THE DISCIPLINE COMMITTEE OF THE COLLEGE OF OPTOMETRISTS OF ONTARIO

Panel: Dr. Bill Chisholm, Chair
Ms. Maureen Chesney
Dr. Heather Chin
Mr. Howard Kennedy
Dr. David White

B E T W E E N:

The College of Optometrists of Ontario	)	Mr. Andrew Porter Counsel for the College of Optometrists of Ontario
- and -	)	
Dr. Casey Tepperman	)	Ms. Tracey Tremayne-Lloyd and Ms. Brooke Shekter Counsel for Dr. Casey Tepperman
	)	Ms. Julie Maciura Independent Legal Counsel
	)	**Heard on April 15, 2019**

DECISION AND REASONS

This matter came before a Panel of the Discipline Committee of the College of Optometrists of Ontario (the "College") on April 15, 2019, at 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. Casey Tepperman ("Dr. Tepperman" or the "Member").

The five members of the Discipline Panel referred to above were in attendance, as well as Dr. Casey Tepperman and his counsel, Ms. Tracey Tremayne-Lloyd and Ms. Brooke Shekter; Mr.

Andrew Porter, 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 9:50 a.m. The Chair introduced the Panel and the other people present in the room.

ALLEGATIONS

College counsel took the Panel through the Notice of Hearing, which was filed as Exhibit 1 and advised the Panel that the College would be asking that allegation (d) be withdrawn on consent.

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

(a) You have committed an act or acts of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* (the "Code") being Schedule 2 to the *Regulated Health Professions Act*, 1991, S.O. 1991 C.18, and defined in the following paragraphs:

With respect to your patient, Patient X:

(a) You failed to refer Patient X to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when you recognized or should have recognized a condition of the eye or vision system that appeared to require such a referral contrary to paragraph 1.11 of Ontario Regulation 119/94, in that you failed, between April, 2008 and October, 2016, to refer Patient X to an ophthalmologist for investigation with respect to a raised nevus found on Patient X's iris;

(b) You failed to maintain the standard of practice of the profession contrary to paragraph 1.14 of Ontario Regulation 119/94, in that you failed, between April, 2008 and October, 2016 to diagnose, appropriately record, adequately monitor, and/or refer Patient X to an ophthalmologist for further investigation of an iris nevus;

(c) You failed to make or maintain Patient X's health record in accordance with applicable standards, in that you did not record Patient X's complete health and oculo-visual history between April, 2008 and October, 2016, including with respect to the finding of an iris nevus, nor any clinical findings with respect to the iris nevus, despite conducting numerous ocular examinations of Patient X, contrary to paragraph 1.24 and Part IV, ss. 10(2)(4) and (6), Ontario Regulation 119/94; and

(d) You engaged in conduct or performed acts that, having regard to all the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable,

unprofessional or unethical contrary to paragraph 1.39 of Ontario Regulation 119/94, in that you engaged in the conduct set out above at paragraphs (a) through (c).

Particulars of the above allegations are set out in Schedule "A" of this Notice of Hearing.

The particulars of the allegations in Appendix "A" are as follows:

1. Patient X was a patient of Dr. Tepperman's colleague from 2003 to 2008, during which period the colleague monitored and recorded, on a regular basis, a nevus found on Patient X's left iris.

2. Dr. Tepperman's colleague subsequently left the practice.

3. Dr. Tepperman first saw Patient X on April 19, 2008, at which time a new history form was completed. There is no mention of an iris nevus on Patient X's left eye in that document.

4. Dr. Tepperman saw Patient X on the following dates:

   (a) April 19, 2008
   (b) August 22, 2008
   (c) January 8, 2011
   (d) March 10, 2012
   (e) March 6, 2013
   (f) April 6, 2013
   (g) August 26, 2013
   (h) December 1, 2014
   (i) December 7, 2015
   (j) October 17, 2016.

5. During these encounters Dr. Tepperman performed a number of comprehensive eye examinations, adjusted prescriptions for Patient X's spectacles and, latterly, monitored the development of Patient X's cataracts.

6. With the exception of a cursory note regarding the March, 2012 encounter, Dr. Tepperman's patient health records for Patient X do not record the diagnosis, presentation, or monitoring of any changes to the nevus present on Patient X's left iris.

7. At the October 2016 encounter, at Patient X's request, Dr. Tepperman made a referral to two ophthalmologists for an assessment of Patient X's suitability for cataract surgery.

8. Thereafter, Patient X was diagnosed by one of the ophthalmologists with a "large 3.8 x 3.0 mm elevated iris nevus at 3 o'clock; smaller 0.5 x 0.5 nevus at 6 o'clock." The ophthalmologist immediately referred Patient X to Princess Margaret Hospital for testing.

9. On December 6, 2016 Patient X was assessed by ocular oncologists at the Princess Margaret Hospital and diagnosed with iris melanoma.

AGREED STATEMENT OF FACTS

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

The Agreed Statement of Facts provided as follows:

Facts

Background

1. This matter came to the attention of the College of Optometrists (the "College") as a result of a written complaint from Patient X received June 12, 2016 relating to the care provided by Dr. Casey Tepperman ("Dr. Tepperman").

2. Dr. Tepperman is a member of the College.

Events at Issue

3. Dr. Tepperman took over the care of Patient X in 2008 from another optometrist who had left Dr. Tepperman's office.

4. At the time that Dr. Tepperman assumed responsibility for Patient X's care, the patient health record disclosed an elevated nevus that had been identified in June 2003 and monitored during subsequent appointments.

5. Dr. Tepperman first saw Patient X on April 19, 2008 at which time a new ocular and general health history form was completed. The history form contained no mention of the presence of a nevus on Patient X's left iris.

6. Dr. Tepperman then saw Patient X on the following dates:

   (a) April 19, 2008;
   (b) August 22, 2008;
   (c) January 8, 2011;
   (d) March 10, 2012;

(e) March 6, 2013;
(f) April 6, 2013;
(g) August 26, 2013;
(h) December 1, 2014;
(i) December 7, 2015; and
(j) October 17, 2016.

7. During these encounters Dr. Tepperman performed a number of comprehensive eye examinations, adjusted prescriptions for Patient X's spectacles and, latterly, monitored the development of Patient X's cataracts.

8. With the exception of a cursory note in the March, 2012 encounter, Dr. Tepperman's patient health records for Patient X do not record the diagnosis, presentation, or monitoring of any changes to the nevus present on Patient X's left iris.

9. During the October 2016 encounter, at Patient X's request, Dr. Tepperman made a referral to two ophthalmologists for an assessment of Patient X's suitability for cataract surgery.

10. Thereafter, Patient X was diagnosed by one of the ophthalmologists with a "large 3.8 x 3.0 mm elevated iris nevus at 3 o'clock; smaller 0.5 x 0.5 nevus at 6 o'clock." The ophthalmologist immediately referred Patient X to Princess Margaret Hospital for further testing.

11. On December 6, 2016 Patient X was assessed by ocular oncologists at the Princess Margaret Hospital and diagnosed with iris melanoma.

12. Patient X underwent an iodine plaque procedure on December 16, 2016 followed by the removal of the radioactive plaque later that month.

13. Based on the most recent information from Princess Margaret Hospital, Patient X's iris is clinically stable without any evidence of change, scarring of the cornea, or any cornea defects. Patient X remained on a brachytherapy regime, and is being followed by Princess Margaret Hospital.

Admissions

14. Dr. Tepperman admits that he failed to make or maintain Patient X's health record in accordance with applicable standards and College policies, in that he did not record Patient X's complete health and oculo-visual history between April 2008 and October 2016, including with respect to the finding of an iris nevus or any associated clinical findings, despite numerous ocular examinations of Patient X, contrary to paragraph 1.24 and part 4, sections 10(2)(4) and (6) of Ontario Regulation 119/94 to the *Optometry Act*.

15. Dr. Tepperman acknowledges that he failed to refer Patient X to an ophthalmologist for investigation when he recognized or should have recognized a raised nevus on Patient X's left eye iris, contrary to paragraph 1.11 of Ontario Regulation 119/94.

16. Dr. Tepperman admits that he failed to maintain the standard of practice contrary to paragraph 1.14 of Ontario Regulation 119/94 in that he failed to diagnose, appropriately record, adequately monitor, and/or refer Patient X to an ophthalmologist for further investigation of an iris nevus.

The Member acknowledges, admits and agrees that these allegations are true.

PLEA

Dr. Tepperman pleaded guilty and accepted the facts and allegations included in the Agreed Statement of Facts.

SUBMISSIONS OF THE PARTIES ON FINDING

The College has the onus of proving the allegations and the standard of proof upon which it must prove those allegations is on a balance of probabilities. College counsel submitted that the College has met its burden to prove the case through the Agreed Statement of Facts and on Dr. Tepperman's acceptance of the facts and allegations in the Agreed Statement of Facts.

Counsel for the member agreed with the submissions of College counsel. Independent legal counsel gave advice to the Panel advising that in addition to finding that Dr. Tepperman engaged in the conduct at issue, it was also their role to determine whether the conduct described in the Agreed Statement of Facts constitutes professional misconduct.

FINDING ON MISCONDUCT

After considering the Agreed Statement of Facts and the submissions of College counsel and counsel for Dr. Tepperman, as well as the admissions of Dr. Tepperman, the Panel found that the facts are sufficient for the College to discharge its onus and prove the allegations of professional misconduct as set out in the Agreed Statement of Facts and specifically, the Panel finds that Dr. Tepperman engaged in professional misconduct as provided by subsection 51(1) (c) of the *Health Professions Procedural Code,* being Schedule 2 to the *Regulated Health Professions Act*, 1991, S.O. 1991 C.18, and defined in paragraphs 11, 14 and 24 of section 1 of Ontario Regulation 119/94, as amended, made under the *Optometry Act, 1991,* S.O. 1991, c. 35.

REASONS FOR FINDING ON MISCONDUCT

Dr. Tepperman agreed that the conduct set out in the Agreed Statement of Facts, to which he admitted engaging, constitutes professional misconduct. After considering the Agreed Statement of Facts and the submissions of counsel, the Panel found that the facts supported findings of professional misconduct against Dr. Tepperman.

The Panel carefully reviewed the three allegations to which an admission was made in order to determine if the facts set out in the Agreed Statement of Facts constitute professional misconduct. The Panel agreed that the conduct in that document does constitute professional misconduct. The facts set out in Exhibit 2 demonstrate that Dr. Tepperman should have recognized the condition of Patient X's eye and should have referred Patient X to an ophthalmologist. Failing to do that also amounted to a failure to maintain the standards of practice of the profession. It was also apparent to the Panel that the facts in Exhibit 2 demonstrate that there are deficiencies with respect to Dr. Tepperman's record keeping.

In making this decision, the Panel took into account the fact that Dr. Tepperman was present at the hearing, was represented by counsel and pled guilty to the Agreed Statement of Facts regarding the allegations.

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

JOINT SUBMISSION ON PENALTY AND COSTS

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

The Joint Submission proposed the following Order:

1. The Member's shall attend in person before the Panel of the Discipline Committee to receive a public, verbal reprimand, a copy of which shall be published on the College Register;

2. The Member shall participate in a College approved Practice Coaching Program at his expense, as follows:

    (a) the Member shall, within six months from the date of the hearing, participate in an initial 2-day session during which the Practice Coach approved by the College shall conduct such observation of and/or discussions relating to the Member's practice as they deem necessary relating to the diagnosis of ocular pathology, including iris

nevus, during eye examinations, and appropriate referral and record-keeping practices;

(b) the Member shall participate in a further half day session approximately 6 months after the initial meeting to review the Member's practices with respect to eye examinations, appropriate referrals, and record-keeping practices;

(c) the Practice Coach shall report to the Registrar confirming that the Practice Coaching has taken place to his or her satisfaction. The Practice Coaching Program shall be completed within one year of the date of the hearing.

3. The Member shall pay $7,500 CDN as a contribution towards the investigation and prosecution costs incurred by the College in this matter.

DECISION ON PENALTY 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 therein.

REASONS FOR ORDER ON PENALTY AND COSTS

The Panel determined that the proposed Order was fair and reasonable, being neither too lenient nor too onerous in the circumstances and as such, made the Order as jointly submitted by counsel for the parties.

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. Tepperman.

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 how the remainder of the profession will be impacted by any penalty Order.

In reaching its decision, the Panel carefully considered the submissions of the parties. In the Panel's opinion, public protection is maintained by this Order by way of the requirement to complete the Practice Coaching Program. There is no evidence that there is a pattern of behaviour at issue in this case. This is one incident related to one patient and while it is a very serious condition that was missed by Dr. Tepperman there is no evidence of any other deficiencies in his practice.

Specific deterrence is achieved through the requirement to complete the Practice Coaching Program, in addition to the publication of this decision. The Practice Coaching Program will serve to prevent a similar occurrence in the future. In addition, the reprimand will provide specific deterrence by ensuring that the Member knows and understands that his conduct does not meet the expectations of his peers or the public.

General deterrence is achieved by way of publication of this decision, as well as through the Practice Coaching Program, the cost of which Dr. Tepperman will bear, and the reprimand. This will send a clear message to the membership that when the College becomes aware of deficiencies in a member's practice those deficiencies will be appropriately addressed by the College.

The Order also addresses the principle of remediation. The Member will be required to participate in an intensive two day session with a Practice Coach who shall observe the Member's practice relating to the areas in which Dr. Tepperman has demonstrated deficiencies, i.e., the diagnosis of ocular pathology, eye examinations and appropriate referral and record-keeping practices. That Practice Coaching will be followed-up by another session six months later to ensure that Dr. Tepperman is incorporating into his practice, the advice and recommendations given by the Practice Coach.

The remedial aspects of the Order will serve to improve the Member's clinical knowledge, skill, and judgement in the future. Given that the conduct at issue here related to clinical practice (rather than ethics or honesty), it is appropriate that the Order be primarily remedial in nature rather than punitive.

The Panel considered that the member has no discipline history at the College, that there is no evidence that this is a pattern of behavior, that he cooperated with the investigation and that he pled guilty, thereby saving considerable time and expense to the College. This also indicates that Dr. Tepperman is taking responsibility for his actions. Those are mitigating factors in his favour.

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 and proportionate one in all the circumstances.

The Panel also felt that it was appropriate to order Dr. Tepperman to pay $7,500 towards the costs of the investigation, prosecution and hearing in this matter. Without such a costs order, it would be Dr. Tepperman's peers who would have to fund the entire cost of the investigation and prosecution of this matter. The Panel is aware that costs are not meant to punish the member but instead are a way of allocating fairly the cost of the investigation and hearing so that the remainder of the profession is not solely responsible for those costs.

At the conclusion of the hearing and after confirming that Dr. Tepperman had waived his right to appeal the reprimand, the Chair, Dr. Bill Chisholm, on behalf of the Panel, delivered the reprimand to Dr. Tepperman, a copy of which is attached to this decision.

Dated this 26 day of April, 2019, at Timmins, Ontario.

(Signed)

Dr. Bill Chisholm, Chair

TEXT OF ORAL REPRIMAND

Delivered on April 15, 2019

College of Optometrists of Ontario and Dr. Casey Tepperman

Dr. Tepperman, would you please stand?

Dr. Tepperman, 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.

Dr. Tepperman; This panel of the Discipline Committee of the College of Optometrists of Ontario has found you guilty of professional misconduct as indicated in the Agreed Statement of Facts. You have failed to comply with regulations that have been put in place to protect the public, most importantly in patient care, but also in record keeping. You betrayed the trust that Patient X put in you.

The purpose of this reprimand is to express our disappointment on behalf of the members of the College and the general public in your actions. Regulations are put in place to protect the public when receiving optometry services, and when regulations are breached, we fail to ensure public safety.

We expect that going through this experience will encourage you to reflect upon your actions in the context of patient care, record keeping and public expectations and you will modify your behaviour accordingly.

Dr. Tepperman, this Panel's expectation is that you will participate in the remediation, successfully complete it and it will result in improved care of your patients.

We trust that you will not find yourself before a Panel of the Discipline Committee again. If you do find yourself in that position again, you can anticipate that the penalty you receive will be more onerous.

Thank you, you may sit down.