THE DISCIPLINE COMMITTEE OF THE COLLEGE OF OPTOMETRISTS OF ONTARIO

Panel: Dr. Dennis Ruskin, Chair
Dr. Dino Mastronardi
Dr. Linda Chan
Mr. Brian Rivait
Mr. Bashar Kassir

B E T W E E N:

The College of Optometrists of Ontario	)	Ms. Bonni Ellis Counsel for the College of Optometrists of Ontario
- and -	)	
Dr. Farrukh A. Sheikh	)	Ms. Rebecca Young Counsel for Dr. Farrukh A. Sheikh
	)	Ms. Julie Maciura Independent Legal Counsel
	)	**Heard on October 3, 2018**

DECISION AND REASONS

This matter came before a Panel of the Discipline Committee of the College of Optometrists of Ontario (the "College") on October 3, 2018, at the College of Optometrists of Ontario, 65 St. Clair Ave E, Suite 900, Toronto, Ontario.

The purpose of the hearing was to consider allegations of professional misconduct referred by the Inquiries, Complaints and Reports Committee against Dr. Farrukh A. Sheikh (the "Member").

The five members of the Discipline Panel referred to above were in attendance, as well as Dr. Farrukh A. Sheikh and his counsel, Ms. Rebecca Young; Ms. Bonni Ellis, counsel for the College, accompanied by Dr. Paula Garshowitz, Registrar; and Ms. Julie Maciura, independent legal counsel to the Discipline Panel.

The hearing was called to order at 10:05 a.m. on October 3, 2018. The Chair introduced the Panel and the other people present in the room.

Publication Ban

On the consent of Dr. Sheikh, College counsel requested, and the Panel granted, a ban on the publication, broadcasting or disclosure of the names of any patients and/or any information that would disclose the identity of any patients, referred to during the hearing or in documents filed at the hearing.

The Panel's reasons for granting the motion are that personal health information or other matters may be disclosed at the hearing, which are of such a nature that the harm created by disclosure would outweigh the desirability of adhering to the principle that hearings be open to the public.

Allegations and Evidence

College counsel took the Panel through the Notice of Hearing, which was filed as Exhibit 1.

The Notice of Hearing made the following allegations against Dr. Sheikh:

1. You have committed an act or acts of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Optometry Act, 1991*, S.O. 1991, c. 35, as amended, and defined in paragraph 1.14 of Ontario Regulation 119/94 in that, on or about August 23, 2016, while practising as an optometrist at the Sanger Eye Clinic in Hamilton, Ontario, you failed to maintain the standards of practice of the profession with respect to:

    a. your delegation of a controlled act(s) to S.S. in relation to patient [redacted] including, but not restricted to, your failure to:

        i. obtain informed consent or to ensure that informed consent was obtained from [redacted] for the delegation;
        ii. establish a formal relationship with [redacted] prior to the delegation;
        iii. adequately supervise S.S.; and/or
        iv. ensure that the delegation was appropriately and/or adequately documented in the patient record.

    b. your assignment of various aspects of patient's [redacted]s eye examination to S.S. including, but not restricted to, your failure to:
        i. obtain informed consent or ensure that informed consent was obtained, from [redacted] for the assignment;

ii. establish a formal relationship with [redacted] prior to the assignment;
iii. adequately supervise S.S.; and/or
iv. ensure that the assignment was appropriately and/or adequately documented in the patient record.

2. You have committed an act or acts of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Optometry Act, 1991*, S.O. 1991, c. 35, as amended, and defined in paragraph 1.18 of Ontario Regulation 119/94 in that, on or about August 23, 2016, while practising as an optometrist at the Sanger Eye Clinic in Hamilton, Ontario, you permitted, counselled, or assisted S.S., a person who is not a member of the College of Optometrists of Ontario ("the College"), to perform one or more of the following controlled acts, which should be performed by a member of the College, in relation to patient [redacted]

   a. communicating a diagnosis identifying, as the cause of a person's symptoms, a disorder of refraction, a sensory or oculomotor disorder of the eye or vision system or a prescribed disease; and/or
   b. prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses.

3. You have committed an act or acts of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Optometry Act, 1991*, S.O. 1991, c. 35, as amended, and defined in paragraph 1.24 of Ontario Regulation 119/94 in that, from approximately August 23, 2016 to approximately September 26, 2016, while practising as an optometrist at the Sanger Eye Clinic in Hamilton, Ontario, you failed to make and/or maintain records in accordance with Part IV and, in particular, you failed to ensure that the patient health record for [redacted] included:

   a. information about your delegation of a controlled act(s) to S.S.;
   b. a copy of the appropriate written consent to treatment; and
   c. information that would allow the person who made every entry in the health record for patient [redacted] to be readily identifiable.

4. You have committed an act or acts of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Optometry Act, 1991*, S.O. 1991, c. 35, as amended, and defined in paragraph 1.28 of Ontario Regulation 119/94 in that, on or about August 23, 2016, while practising as an optometrist at the Sanger Eye Clinic in Hamilton, Ontario, you allowed to be submitted an account for professional services that you knew or ought to have known was false or misleading and, in particular, you allowed a claim to be submitted to [redacted]s insurance company in relation to an eye examination in circumstances where the information submitted to the insurance company suggested that:

a. you had completed [redacted]s eye examination on that date, when that was not the case; and
b. [redacted] had received a complete eye examination on that date, when that was not the case.

5. You have committed an act or acts of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Optometry Act, 1991*, S.O. 1991, c. 35, as amended, and defined in paragraph 1.30 of Ontario Regulation 119/94 in that, from approximately August 23, 2016 to approximately September 26, 2016, while practising as an optometrist at the Sanger Eye Clinic in Hamilton, Ontario, you, or the administrative staff who support your practice, failed to issue a statement or receipt that itemizes an account for professional goods or services provided to patient [redacted] when he requested such a statement or receipt.

6. You have committed an act or acts of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Optometry Act, 1991*, S.O. 1991, c. 35, as amended, and defined in paragraph 1.39 of Ontario Regulation 119/94 in that, from approximately August 23, 2016 to approximately September 26, 2016, while practising as an optometrist at the Sanger Eye Clinic in Hamilton, Ontario, you engaged in conduct or performed an act that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical and, in particular, you:

   a. delegated a controlled act(s) to S.S. in relation to patient [redacted] without:

      i. obtaining informed consent and/or ensuring that informed consent was obtained from [redacted] for the delegation;
      ii. establishing a formal relationship with [redacted] prior to the delegation;
      iii. adequately supervising S.S.; and/or
      iv. ensuring that the delegation was appropriately and/or adequately documented in the patient record;

   b. assigned various aspects of patient's [redacted]s eye examination to S.S. without:

      i. obtaining informed consent and/or ensuring that informed consent was obtained, from [redacted] for the assignment;
      ii. establish a formal relationship with [redacted] prior to the assignment;
      iii. adequately supervise S.S.; and/or
      iv. ensure that the assignment was appropriately and/or adequately documented in the patient record;

   c. permitted, counselled, or assisted S.S., a person who is not a member of the College of Optometrists of Ontario ("the College"), to perform one or more of the following controlled acts, which should be performed by a member of the College, in relation to patient [redacted]

i. communicating a diagnosis identifying, as the cause of a person's symptoms, a disorder of refraction, a sensory or oculomotor disorder of the eye or vision system or a prescribed disease; and/or
ii. prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses;

d. failed to make and/or maintain records in accordance with Part IV and, in particular, you failed to ensure that the patient health record for [redacted] included:

i. information about your delegation of a controlled act(s) to S.S.;
ii. a copy of the appropriate written consent to treatment; and
iii. information that would allow the person who made every entry in the health record for patient [redacted] to be readily identifiable.

e. submitted an account for professional services that you knew or ought to have known was false or misleading and, in particular, you allowed a claim to be submitted to [redacted]s insurance company in relation to an eye examination in circumstances where the information submitted to the insurance company suggested that:

i. you had completed [redacted]s eye examination on that date, when that was not the case; and
ii. [redacted] had received a complete eye examination on that date, when that was not the case; and/or

f. failed to have the appropriate administrative processes in place to ensure that patient [redacted] received an itemized statement or receipt when he requested one.

Agreed Statement of Facts

College counsel advised the Panel that agreement had been reached on the facts and filed an Agreed Statement of Facts that was signed by Dr. Sheikh and the Registrar of the College and was marked as Exhibit 2.

The Agreed Statement of Facts provided as follows:

THE MEMBER

1. Dr. Farrukh Sheikh ("the Member") graduated from City University in London in the United Kingdom, in 2003. As an internationally trained optometrist, he was required to (and did) complete the International Optometric Bridging Program before he was registered with the College in the general class in July 2011.

2. The Member practises at the Sanger Eye Clinic, which currently has two locations in Hamilton as well as locations in Caledonia and Hagersville. The Member's primary

practice is at the 200 James Street clinic in Hamilton, which is where the events at issue in this proceeding took place ("the Clinic"). However, the Member also practices at the Caledonia and Hagersville locations.

3. Steve Rodney Sanger ("Mr. Sanger") is an optician registered with the College of Opticians of Ontario. Mr. Sanger has never been registered with the College as an optometrist.

4. At the time the events in this matter took place, the Member was a member in good standing at the College and was subject to the jurisdiction of the College.

5. The Member has no prior discipline history with the College.

6. However, the Member was previously the subject of a complaint that was reviewed by College's Inquiries, Complaints and Reports Committee (ICRC) in 2014. One of the concerns identified by the patient in that matter was that he was unaware of the Member's identity or credentials until several months after his examination. As part of its disposition, the ICRC made the following observation and recommendation to the Member:

[T]he practitioner providing care did not appear readily identifiable on the examination record. In order to avoid any confusion, the Panel recommends to Dr. Sheikh to ensure the examination record includes his name if he was the practitioner providing services to the patient.

THE COMPLAINT

A. Background

7. On September 22, 2016, the College received a written complaint regarding the Member from [redacted] who attended the Clinic for the first time on August 23, 2016. Although this was [redacted]s first visit to the Clinic, he had been wearing prescription glasses for approximately forty years and had received multiple eye examinations during that time.

8. [redacted] had initially called the Clinic on August 19, 2016 to request an appointment, after his previous optometrist moved from Hamilton. At the time, [redacted] had been suffering from headaches, which he thought might be caused by the current prescription for his glasses needing to be updated. According to [redacted] he specifically asked for an appointment with an optometrist when he called the Clinic and was given an appointment on August 23, 2016 at 1:30 pm.

9. The complaint that [redacted] filed with the College related to his August 23, 2016 appointment and his subsequent communications with the Clinic. At the same time that [redacted] filed his complaint with the College about the Member, he also filed a complaint about Mr. Sanger with College of Opticians of Ontario.

B. August 23, 2016 - the Initial Appointment

10. Shortly after [redacted] arrived at the Clinic on August 23, 2016 for his 1:30 appointment, he was approached by a man who advised [redacted] that he would be conducting his eye examination. According to [redacted] the man did not introduce himself but [redacted] assumed that he was an optometrist, as he had requested when he booked his appointment. Although [redacted] was not aware of it at the time, the man was Mr. Sanger. [redacted] does not indicate that Mr. Sanger introduced himself as a doctor or optometrist.

11. Mr. Sanger conducted [redacted]s eye exam in the examination room. Mr. Sanger's certificate of registration from the College of Opticians of Ontario and the Member's certificate of registration from the College are displayed in the room.According to [redacted] the eye examination he received from Mr. Sanger was similar to previous eye exams that he had received. [redacted]s eye examination included tonometry, to measure the pressure of the fluid inside his eyes (intra-ocular pressures) as well as subjective refraction. However, he did not receive a retinal scan (digital retinal imaging).

12. During his appointment, [redacted] provided Mr. Sanger with a copy of his previous prescription. According to [redacted] Mr. Sanger advised him that the change in his prescription for hyperopia (farsightedness) with astigmatism was significant.

13. After Mr. Sanger completed [redacted]s eye examination, he accompanied [redacted] back to the reception to look at frames, at which time Mr. Sanger provided the receptionist with a piece of paper. [redacted] observed the receptionist write out his eyeglass prescription on a pre-signed prescription pad. [redacted] did not notice or pay attention to the name or signature on the prescription pad at the time. The prescription that [redacted] received from the Clinic that day (Appendix "A") was as follows:

Rx	Sph	Cyl	Axis	Add	Prism
OD	+2.00	-2.00	89	+2.25	-
OS	+1.75	-1.75	87	+2.25	-

14. Throughout his appointment, [redacted] assumed that Mr. Sanger was an optometrist. [redacted] did not meet the Member at the August 23, 2016 appointment.

15. If the Member were to testify, the Member would say that he was at the Clinic that day but was unexpectedly required to take an overseas phone call regarding an ill family member. The Member would further state that he had delegated [redacted]s care to Mr. Sanger and that he was confident in Mr. Sanger's competence to perform the initial portion of the eye examination. The Member would also state that he intended to participate in [redacted]s eye examination but was unable to do so because of the unexpected call. If the Member were to testify, he would state that he reviewed [redacted]s patient health record before [redacted]s prescription was sent to be filled.

C. Manulife Claim

16. [redacted] ultimately purchased lenses for two pairs of glasses from the Clinic, one to be fitted into his existing frame for reading glasses and one to be fitted into his existing sunglasses frame, both of which he provided to the Clinic. The Clinic placed the order for [redacted]s lenses on August 24 at 10:35 a.m., in accordance with the prescription authored by Mr. Sanger.

17. The total cost of [redacted]s eye examination, the lenses, and fitting the two sets of new lenses into his existing frames was $855, after the Clinic applied a $100 discount. Based on his private insurance policy with Manulife, [redacted] was required to pay $480 towards the total costs of the lenses out of pocket, which he did at that time. The Clinic received [redacted]s permission to send an electronic claim to Manulife for the balance of the cost the same day, so that the outstanding balance of $375 could be paid by Manulife directly to the Clinic.

18. The electronic claim that the Clinic submitted to Manulife described the fees charged to [redacted] as follows:

- eye exam - $135
- bifocal lenses - $385
- bifocal lenses - $435

19. The electronic claim makes no reference to Mr. Sanger's name and, instead, the information provided by the Clinic to Manulife identifies the Member as the service provider and includes his College registration number.

20. Manulife paid the Clinic $375 by cheque on August 24, 2016, which included the $135 cost of the eye examination conducted by Mr. Sanger.

D. September 7, 2016 Attendance

21. On September 7, 2016, [redacted] attended the Clinic, as he had not received any update regarding his glasses since his initial visit. During this visit [redacted] again spoke to Mr. Sanger, although he was still unaware that Mr. Sanger was not an optometrist.

22. Mr. Sanger provided [redacted] with his sunglasses and advised him that his reading glasses were not yet ready. When [redacted] tried on his sunglasses, he advised Mr. Sanger that he did not see well with them. According to [redacted] Mr. Sanger advised him that it would take some time to adjust to the new prescription.

23. The Clinic later contacted [redacted] to advise him that the frames for his reading glasses had broken when they tried to insert the new lenses. [redacted] returned to the Clinic to discuss this with Mr. Sanger and, ultimately, after some discussion, Mr. Sanger agreed to provide [redacted] with a new set of frames for the lenses at no charge.

24. Several days later, [redacted] returned to the Clinic to repeat his concerns about not being able to see well out of his new sunglasses. According to [redacted] he was again advised that it would take some time for him to adjust to the new prescription.

E. September 19, 2016 Attendance and Requests for Itemized Receipt

25. On September 19, 2016, [redacted] returned to the Clinic to get an update on his reading glasses. He was again greeted by Mr. Sanger, who advised him that his glasses were ready. When [redacted] tried on the second pair of glasses, he advised Mr. Sanger that he had difficulty seeing out of them as well. According to [redacted] Mr. Sanger, in response, repeated his earlier advice that it would take some time to get used to the new prescription.

26. Around the same time, [redacted] received an e-mail from Manulife asking him to confirm that he had received the optometry products and services listed on the claim submitted to Manulife by the Clinic. [redacted] realized that he had not received an itemized receipt from the Clinic setting out this information, so he contacted them later that day to request one. [redacted] was advised by the receptionist that she would e-mail a copy of his itemized receipt to him.

27. [redacted] states that when he had not received the promised e-mail the following day, he again contacted the Clinic and was assured that he would receive the itemized receipt later that day.

28. On September 21, 2016, [redacted] contacted the Clinic again to ask about the receipt and was advised that their computers were down, but that it would be sent.

29. Later that evening, [redacted] noticed that his prescription was signed by the Member, whose name was not familiar to him. He then looked up Mr. Sanger, whose name was included on the prescription, and realized that he was not listed on the College's public register but was, instead, listed on the public register for the College of Opticians of Ontario.

F. September 22, 2016 Call and Attendance

30. At approximately noon on September 22, 2016, [redacted] called the Clinic to ask the name of the person who had performed his eye examination. The receptionist advised him that it was the Member. When [redacted] advised the receptionist that he had never met the Member, she responded by providing a physical description of Mr. Sanger and then confirmed that "Steve Sanger" had performed [redacted]s eye examination. [redacted] then re-iterated his request for the receipt and, when the receptionist asked why he required it, [redacted] advised her that his insurance company needed him to confirm who had performed his eye examination. The receptionist advised [redacted] that she would try to send the receipt to him shortly.

31. In his complaint, which [redacted] filed with the College after this phone call, he advised the College that he was very upset to learn that his eye examination and prescription had not been completed by an optometrist.

32. On September 22, 2016, [redacted] attended the Clinic at approximately 16:30, after filing his complaint with the College, to obtain his itemized receipt (Appendix "B"). [redacted] had a discussion with the receptionist about what was listed on the receipt and, according to [redacted] the receptionist advised him that he had received a full eye examination, including a retinal scan. [redacted] advised the receptionist that was not the case, which prompted the receptionist to check his patient health record. When the receptionist realized that [redacted] was correct, she asked [redacted] if he had five minutes to have the test performed then.

33. [redacted] agreed to have the retinal scan performed and, it was at this time, that he met the Member for the first time. The Member performed the retinal scan on [redacted] and also advised [redacted] that he should make a follow-up appointment to have his eyes re-tested.

G. September 26, 2016 Attendance

34. [redacted] did not make a follow-up appointment, but instead, returned to the Clinic on September 26, 2016 for the purpose of requesting a refund, as he was upset that he was still unable to see properly out of either pair of glasses with the prescription provided by Mr. Sanger, who he now knew was not an optometrist.

35. According to [redacted] Mr. Sanger initially refused to provide him with a refund, but ultimately agreed to do so. Mr. Sanger also suggested that [redacted] should have his eyes tested by the Member.

36. [redacted] agreed to have his eyes re-tested by the Member, who performed a complete eye examination and provided [redacted] with a new prescription as follows:

Rx	Sph	Cyl	Axis	Add	Prism
OD	+2.00	-2.00	85	+2.00	-
OS	+1.50	-1.00	85	+2.00	-

37. [redacted] did not purchase or obtain eyeglasses from the Clinic using the revised prescription. [redacted] had not informed the Clinic that he had filed a complaint with the College.

H. Investigation by the College of Opticians of Ontario

38. In response to [redacted]s complaint to this College and to the College of Opticians of Ontario, the latter appointed an Investigator, who was directed to make an appointment, in an undercover manner, with Mr. Sanger. On October 3, 2016, the Investigator contacted the Clinic and asked to schedule an eye examination with "Dr. Sanger". The investigator was advised that Mr. Sanger was not an optometrist and did not perform eye examinations. The investigator was offered an appointment with the Member. When the Investigator attended the Clinic for the appointment, he was greeted by the Member.

THE LEGISLATION AND STANDARDS

A. Controlled Acts – the Legislation

39. Controlled acts are defined in subsection 27(2) of the *Regulated Health Professions Act, 1991* (RHPA), and include:

> 1. Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in

circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis.

9. Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses other than simple magnifiers.

40. Section 27 of the RHPA creates a prohibition against unauthorized individuals performing controlled acts.

Controlled acts restricted

27 (1) No person shall perform a controlled act set out in subsection (2) in the course of providing health care services to an individual unless,

(a) the person is a member authorized by a health profession Act to perform the controlled act; or

(b) the performance of the controlled act has been delegated to the person by a member described in clause (a).

41. Optometrists are authorized by their health profession Act, the *Optometry Act*, to perform the following:

Authorized acts

4 In the course of engaging in the practice of optometry, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to perform the following:

1. Communicating a diagnosis identifying, as the cause of a person's symptoms, a disorder of refraction, a sensory or oculomotor disorder of the eye or vision system or a prescribed disease.

…

3. Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses.

B. Delegation of Controlled Acts – the Legislation

42. A person who is authorized to perform a controlled act, can delegate that act to another individual, but only if that delegation is done in a manner that corresponds to the applicable regulations that govern the delegator and the delegate.

Delegation of controlled act

28 (1) The delegation of a controlled act by a member must be in accordance with any applicable regulations under the health profession Act governing the member's profession.

Idem

(2) The delegation of a controlled act to a member must be in accordance with any applicable regulations under the health profession Act governing the member's profession.

43. According to the RHPA, therefore, an optometrist would only be permitted to delegate the act of prescribing to a non-optometrist if that delegation was done in accordance with any applicable regulations under the *Optometry Act*. The *Optometry Act* and its regulations are silent on the issue of delegation. However, the College has standards of practice that apply when an optometrist is delegating a controlled act or assigning a non-controlled procedure to another person.

C. Delegation of Controlled Acts & Assignment of Other Procedures – the OPR

44. Section 4.3 of the *Optometric Practice Reference - Standards of Practice* (OPR) sets out the expectations that apply when optometrists are delegating controlled acts and/or assigning the performance of a non-controlled act to another person.

45. Both delegation and assignment require supervision, although the level of supervision required depends on the level of risk associated with the procedure. Procedures that carry more risk, including the delegation of any controlled act(s) and "any assigned activities, which require interpretation in the performance of the procedure and/or may present a risk of harm to the patient", require direct supervision.

46. Direct supervision requires the optometrist to be "physically present in the same clinical location" so that the optometrist can "immediately intervene when necessary".

47. According to the OPR. "the responsibility for all aspects of delegated acts or assigned procedures always remains with the optometrist".

48. On the issue of delegation specifically, the OPR states that this "will only occur after the optometrist has established a formal relationship with the patient, which normally will include an interview, an assessment, recommendations if appropriate, and informed consent about any clinical investigations and proposed therapy". Further, delegation requires the informed consent of the patient, with proper documentation of both the delegation and the consent.

49. With respect to the assignment of care, the OPR notes that some non-controlled acts also require direct supervision. Tonometry and subjective refraction are two such examples due to the immediate and/or potential risk of harm that these procedures carry.

50. As is the case with delegation, the OPR sets out the expectation that the assignment of care will be documented.

51. The Member acknowledges, with respect to [redacted]s eye examination on August 23, 2016, that:

    a. [redacted] was not advised that any aspect of his care had been delegated or assigned to Mr. Sanger by the Member;

b. [redacted] had not met the Member when Mr. Sanger performed his eye examination and, in fact, had no contact whatsoever with the Member until September 22, 2016;

c. [redacted]s consent to the delegation of care was not recorded anywhere in his patient health record and, in fact, [redacted] did not consent to Mr. Sanger performing any aspect of his eye examination;

d. Mr. Sanger performed the controlled acts of diagnosing and prescribing in relation to [redacted] and also performed tonometry to obtain readings of [redacted]s intra-ocular pressures as well as subjective refraction; and

e. the delegation and/or assignment of care to Mr. Sanger was not documented as such in [redacted]s patient health record.

52. The Member further acknowledges that he is responsible for the administrative side of his practice, which includes having appropriate administrative processes in place and also makes him responsible for the conduct of his administrative staff, including in relation to accounts submitted under his name and the information they communicate to patients.

53. It is also professional misconduct for a member to permit, counsel or assist any person who is not a member to perform a controlled act which should be performed by a member.

54. The Member acknowledges that, by leaving a pre-signed prescription pad at the reception, he permitted and/or assisted Mr. Sanger to perform the controlled act of prescribing to [redacted] in circumstances where the requirements for that controlled act to be appropriately delegated from the Member to Mr. Sanger had not been met.

D. Patient Health Records

55. The requirements for patient health records are set out in Part IV of O. Reg. 119/94, section 7 of which places the onus on members to "take all reasonable steps to ensure that records in relation to his or her practice are kept in accordance with this Part," including "verification by the member, at reasonable intervals".

56. The specific requirements for the patient health record are set out in subsections 10(2) and 10(4) of Part IV, which include the following expectations:

(2) The patient health record must include the following:

10. Information about every delegation of a controlled act within the meaning of subsection 27 (2) of the *Regulated Health Professions Act, 1991*, delegated by the member.

(4) Every entry in the patient health record must be dated and the person who made the entry must be readily identifiable.

57. With respect to [redacted]s patient health record, the Member acknowledges that it did not contain any of the following:

a. information about any delegation of a controlled act from the Member to Mr. Sanger;

b. any information that would readily identify Mr. Sanger and/or the Member as the authors of their respective notations.

ADMISSIONS

58. The Member admits, with respect to allegation 1 in the Notice of Hearing (Exhibit #1), that he committed an act or acts of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Optometry Act*, *1991,* S.O. 1991, c. 35, as amended, and defined in paragraph 1.14 of Ontario Regulation 119/94 in that, on or about August 23, 2016, while practising as an optometrist at the Sanger Eye Clinic in Hamilton, Ontario, he failed to maintain the standards of practice of the profession with respect to:

a. his delegation to Mr. Sanger, the controlled act(s) of communicating a diagnosis and prescribing eyeglasses to patient [redacted] and, specifically, with respect to his failure to:

i. obtain informed consent or to ensure that informed consent was obtained from [redacted] for the delegation;

ii. establish a formal patient/practitioner relationship with [redacted] prior to the delegation; and

iii. ensure that the delegation was appropriately and/or adequately documented in the patient record.

59. The Member admits, with respect to allegation 2 in the Notice of Hearing, that he committed an act or acts of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Optometry Act, 1991*, S.O. 1991, c. 35, as amended, and defined in paragraph 1.18 of Ontario Regulation 119/94 in that, on or about August 23, 2016, while practising as an optometrist at the Sanger Eye Clinic in Hamilton, Ontario, he permitted, counselled, or assisted Mr. Sanger, a person who is not a member of the College to perform one or more of the following controlled acts, which should be performed by a member of the College, in relation to patient [redacted]

a. communicating a diagnosis identifying, as the cause of [redacted]s symptoms, a disorder of refraction; and/or

b. prescribing, for vision or eye problems, eye glasses.

60. The Member admits, with respect to allegation 3 in the Notice of Hearing, that he committed an act or acts of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Optometry Act, 1991*, S.O. 1991, c. 35, as amended, and defined in paragraph 1.24 of Ontario Regulation 119/94 in that, from approximately August 23, 2016 to approximately September 26, 2016, while practising as an optometrist at the Sanger Eye Clinic in Hamilton, Ontario, he failed to make and/or

maintain records in accordance with Part IV and, in particular, he failed to ensure that the patient health record for [redacted] included:

a. information about his delegation of a controlled act(s) to Mr. Sanger; and

b. information that would allow his entries and the entries of Mr. Sanger in the health record for patient [redacted] to be readily identifiable.

61. The Member admits, with respect to allegation 4 in the Notice of Hearing, that he committed an act or acts of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Optometry Act, 1991*, S.O. 1991, c. 35, as amended, and defined in paragraph 1.28 of Ontario Regulation 119/94 in that, on or about August 23, 2016, while practising as an optometrist at the Sanger Eye Clinic in Hamilton, Ontario, he allowed to be submitted an account for professional services that he knew or ought to have known was false or misleading and, in particular, he allowed a claim to be submitted to [redacted]s insurance company in relation to an eye examination in circumstances where the information submitted to the insurance company suggested that:

a. he had completed [redacted]s eye examination on that date, when that was not the case; and

b. [redacted] had received a complete eye examination on that date, when that was not the case.

62. The Member admits, with respect to allegation 5 in the Notice of Hearing, that he committed an act or acts of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Optometry Act, 1991*, S.O. 1991, c. 35, as amended, and defined in paragraph 1.30 of Ontario Regulation 119/94 in that, from approximately August 23, 2016 to approximately September 26, 2016, while practising as an optometrist at the Sanger Eye Clinic in Hamilton, Ontario, the administrative staff who support his practice, failed to issue a statement or receipt that itemizes an account for professional goods or services provided to patient [redacted] when he requested such a statement or receipt.

63. The Member admits, with respect to allegation 6 in the Notice of Hearing, that he committed an act or acts of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Optometry Act, 1991*, S.O. 1991, c. 35, as amended, and defined in paragraph 1.39 of Ontario Regulation 119/94 in that, from approximately August 23, 2016 to approximately September 26, 2016, while practising as an optometrist at the Sanger Eye Clinic in Hamilton, Ontario, he engaged in conduct or performed an act that, having regard to all the circumstances, would reasonably be regarded by members as dishonourable and unprofessional and, in particular, he:

a. delegated a controlled act(s) to Mr. Sanger in relation to patient [redacted] without:

i. obtaining informed consent and/or ensuring that informed consent was obtained from [redacted] for the delegation;

ii. establishing a formal patient/practitioner relationship with [redacted] prior to the delegation; and/or

iii. ensuring that the delegation was appropriately and/or adequately documented in the patient record;

b. permitted, counselled, or assisted Mr. Sanger, a person who is not a member of the College, to perform one or more of the following controlled acts, which should be performed by a member of the College, in relation to patient [redacted]

i. communicating a diagnosis identifying, as the cause of [redacted]s symptoms, a disorder of refraction; and/or

ii. prescribing, for vision or eye problems, eye glasses;

c. failed to make and/or maintain records in accordance with Part IV and, in particular, he failed to ensure that the patient health record for [redacted] included:

i. information about his delegation of a controlled act(s) to Mr. Sanger; and

ii. information that would allow his entries and the entries of Mr. Sanger to be readily identifiable.

d. submitted an account for professional services that he knew or ought to have known was false or misleading and, in particular, he allowed a claim to be submitted to [redacted]s insurance company in relation to an eye examination in circumstances where the information submitted to the insurance company suggested that:

i. he had completed [redacted]s eye examination on that date, when that was not the case; and

ii. [redacted] had received a complete eye examination on that date, when that was not the case; and/or

e. failed to have the appropriate administrative processes in place to ensure that patient [redacted] received an itemized statement or receipt when he requested one.

64. With respect to (a) to (e), in paragraph 63, above, the Member admits that his conduct would reasonably be regarded by members as dishonourable and unprofessional.

65. By this document, the Member confirms that he:

a. understands fully the nature of the allegations against him;

b. has no questions with respect to the allegations against him;

c. understands that by signing this document he is consenting to the evidence contained therein being presented to the Panel;

d. understands that by admitting to the allegations, he is waiving his right to require the College to prove the allegations against him in a contested hearing;

e. understands that any agreement between him and the College with respect to the Order that the parties will jointly propose to the Panel does not bind the Panel; and

f. understands that the Panel's Order as well as its decision and a summary of its reasons, including reference to his name, will be published in the College's annual report and on its website, may also appear in other publications of the College, and will be published on CanLii; and

g. understands and acknowledges that he is executing this ASF voluntarily, unequivocally, free of duress, free of inducement or bribe, and that he has obtained legal advice regarding the settlement of the subject matter of this proceeding, including in relation to his ASF, from Rebecca Young of DAMIEN FROST & Associates LLP.

Plea

Dr. Sheikh pleaded guilty and made admissions to the facts and allegations included in the Agreed Statement of Facts.

Submissions of the Parties on Finding

College counsel submitted that the College must prove the allegations on a balance of probabilities and in her submission it has done so here through the Agreed Statement of Facts and attachments to it, as well as Dr. Sheikh's guilty plea. The evidence in the Agreed Statement of Facts establishes that it is more likely than not that Dr. Sheikh engaged in the conduct attributed to him and that the conduct amounts to the type of misconduct to which he has made admissions.

Finding on Misconduct

After considering the Agreed Statement of Facts and the submissions of College counsel and counsel for Dr. Sheikh, as well as the admissions of Dr. Sheikh, the Panel found that the facts are sufficient for the College to discharge its onus and prove the allegations in paragraphs 1 through 6 of the Notice of Hearing (other than those allegations which were withdrawn as described below) and specifically, the Panel makes the findings of misconduct against Dr. Sheikh set out in paragraphs 58 through 64 of the Agreed Statement of Facts.

The Panel agreed to the request by College counsel (consented to by Dr. Sheikh) to withdraw the following allegations from the Notice of Hearing: 1.a.iii; 1.b, 3.b, 6.a.iii, 6.b., and 6.d.ii.

Reasons for Finding of Misconduct

Dr. Sheikh agreed that the conduct set out in the Agreed Statement of Facts, in which he admitted engaging, constitutes professional misconduct. After considering the Agreed Statement of Facts and the submissions of counsel, the Panel found that the College proved the allegations on a balance of probabilities.

It was obvious to the Panel that the conduct described in the Agreed Statement of Facts did constitute professional misconduct. The delegation of controlled acts must be done in compliance with all College requirements and the documentation relating to such delegation must be accurate, and members of the profession are responsible for the conduct of their staff and colleagues over whom they have a supervisory role. These are well-known regulatory requirements.

The Panel indicated that it was prepared to proceed to the sanction phase of the hearing.

Joint Submission on Order and Costs

College counsel advised the Panel that the parties had reached agreement as to an appropriate Order in this matter and provided to the Panel a Joint Submission on Order and Costs that was signed by Dr. Sheikh and a College representative and was filed as Exhibit 3.

The Joint Submission proposed the following Order:

1. Requiring the Member to appear before the Panel to be reprimanded at the conclusion of the hearing on October 3, 2018.

2. Directing the Registrar to suspend the Member's certificate of registration for three (3) weeks, uninterrupted, commencing at 12:01 am on October 4, 2018 and ending at 11:59 pm on October 24, 2018.

3. Directing the Registrar to impose the following terms, conditions and limitations on the Member's certificate of registration:

    a) the Member successfully complete, at his own expense, with an unconditional pass, and within one (1) year of the date that this Order becomes final, the ProBe Program on professional/problem-based ethics offered in Ontario;

    b) the Member shall submit, to the Registrar, an essay of at least 1,000 words on the following topics, that the Registrar deems satisfactory:

(i) the delegation of controlled acts, as defined in the *Regulated Health Professions Act, 1991*, and the assignment of care, with discussion of the following specific topics:

A. the legislation and College publications the Member reviewed relevant to the delegation of controlled acts and to the assignment of care;

B. the process for optometrists to delegate controlled acts and the process for optometrists to assign care, with reference to the applicable standards of practice and/or other legislated requirements;

C. the purpose of allowing regulated health professionals, including optometrists, to delegate controlled acts and to assign care;

D. the purpose of the controls that exist to limit the circumstances in which regulated health professionals, including optometrists, can delegate controlled acts and can assign care; and

(ii) the Member's reflections on how the appointment of the patient at issue in his discipline hearing should have been handled differently.

c) the Member shall not delegate controlled acts (as defined in the *Regulated Health Professions Act, 1991*) until he has received written confirmation from the Registrar that the essay referred to in 3(b), above, is satisfactory; and

d) the Member shall co-operate fully in an unannounced inspection of his practice by the College, within one (1) year of either the end of the suspension referred to in paragraph 2, or the date of the Registrar's approval referred to in paragraph 3(b), whichever occurs later. The practice inspection shall include any inquiries, chart reviews, interviews, attendances and/or investigative techniques the Registrar deems appropriate to assess the Member's compliance with the College Standards and applicable legislation relating to the delegation of controlled acts and the assignment of care, and shall be at the Member's cost, up to a maximum of $1,500.

4. Directing the Member to partially reimburse the College for its costs in relation to this proceeding in the amount of $20,000 to be paid according to the following schedule:

a) one cheque dated October 3, 2018 in the amount of $2,000; and

b) twelve, post-dated cheques, provided to the College on October 3, 2018, each in the amount of $1,500 and each dated on the third day of the month commencing, November 3, 2018.

Counsel Submissions on Order

College counsel reviewed the test for rejecting a joint submission as set out by the Supreme Court of Canada in *R. v. Anthony-Cook.* A Panel may only reject the joint submission if its acceptance of the proposal would bring the administration of the discipline process into disrepute or would be otherwise contrary to the public interest. A proposal that would bring the administration of the process into disrepute or would be contrary to the public interest is one that is so markedly out of line with the expectations of reasonable persons aware of the circumstances of the case that they would view it as a breakdown in the proper functioning of the system.

College counsel reviewed the reasons why the test for rejecting a joint submission is so high, including the fact that they save considerable time and expense for the College and members of the profession would not be prepared to enter into agreements if they were routinely rejected.

College counsel submitted that in making its decision on Order, the Panel needed to consider the profession at large, Dr. Sheikh, and the public. The Panel's order must make it clear to the profession what consequences one will face if they engage in this type of behaviour. The public also needs to know that the profession is governed appropriately and so the Panel must consider how the public will view the penalty.

College counsel submitted that the Panel needed to consider the purposes of a discipline order, that is: general deterrence, specific deterrence, remediation and public protection. Not only is Dr. Sheikh to be deterred from engaging in this misconduct again, but so is the rest of the membership. Many components of the proposed order are focused on remediation and are aimed at ensuring that Dr. Sheikh has the knowledge necessary to ensure that this conduct does not reoccur. The proposed order's remedial elements include the essay, which requires Dr. Sheikh to understand the controlled act scheme and to demonstrate that knowledge to the Registrar so that the College is confident that he has learned from this experience. Dr. Sheikh is also required to participate in an unannounced inspection of his practice within a year, which will allow the College to confirm that he has learned from the ProBe course.

The suspension itself is a deterrent, both general and specific.

The other purpose of the Order is public protection. Public protection is the very reason the College exists. In counsel's submission, the proposed Order does protect the public, largely in relation to the remediation components. By making sure the conduct is not repeated the public will be protected.

College counsel also submitted that the Panel should ensure that the public will be confident in its Order and will have confidence that it can effectively regulate its members. Finally, when deciding whether the Order meets that high threshold, the Panel should consider the seriousness of the conduct as well as any aggravating and mitigating factors.

With respect to the seriousness of the conduct, findings were made with respect to six different heads of misconduct, some in relation to delegation of controlled acts, some regarding billing the insurer, and some regarding the receipt for services and it not being readily available when requested. The availability of a re-signed prescription pad is problematic in light of prescribing being controlled acts that optometrists are entrusted with. It is a privilege to have controlled acts and with that privilege and trust comes responsibility. The breach in this regard was an aggravating factor.

Mitigating factors in favour of Dr. Sheikh are the fact that he pled guilty and that this is his first time before discipline. As well, the conduct is in relation to one patient only and it occurred over a relatively brief period of time, so it is not a pattern of conduct.

College counsel stated that she had a fair bit of difficulty finding any cases that were similar on the facts to this one. She reviewed the decision in *CPSO v Mohan*, which involved a travel clinic physician who delegated acts to a physician assistant without complying with the College's rules around delegation. The Discipline panel in that decision ordered a three month suspension of the doctor's certificate of registration finding that his conduct tarnished his own reputation and that of the profession.

College counsel quoted from the decision saying that our health system operates on the honour system that patients will be fully informed and can trust that the professionals they are seeking advice from are who they say they are and are acting within the rules and regulations of the profession.

Counsel for Dr. Sheikh echoed many of the submissions of College counsel and also submitted that it was a mitigating factor that he fully intended to complete the eye examination in question. When the College had an undercover investigator attend the clinic (after the complaint was made), the investigator was told that Mr. Sanger was not an optometrist, making it clear that the present case was an isolated incident.

Defence counsel submitted that in addition to the factors referenced by College counsel, the circumstances of the member should also be considered, including the fact that he has no prior history. Dr. Sheikh also has three young children and is the sole provider for his family and the proposed penalty will have a serious financial impact on him. As such, it sends a proper message to the profession and to the public.

Decision on Order and Costs

After deliberating and considering the information filed and the submissions of counsel, the Panel accepted the Joint Submission on Order and Costs as proposed by the parties and made the Order requested.

Reasons for Order

The Panel determined that the proposed Order was fair and reasonable, being neither too lenient nor too onerous in the circumstances and it accordingly made the Order on penalty and costs as jointly submitted by counsel for the parties and filed as Exhibit 4.

The Panel is aware that it may only reject the joint submission if its acceptance of the proposal would bring the administration of the discipline process into disrepute or would be otherwise contrary to the public interest.

In determining the appropriate Order in this particular case, the Panel reminded itself that the primary purpose of the proceedings is protection of the public. The public must have confidence in the profession's ability to regulate itself effectively and in a manner that protects the public. Additionally, the Panel also must consider the particular circumstances of Dr. Sheikh.

When considering the interests of the profession the Panel recognizes that it has a duty to enforce and maintain the high standards of practice that the public expects of College members and that members expect of themselves. In each case, a Panel of the Discipline Committee must consider the extent to which a message to the profession is required to make it clear that the conduct in issue will not be tolerated.

In reaching its decision, the Panel considered submissions of College counsel as well as Dr. Sheikh's counsel. The Panel also considered the previous discipline case provided to it.

In the Panel's opinion, public interest is maintained by this Order by way of the suspension of the Dr. Sheikh's certificate, the restrictions on his practice (the suspension on delegating controlled acts, and an unannounced inspection), the requirement to complete the ProBe course, and the 1000 word essay.

Specific deterrence is achieved by way of a suspension of the Member's certificate and the imposed terms, conditions and limitations once he returns to practice. These terms will serve to deter the Member from engaging in similar conduct in the future.

General deterrence is achieved by way of suspension and the terms, conditions and limitations on the Member's certificate, including the requirement to write an essay. These terms, which are comprehensive and will ultimately span over one year, will send a clear message to the membership that such behaviour will not be tolerated.

The Order also addresses remediation of the Member by way of the requirement that he successfully complete the ProBe course. The Panel believes that successful completion of this course will improve the Member's decision-making in the future and ultimately improve his practice going forward.

The Panel did consider that the member pled guilty, thereby saving considerable time and expense to the College as well as that it was Dr. Sheikh's first time before the Discipline Committee, and the conduct only involved one patient and was over a short period of time. Those are mitigating factors. However, an aggravating factor included the fact that the Member had received a prior warning from the ICRC about similar conduct.

After balancing all of the relevant factors in this case, the Panel felt that the proposed Order as to penalty and costs was an appropriate one in all the circumstances.

Upon reviewing the order included in the one past case provided by College counsel, the Panel concluded that the proposed Order was within the range of what had been ordered in that case dealing with similar (although not identical) conduct, taking into account both the aggravating and mitigating factors. The Panel did feel, however, that the proposed order in this case was on the low end of the range of what is reasonable, given that the only case provided to it was one in which a discipline panel ordered a three month suspension.

The Panel also felt that it was appropriate to order Dr. Sheikh to pay $20,000 towards the costs of the investigation, prosecution and hearing in this matter. Without such a costs order, it would be Dr. Sheikh's peers who would have to fund the entire cost of the investigation and prosecution of this matter.

At the conclusion of the hearing and after confirming that Dr. Sheikh had waived his right to appeal the reprimand was delivered the reprimand to Dr. Sheikh, a copy of which is attached to this decision.

Dated this 31 day of October, 2018, at Toronto, Ontario.

(Signed)

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Dr. Dennis Ruskin, Chair

TEXT OF ORAL REPRIMAND

Delivered on October 3, 2018

College of Optometrists of Ontario and Dr. Farrukh A. Sheikh

Dr. Sheikh, would you please stand up?

Dr. Sheikh, the fact that you have received this reprimand will be part of the public portion of the Register, and as such will form part of your record with the College.

The purpose of this reprimand is to express our disappointment on behalf of the members of the college and the general public in regard to your actions.

We are also disappointed that you are before a Discipline panel of the College considering that you received advice from a Panel of the ICRC in 2014, which this panel believes should have been a strong reminder to you about the different responsibilities of different health professionals.

The public is not protected when unauthorized persons carry out controlled acts assigned to an optometrist. You betrayed the trust that this patient put in you when you did not follow the requirements regarding delegation. Your actions tarnish your reputation as well as that of the profession of optometry.

The Panel's expectation is that you will complete the remediation, that is, the ProBE ethics and boundaries course, the essay regarding the delegation of controlled acts and the assignment of care, and that you cooperate with the unannounced inspection. The Panel also suggests that you carefully evaluate your ongoing business relationships to make sure they are in compliance with the College's rules and the panel reminds you that it is your responsibility to ensure that you are not influenced by anyone in a way that would compromise public trust or your own professional obligations.

We trust you will not find yourself before a Panel of the Discipline Committee again and if you do, you can anticipate that the penalty you receive will be more onerous. We expect that you will take this experience seriously and will modify your behaviour accordingly.

Thank you – you may sit down.