed that this is the only occasion where his handwriting can be found in the patient record.

Dr. Sheikh described that during this appointment, he did an eye examination, checking the Patient's muscle balance; he used an auto refractor, took measurements and used a slit lamp. He stated that he never prescribed or dispensed contact lenses for R.L. and confirmed knowing however that such lenses had been prescribed and dispensed.

He stated that Mr. Sanger joined them after this examination and that both of them examined the Patient's eyes with a slit lamp. Dr. Sheikh recalled that he and Mr. Sanger recommended scleral lenses to the Patient.

Dr. Sheikh stated that it was not the Clinic's practice to include services billed to OHIP on a patient's receipt for services. The patient's receipt would not show an eye examination being done.

Dr. Sheikh stated that he was present on January 30, 2017, but acknowledged that his handwriting does not appear anywhere on the patient record of that visit.

Dr. Sheikh stated that he recalled examining R.L. on June 9, 2017 and noted that he needed a Meibomian gland expression but was uncomfortable doing this leaving it for Dr. Struk to perform who was more experienced in that area. Again, there is no record of Dr. Sheikh`s attendance on the patient record and there was no explanation as to why the record fails to mention Dr. Sheikh's presence at the appointment. That said, Dr. Sheikh testified that he checked R.L.'s eyes and billed OHIP for an examination. Dr. Sheikh stated that he was present on August 2, 2017 and did a minor ocular assessment on the Patient, for which he billed OHIP. He stated that he also met and examined E.C., noted this examination in her patient record but did not take any eye exam measurements. He conceded that the measurements are recorded in different handwriting.

OHIP Billings

Dr. Sheikh stated that he handled his own OHIP billings, billed for uninsured patient services and for Dr. Struk, who worked part time. Dr. Sheikh stated that he was paid a bi-weekly salary. Dr. Sheikh stated that he kept a billings diary at every clinic location so that he and Dr. Struk could track their billings.

Dr. Sheikh's discipline history

The Panel was provided with some evidence of Dr. Sheikh's discipline history with his own College. The discipline history involved Dr. Sheikh's work at the Clinic. While the Panel agreed to receive the evidence for the purposes of assessing Dr. Sheikh's credibility, it did not rely on the evidence to assess the credibility of the Member.

This Panel is of the opinion that any reliance on this evidence would be highly prejudicial to the Member and potentially outweigh its probative value. For these reasons the Panel has not recited any of the discipline evidence and we have not considered it in our deliberations.

Findings of Fact

Before dealing with the evidence heard and making findings of fact, it is important to state that the burden of proof in a hearing such as this is the civil burden of proof. It is the burden of the College to prove the allegations made against the Member on a balance of probabilities. This means that the College must convince the Panel that the evidence led demonstrates that the Member has more probably committed the alleged breaches than not. The civil burden of proof does not require proof beyond a reasonable doubt.

In their closing submissions, the parties agreed that in order for the Panel to make findings of fact, it must assess the credibility of the witnesses and in doing so, consider the following guidance:

i) Did the witness have an opportunity to observe the events s/he is testifying to?
ii) Was the witness directly involved in the events?
iii) Does the witness' narrative "hang together", does it make sense?
iv) Is the witness' narrative consistent?
v) Has the witness provided contradictory statements? If so, is there an explanation for such inconsistencies?

vi) Does the witness have a financial or other interest in the outcome of the proceedings, such that his/her testimony may be impacted by such interest?

We now turn to our findings.

In assessing the evidence presented, we took into account that there were 13 appointments at issue in this matter, spanning approximately 9 months. This hearing took place over 2 years after the events in issue. The Panel assessed the witnesses' credibility and reliability within this context.

To the extent possible, the Panel preferred to rely on the Patient's records and other documents filed during the course of the hearing, rather than on the evidence of the witnesses.

Did the Member engage in a manner tantamount to holding himself out as an optometrist and/or physician (Notice of Hearing, allegations 4-5)

The College alleges that in his dealings with the Patient, Mr. Sanger held himself out, or permitted himself to be held out, as a member of the College of Optometrists of Ontario and/or the College of Physicians and Surgeons of Ontario by: (a) performing an optometric examination on the Patient; (b) performing refraction on the Patient; (c) permitting a "prescription" or "prescriptions" to be issued to the Patient for contact lenses; and/or (d) squeezing mucous from the eye ducts of the Patient.

In order to make findings relevant to this particular allegation, the Panel did not find it necessary to determine whether the Patient received care just from Mr. Sanger, as he testified, or whether Dr. Sheikh and Dr. Struk were also involved in his care. While it is likely that the optometrists were present in and around the office during at least some of R.L.'s appointments, despite his recollection to the contrary, the Panel is nonetheless satisfied that based on the records and on Mr. Sanger's own admissions, he engaged in the conduct alleged amounting to holding himself out as an eye doctor. First, Mr. Sanger never wore his badge and refracted R.L. Second, the records indicate that Mr. Sanger sent the final spectacle prescription (Rx) to Dr. Tong. The optometrists confirmed that they did not do refraction for the purposes of preparing a final spectacle prescription, leaving the panel to infer that it was Mr. Sanger who did so, contrary to the standards of practice.

Finally, the Member admitted that he performed the Meibomiam gland squeeze on the Patient. While Mr. Sanger testified that Dr. Struk was also present for the procedure, both he and Dr. Struk acknowledged that Dr. Struk was "in and out" of the treatment room and was not involved in "directly supervising" the Member. The Member ought not to have performed this procedure without direct involvement by Dr. Struk or another optometrist. In doing so, he stepped outside of his role as an optician and carried out an invasive procedure that should have been done by an optometrist or medical doctor, or at least ought to have been done under direct supervision.

In the circumstances, the Panel finds that the Member engaged in professional misconduct as set out in paragraph 5(a) through (c) of the Notice of Hearing.

With respect to the factual allegation set out at paragraph 4(c), regarding the issuance of a "prescription", the Panel is not satisfied that the facts presented prove on a balance of probabilities that the Member issued a "prescription" to the Patient for **contact lenses**. There was no evidence before us of a "contact lens prescription" and no expert evidence filed to show

that the information in the Patient's file amount to a "contact lens prescription". Generally speaking, contact lenses are not prescribed, but fitted.

Did the Member prescribe contact lenses to the Patient and engage in Billing Improprieties? (Notice of Hearing, allegations 6-7)

The College alleges that in addition to performing an optometric examination (or examinations) on the Patient and performing refraction, the Member billed or authorized the billing of OHIP and/or the insurer of the Patient for oculo-visual minor assessments in the name of Dr. Sheikh and issued or authorized the issuing of a prescription for contact lenses to the Patient that was incorrect.

As set out above, the Panel concludes that the Member did perform an optometric examination on the Patient and did perform refraction as alleged given that he ultimately provided Dr. Tong with a final spectacle prescription. This could only be generated following an examination and refraction of the Patient.

With respect to the allegation that the Member was involved in improper billing to OHIP or another insurer, the Panel is not satisfied on the facts before it that the Member engaged in such conduct. There was clear documentary evidence to show that Dr. Struk and/or Dr. Sheikh were involved in billing OHIP. There were no financial records led in evidence or operational agreements as between Mr. Sanger, and Drs. Sheikh and Struk that might have assisted in determining whether Mr. Sanger agreed to and /or instructed Dr. Sheikh to bill OHIP for services that he did not perform and that Mr. Sanger performed that are not to be billed by an optician.

We are unable to conclude that the OHIP billings made in connection with the Patient's treatment were improper and in any event, we are not satisfied that the Member was in any way responsible for the billings. Whether Drs. Sheikh and Struk interacted enough with the Patient to warrant an OHIP billing is not a question for this Panel to consider.

With respect to the allegation in paragraph 6(d) contact lens specifications were given to Dr. Tong and it was clearly marked the left eye needed to be re-fit. No expert evidence was called with respect to the issue of whether an 'incorrect' prescription was issued. As stated previously there is no documentary evidence that a prescription was written or issued. Drs. Sheikh and Struk were not examined about the issuance of a "correct prescription". More importantly, Dr. Tong who looked after R.L. following his October 31, 2017 appointment dealt in her evidence with whether or not the lenses fit properly based upon the way in which they landed on Mr. R.L.'s sclera. The subject of prescription correctness was never raised.

Accordingly, we find that the College did not meet its burden of proof with respect to the allegation made in paragraph 6(d) of the Notice of Hearing.

Did the Member fail to maintain adequate records with regard to R.L.'s Care? (Notice of Hearing, allegations 8-10)

The College alleges that in the course of his treatment of the Patient, Mr. Sanger failed to document the provision of a substance on or about February 21, 2017 and that he had received it from a physician in a hospital; failed to document the ongoing management plan for the Patient, including the schedule for follow-up; and failed to retain a copy of the "prescription(s)" made in connection with the Patient's treatment. The College further alleges that the Member collected unnecessary information from the Patient, including information regarding his wife's OHIP number.

Mr. Sanger agreed that on February 21, 2017 he supplied the Patient with a saline solution which he had obtained from a friend working at St. Joseph's Hospital and that he did not document this in the patient record. He admitted that this failure amounted to a breach of the College's standards.

Further, Mr. Sanger agreed that his failure to include an ongoing management plan for the Patient in the patient records amounted to a breach of the College's standards.

Lastly Mr. Sanger did not retain a copy of prescriptions thereby breaching the College's standards.

Mr. Sanger's records for the Patient were woefully inadequate. The Panel found it difficult to understand from the records Mr. Sanger's treatment plan or even the full extent of the treatment performed. The records did not indicate who was present at each appointment, there were dates missing and no real plan of action noted.

With regard to the collection of E.C.'s OHIP information, the Panel notes that E.C. was assessed at the Clinic during a visit in August. In the circumstances, it was not inappropriate for her information to be collected.

Accordingly, in view of Mr. Sanger's admissions and the Panel's assessment of the Patient records, the Panel finds that the College has met its burden of proof with respect to the allegations at paragraph 8(a), (b) and (c) of the Notice of Hearing, but not in paragraph 9 of the Notice of Hearing.

Did the Member Dispense contact lenses without a prescription (Notice of Hearing, allegations 11-14)

The College alleges that the Member dispensed contact lenses to the Patient without a prescription from an optometrist of physician.

During cross examination, Mr. Sanger agreed that he created his own 'prescription' after refracting and printing out the refraction slips ultimately sent to Dr. Tong, using his auto refractor. Mr. Sanger's agreement was an admission that he preformed a manifest over refraction. This is commonly done when fitting contact lenses, however the original final spectacle lens prescription ought to have been completed or authorized by one of the optometrists. There was no evidence to suggest that was done here. A copy of a final spectacle lens prescription was sent to Dr. Tong. This prescription was not generated by either optometrist.

Accordingly, we find that based on Mr. Sanger's own admission, the College has met its burden of proof with respect to the allegation in paragraph 11 of the Notice of Hearing. As such, the Member contravened the standards of the profession in creating his own prescription, after refracting and such conduct would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

In addition to this conduct being a breach of the standards and conduct that other members would regard as disgraceful, dishonourable and unprofessional, the Panel finds that Mr. Sanger's decision to create his own prescription, which he provided as part of the Patient's records to the new optometrist violates subsection 5(1) of the *Opticianry Act, 1991*.

Finally, the College alleges that the contact lenses dispensed to the Patient were not appropriate as they were fabricated with an incorrect prescription. The evidence does not support this allegation. The contact lenses provided to the Patient were not done pursuant to a specific prescription. The lenses were never finalized. There were clearly adjustments needed, but that does not mean that the lenses provided were inappropriate.

In the circumstances, the Panel makes no finding with respect to this specific allegation.

Did the Member fail to provide the Patient with his patient file?

The College alleges that the Member failed to provide the Patient with his patient file upon request. The College further alleges that when the Patient's new optometrist requested the file, she was not provided with the complete file and was instead only provided with a one page summary of the treatment provided to the Patient.

Mr. Sanger was asked for a copy of the Patient's file, but only provided a summary. We find that the evidence of the Patient and of his new optometrist, Dr. Tong clearly establish an initial refusal and a subsequent delay in making the complete patient file available to R.L.'s new optometrist as was requested. At the end of the day, the file requested clearly was not made available in its entirety and left Dr. Tong without potentially helpful treatment information.

Accordingly, we find that the College has met its burden of proof is establishing that Dr. Sanger did not provide the Patient with his entire patient file when it was requested.

Summary of Findings

Based on the findings as set out above, the Panel finds the Member to have engaged in professional misconduct as alleged in the following paragraphs of the Notice of Hearing: 4(a), (b), (d), 5(a)-(c), 6(a), (b), 7(a), (b), (d), (e), 8, 10, 11, 13, 14, 15 and 16.

The Panel is grateful to counsel for their assistance in this matter. As described above, the Panel had to consider competing testimony, together with a significant volume of documentary evidence. In the end, the Panel was able to reach it decision on each of the allegations based on a careful review of the documentary evidence, the Member's admissions and on the uncontested evidence with respect to the treatment provided.

The parties can contact independent legal counsel to schedule a penalty hearing.

I, **Rob Vezina**, 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:

Rob Vezina, Chairperson and Professional Member

Oct 15, 2020
Date

Daniela Celi, RO
Jacalyn Cop-Rasmussen, Public Member
Jack Zwicker, Public Member