THE DISCIPLINE COMMITTEE OF THE COLLEGE OF OPTOMETRISTS OF ONTARIO

Panel: Ms. Ellen Pekilis, Chair
Dr. Jenna Astorino
Mr. Bashar Kassir
Dr. Kamy Morcos
Dr. Christopher Nicol

B E T W E E N:

The College of Optometrists of Ontario	)	Ms. Julia Martin Counsel for the College of Optometrists of Ontario
- and -	)	
Dr. Gregory Miller	)	Self-represented
	)	Ms. Julie Maciura Independent Legal Counsel
	)	**Heard on May 28, 29 and 30, 2019**

DECISION AND REASONS ON FINDING

This matter came before a Panel of the Discipline Committee of the College of Optometrists of Ontario (the "College") on May 28, 29 and 30, 2019, at Victory Verbatim, 222 Bay Street, 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. Gregory Miller (the "Member").

The five members of the Discipline Panel referred to above were in attendance, as well as Dr. Gregory Miller; Ms. Julia Martin, 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 approximately 9:30 a.m. on May 28, 2019. The Chair introduced the Panel and the other people present in the room.

Publication Ban

College counsel requested, with the consent of Dr. Miller, and the Panel granted, a ban under subsection 45(3) of the *Code* 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 the documents filed at the hearing.

The Panel's reasons for granting the publication ban under subsection 45(3) 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.

Motion for Adjournment

Dr. Miller requested that the hearing be adjourned. Dr. Miller submitted that he believed he had an agreement with College counsel to delay the start of this hearing (hearing #2) until after his previous discipline hearing (hearing #1) was concluded. Dr. Miller thought that this agreement meant that he would not have to start hearing #2 until his appeal to Divisional Court of the decision in hearing #1 was completed. Dr. Miller acknowledged getting many emails about scheduling this hearing over the past few weeks but he says that he assumed someone at the College would realize what was going on, so he did not respond to the College.

Dr. Miller says that he finally contacted the College after he got a call from the lawyer who is representing him in his appeal of hearing #1 telling him to contact the College.

The Notice of Hearing was marked as Exhibit 1 on the motion for adjournment. The Affidavit of Eyal Birenberg, Coordinator, Investigations and Hearings, was marked as Exhibit 2 on the motion.

The College opposed the request for an adjournment. College counsel took the Panel through the events in this matter chronologically by reference to Mr. Birenberg's affidavit.

Hearing #2 was originally scheduled to be held from October 23-25, 2018.

Hearing #1 had been scheduled for July 10 and 11, 2018 but had to be rescheduled because the lawyer who was going to carry out the cross-examination of the complainant in that hearing was not available until October 10, 2018.

Hearing #1 was then rescheduled for October 10 and 11, 2018 and so as a result there would only be two weeks between the two hearings (because hearing #2 was scheduled to start on October 23). As such, the College agreed to reschedule hearing #2.

Hearing #2 was then rescheduled to February 5-7, 2019.

However, the Discipline Panel's decision on the issue of misconduct in hearing #1 was released on January 11, 2019 and given that hearing #2 was now scheduled for February 5-7, 2019, Dr Miller requested an extension of hearing #2 so as to give him time to prepare for the penalty phase of hearing #1.

The College consented to his request and hearing #2 was then adjourned without a new date (given that the penalty phase of hearing #1 had not yet been scheduled).

The penalty phase of hearing #1 eventually proceeded on March 4, 2019.

Dr. Miller has appealed the finding of misconduct in hearing #1 but the material in that appeal has not yet been filed in court and no date for argument of the appeal has been set.

On April 16, 2019, the College started trying to schedule the dates for hearing #2 given that both phases of hearing #1 had finished. College counsel reviewed the multiple communication attempts (April 16, 22, 23, 26, May 6, 13, 2019) with Dr. Miller to schedule hearing #2, including emails, phone calls, regular mail and courier. Finally, on May 6, 2019, Mr. Birenberg emailed the lawyer assisting Dr. Miller with the appeal of hearing #1 and as result, on May 15, 2019, Dr. Miller finally contacted the College requesting an adjournment of hearing #2.

When asked why he did not contact the College sooner despite the numerous emails and letters he was receiving about scheduling hearing #2, Dr. Miller repeatedly said that he thought someone at the College would talk to someone else and straighten things out.

Dr. Miller stated that he wished to call a physician from the Evaluators to give evidence on his behalf in hearing #2.

In response to a question from the Panel, Dr. Miller said that the agreement that he thought was in existence with respect to delaying hearing #2 was made directly with College counsel. When it was pointed out to him that some of the emails in April and May 2019 regarding the scheduling of hearing #2 came directly from College counsel herself, Dr. Miller was unable to explain why that did not cause him enough concern about his understanding of their agreement to contact her directly to clarify their agreement.

The College took the position that it was not unfair to Dr. Miller to proceed now because none of the information in the hearing is new to him; he has known about the case for years (the complaint was made in 2015). College counsel said that the disclosure was sent to him over a year ago. He originally expected the hearing would go ahead in October 2018 and then he thought it would be going ahead in February 2019. It was not until January 2019 that the February dates were adjourned and as such, Dr. Miller must have started to prepare for the hearing back in October 2018 or at the latest in February 2019.

College counsel reviewed the statutory authority for granting an adjournment, which is in section 21 of the *Statutory Powers Procedures Act* ("SPPA"). Section 16 of the SPPA also allows the panel to order terms (such as making this the last adjournment (i.e., peremptory) or granting it on the condition that Dr. Miller did not practise in the interim).

College counsel took the panel through relevant case law dealing with adjournments including *College of Optometrists v Metzger*, *Yune v. RCDSO* (which outlined the principles articulated by the Divisional Court in *Kalin v Ontario College of Teachers*), *LSUC v Piersanti*, *Howe v. Institute of Chartered Accountants of Ontari*o and *LSUC v Charalabidis*.

College counsel reviewed the relevant factors in relation to adjournments. She submitted that the College would experience prejudice if an adjournment was granted because the matter had been outstanding for some time. College witnesses had taken time off work or school and were present and ready to testify. Dr. A, one of the witnesses, was on hold and would be coming from Georgetown; he had taken time off work to testify. The expert witness was present in the hearing room. The Discipline Panel was present, as were College counsel and independent legal counsel and the hearing room had been rented.

College counsel submitted that in relation to the timing of Dr. Miller's adjournment request, it was made less than two weeks prior to the start of the hearing. She said this was the second adjournment request made by Dr. Miller. College counsel submitted that there is a public interest in getting the matter completed in a timely manner. The complainant has been waiting for years to have the matter adjudicated.

Upon questioning by the Panel, Dr. Miller clarified that he was seeking an adjournment until early July, 2019, so that all of his material in relation to the appeal of hearing #1 could be filed in court. He clarified that he was not seeking an adjournment until his appeal was actually heard. Dr. Miller also confirmed that he is still currently practising optometry.

College counsel advised that the College still opposed the request on the same grounds already provided.

Decision on Adjournment Request

After considering the submissions of the parties and the chronology of events set out in Mr. Birenberg's affidavit, the Panel denied the request for an adjournment.

In the Panel's opinion the potential prejudice to Dr. Miller in proceeding was outweighed by the prejudice to the College and the public interest in delaying completion of the matter. The complainant has been waiting for four years to have this matter heard, while Dr. Miller has continued in active practice. In addition, the Panel considered that Dr. Miller has already had the benefit of a previous adjournment but waited until shortly before this hearing date to raise a renewed request for an adjournment. The College had gone to considerable trouble to find a new

date at which it could reassemble a panel and its witnesses, some of whom had travelled a considerable distance to be present and had booked time off from work.

The College took considerable effort to communicate the new dates, and Dr. Miller was non-responsive. Given the gravity of the situation, the Panel found that Dr. Miller's reasons for non-response to College communication (that he believed it was somebody else's responsibility to sort out the scheduling) to be insufficient. If Dr. Miller believed that there was an agreement for adjournment that was not being respected, he could have communicated that fact to the College but he chose not to do so. In making its decision, the Panel took note of the fact that Dr. Miller is self-represented in this matter, but also that he acknowledged having received numerous communications from the College about scheduling the date of this matter to which he failed to respond despite the fact that he was aware that the communications were inconsistent with his understanding of the situation.

Allegations

The Notice of Hearing was marked as Exhibit 1 in the hearing. College counsel took the Panel through the Notice of Hearing.

The Notice of Hearing included the following allegation against Dr. Miller:

a. You failed to maintain the standards of practice of the profession as set out at paragraph 1.14 of Ontario Regulation 119/94 in that you did not identify, document or conduct further examination of Ms. X's optic disc swelling;

b. You failed to refer Ms. X to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when you recognized or should have recognized that she had a condition of the eye or vision system that appears to require such referral as set out at paragraph 1.11 of Ontario Regulation 119/94.

c. 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 as set out in paragraph 1.39 of Ontario Regulation 119/94 for making unprofessional remarks regarding vision therapy.

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

The particulars of the allegation in Schedule A were as follows:

1. Dr. Gregory Miller is an optometrist who has practised in Ontario since on or about June 17, 1968.

Ms. X

2. On or about January 5, 2015, after having been injured in a car accident, Ms. X attended Dr. Miller's office for an independent optometric assessment required by her insurance company, Belair Direct.

Failure to Maintain Standards and Failure to Refer

3. Dr. Miller conducted an examination of Ms. X's eyes but failed to identify and document that she had optic disc swelling in her left eye, which is a serious ocular health condition.

4. Dr. Miller also failed to conduct any further testing of Ms. X regarding the optic disc swelling and failed to report it to Ms. X's physician.

5. The fact that Ms. X had this problem was included in the files sent to Dr. Miller from Belair Direct regarding Ms. X and identified by prior treating optometrists. Ms. X also reported it to Dr. Miller herself.

6. In addition, Dr. Miller recognized or should have recognized that Ms. X required a referral to another optometrist or a physician for her condition but failed to do so.

Unprofessional remarks

7. Ms. X told Dr. Miller that an optometrist and a physician had recommended that she see a vision therapist for the problem with her eyes.

8. Dr. Miller then made the following remarks to Ms. X about vision therapy:

    a. that there is no such thing as vision therapy and if there is it is a scam;

    b. that he does not believe in vision therapy; and

    c. that if Ms. X attended for vision therapy she would just be wasting her money.

Plea

Dr. Miller pleaded not guilty to the allegations.

College's Opening Submissions

College counsel made brief opening submissions outlining how she believed the evidence would flow. She suggested that the Panel would hear that Dr. Miller did an independent optometric assessment in January 2015 of Ms. X. Ms. X had been in a car accident in 2013. She had sustained a mild brain injury and some physical trauma and she had a swollen left optic disc (also known as the optic nerve). The first optometrist Ms. X saw was Dr. A, who the College would be

calling. Dr. A identified the swollen optic nerve in her left eye in 2014 and sent Ms. X to a neuro-ophthalmologist to see what was causing it. He also recommended that she see an optometrist to get vision therapy.

For the insurance company to cover the cost of vision therapy Ms. X required their approval. The insurance company sent her to Dr. Miller for an assessment. On January 5, 2015, Ms. X saw Dr. Miller and she told him about her left optic disc swelling. She had taken with her the records from other health professionals and a retinal image of her left eye taken by Dr. A but Dr. Miller did not look at those.

College counsel submitted that Dr. Miller told Ms. X that he doesn't believe in vision therapy and that it is a scam; that there is no such thing and if she gets it, she is wasting her money.

College counsel submitted that Ms. X will say that Dr. Miller did perform some tests of her eye but he concluded that there was nothing the matter with her eye. Dr. Miller said to her that the back of her eye and fundus, where you would expect to see the swelling, was normal. He also concluded that she sustained no issues with her eyes as a result of the accident. As a result of his assessment the coverage for vision therapy was refused.

Ms. X said she was desperate to get help and even though the insurance coverage was refused, she still wanted to get the vision therapy treatment, so she ended up seeing Dr. B. She saw Dr. B 16 days after she saw Miller. Dr. B found that Ms. X had optic disc swelling and that it was visible with regular equipment that would be available in any regular optometrist office. Dr. B took an image of her eye when he saw her.

College counsel said that the College's expert would testify that it is his opinion that based on the records and on Miller's report that Dr. Miller failed to maintain the standards of practice of the profession by not identifying, documenting and further testing the optic disc swelling in Ms. X's left eye.

The expert will say that Dr. Miller ought to have referred Ms. X to another health professional for the optic nerve swelling and that the remarks he made regarding vision therapy were unprofessional for a member of the College

The expert will say that it does not matter that Dr. Miller was doing an independent optometric assessment. Although it was not a patient-optometrist relationship there is still an obligation to maintain the standards of the profession and an oculo-visual assessment includes certain steps that Dr. Miller did not do. Dr. Miller said that Ms. X's eyes were perfectly normal. There was no indication from his assessment report or charting that he was aware of Ms. X's optic nerve swelling.

College counsel tendered a Brief of Documents to which Dr. Miller consented. Those were marked as Exhibit 2.

Dr. Miller's Opening Submissions

Dr. Miller made brief opening remarks suggesting that he was carrying out an independent optometric assessment under the Statutory Accident Benefits Schedule ("SABS") applicable to motor vehicle accidents when he saw Ms. X. He submitted that the rules regarding those assessments are very strict and there are only certain things he can do pursuant to those assessments.

Dr. Miller further stated that when performing an independent medical evaluation under the SABS rules for insurance purposes, the individual is consulting him as an insurance claimant and not as a patient. Dr. Miller suggested that on this basis, the College's standards of practice had no application to assessments that were done under the SABS regime.

Evidence of Dr. A

Dr. A is an optometrist practising in Georgetown, Ontario. From 2008 to 2016 he practised at Clinic A in Georgetown. He has had his own practice since 2016.

Dr. A testified that he saw Ms. X for the first time on January 7, 2014. Her main complaint was a spot and a haze in the upper left corner of her left eye which had been there since her car accident. Dr. A examined Ms. X and a summary of his findings is on page 34 of Tab 5 of Exhibit 2.

Dr. A noted that Ms. X's left optic nerve was extremely inflamed. It was red and there was a lot of blood and swelling. He was not certain of the cause. Dr. A ultimately referred her to a neuro-ophthalmologist for further assessment.

Dr. A took a retinal photograph of both the left and right eyes of Ms. X when he saw her. The image of her left eye that was taken in 2014 by Dr. A was marked as Exhibit 3. The image he took of her right eye was marked as Exhibit 4.

Dr. A's findings are documented on page 34 of Tab 5 of Exhibit 2. He carried out a dilated fundus examination, using tropicamide 1.0% to dilate Ms. X's eye. The drops dilate the pupil, allowing the optometrist to examine the inside of the eye more completely.

On his chart, the left column of data is in reference to Ms. X's right eye and the right column is about her left eye (because when one holds the page up to someone's face then the information is entered in the chart under the eye being examined). Dr. A said that OD stands for right eye and OS stands for left eye.

Dr. A said that all of the findings in Ms. X's right eye were normal.

Dr. A described the optic nerve. He explained the yellowish orange centre in the image is the nerve. It looks like a hole in a donut. The outer ring is slightly darker in colour and is the "dough" in the donut.

The C/D ratio is the measurement of the cup and the disc - the cup is the brighter spot within the yellow spot in the middle of the eye and the disc is the central part of the eye within which the cup sits. For the right eye Ms. X's C/D ratio was .5.

In her left eye Dr. A really could not see any central portion of the cup; so he would assess this as a zero C/D ratio. He could see that her left nerve was pushed into the center of her eye. It was elevated or swollen ('edema' is swelling). All of the nerve was swollen but the bottom section was more swollen than the top. The margin of the nerve is indistinct on her left eye. The colour in her left eye is red. Dr. A used the terms "hyperaemic" and "hemorrhage inf"; by doing this he was not technically describing a colour but is saying it is red – i.e., 'hemorrhage' is bleeding. Dr. A also used the term "inf", which stands for "inferior"; i.e., it is mostly the bottom part that was swollen.

The laminate cribosa is in the centre of the cup (the central yellow section). Dr. A could see it in the right eye but in Ms. X's left eye the nerve was so swollen he could not see the cup.

Dr. A said that one can see into the back of the eye without dilation but that it is far easier to see when the pupils are larger.

The equipment he used during his examination of Ms. X was a slit lamp. It is a machine on an arm that swings in front of the face. The slit lamp looks like a microscope. To get to the back of the eye, the optometrist holds up a lens to focus the light further back.

He charted "papillitis", which in general terms means inflammation. (Dr. A said that "papil" is another word for optic nerve.) Ms. X had an inflammation of the optic nerve in the left eye which was definitely not normal. Dr. A referred her to the neuro-ophthalmologist for further diagnosis and treatment recommendations.

Ms. X felt comfortable with Dr. A and would return to him and ask what could be done for her so he suggested she could seek a consult from individuals who do vision therapy. Dr. A suggested she could go west to Guelph to see Dr. B or east to Vaughn to see Dr. C. He believed she agreed to go see Dr. C in Vaughan. She eventually came back to Dr. A and also saw either a chiropractor or massage therapist in Guelph. As she was already seeing someone else in Guelph, he suggested that she go see Dr. B.

Dr. A saw Ms. X four times at Clinic A and two times at his new practice. Ms. X still sees him for routine care and Dr. A believes she still also sees Dr. B.

Dr. A took photographs of Ms. X's eyes in 2016 and these were marked as Exhibit 5 (left eye) and Exhibit 6 (right eye). Dr. A said the 2016 image shows that her left eye is

dramatically improved since 2014. It is still not 100 percent but it is much improved. The right eye was identical both times.

Cross-Examination of Dr. A

Dr. Miller asked two questions of Dr. A. He asked if Ms. X sought Dr. A out as a patient with expectation of treatment and ongoing care. Dr. A responded affirmatively.

Dr. Miller then asked whether Dr. A anaesthetizes the eye with numbing drops before he assesses it. Dr. A said that if he is testing for pressures then he does.

Re-examination of Dr. A

College counsel asked Dr. A if the eye still stings if numbing drops are used. Dr. A said that he believes that if he used an anaesthetic drop first and then the tropicamide that the tropicamide drops would not sting as much as they would if the anaesthetic drops were not used.

Assessment of Dr. A's Evidence

Dr. A was clearly able to observe Ms. X during his examinations with her. He was easily able to clearly describe all the records that were put in front of him.

Dr. A was assisted in his recall by reviewing his case records for Ms. X. Prompted by these records he had a clear memory of her case and was easily able to identify her unique eye structure. However, he had difficulty recalling the exact date on which the photographs in Exhibit 5 and 6 were taken. He attributed dates to the photographs by making assumptions in relation to the source of the photographs and the dates that he switched practice locations.

Dr. A has no interest in the outcome of this case. His services are not in any way at issue in this matter.

Dr. A's evidence was both plausible and reasonable. It was based directly on a review of his records and the photographs from the patient file. He was able to clearly and persuasively explain how the photographs and file records demonstrate Ms. X's optic disc swelling in the left eye at the time that he saw her.

His evidence was completely consistent throughout. Dr. A's evidence is externally consistent with the reports of the neuro-ophthalmologist in [Tab 6 of Exhibit 2] and Dr. B in [Tab 7 of Exhibit 2] that Ms. X's left eye demonstrated a swollen optic disc.

Evidence of Ms. X

Ms. X was called as a witness by the College. Ms. X was a physiotherapist in the Philippines and worked in Canada as a physiotherapy assistant and also part-time as a pharmacy technician. She is currently in the process of becoming a registered massage therapist.

She described the motor vehicle accident that she had on September 18, 2013 and the injuries she suffered as a result of that accident. She described the headaches and vision problems she suffered and showed the Panel photographs (marked as Exhibit 7) that she took to document her injuries.

Ms. X described seeing Dr. A who told her that she had a swollen optic nerve. He referred her to the neuro-ophthalmologist. She saw the neuro-ophthalmologist every two weeks at first to monitor her eye, then every third week, then every month. She saw him many times.

At some point her eyes were not getting any better and she was still having headaches. The medication prescribed for her gave her heaviness in her chest so she would not take it any longer. Since the doctors could think of no further treatment alternatives, Ms. X considered trying vision therapy.

Dr. A recommended that she see Dr. C but Ms. X wasn't able to get coverage to see Dr. C. Since this was a motor vehicle accident, Ms. X had to go through Belair Direct (her insurance company) to get approval for insurance coverage for any treatment. The insurance company sent her to Dr. Miller for an assessment in relation to Dr. C's treatment plan for vision therapy.

Ms. X described her assessment with Dr. Miller on January 5, 2016, which was done at the request of Belair Direct. Ms. X said that when she saw Dr. Miller he started the appointment by asking her why she believed in vision therapy and told her it was a scam and asked her why she would want to waste her money on it.

She said he then gave her a quick assessment which took about 20 or 30 minutes in total. She claimed that he asked her to read an eye chart but stopped her at the first letter E and said her vision was fine. She had brought her photographs with her but Dr. Miller said he did not want to see them. She told Dr. Miller that Dr. A had said that her left optic nerve was swollen and bleeding and that Dr. A had referred her to the neuro-opthalmologist.

Ms. X was adamant that Dr. Miller did not dilate her eyes because he only put one type of drop in her eyes and they did not sting. Prior to seeing Dr. Miller she had seen many different physicians and ophthalmologists and they had always used drops that made her eyes sting and her vision blurry for some time afterwards. That did not happen during her appointment with Dr. Miller.

Dr. Miller also did not do a Humphrey test for peripheral vision, nor did he do the test where you look into the machine and press a button when you see the flashing image. He also did not have Ms. X look into a machine that directed a puff of air into the eye. Dr. Miller did not use a flashlight and look in her eyes.

Dr. Miller did do a lens test to see if she needed glasses.

Ms. X said Dr. Miller was more concerned about her age and her weight, and advised her that she needed glasses. Ms. X felt that was unusual because only her left eye was swollen so she

wondered how her age and weight could affect just one eye. Ms. X felt that Dr. Miller was not taking her seriously.

Based on Dr. Miller's assessment, the treatment plan for vision therapy was denied. Because Ms. X really wanted her eyes and vision and headaches to improve, she paid out of her own pocket for vision therapy from Dr. B, which she says has made a huge difference for her. She is now able to read and her eyesight and headaches have improved enough to be able to attend a massage therapy education program.

Ms. X was referred to the list of documents (pages 9-14 of Tab 1 of Exhibit 2) attached to Dr. Miller's assessment report (which purport to be references to medical records relating to Ms. X) and she denied recognizing most of them. Most of them were dated prior to her car accident and relate to treatment obtained in Ottawa, where Ms. X has never received treatment. Ms. X assumes the reports relate to a different patient. She only recognized three of the doctor's names on page 14.

Ms. X testified adamantly that Dr. Miller told her that he did not believe in vision therapy, that it was a scam and that she would be wasting her money if she tried it.

The letter from Belair Direct dated January 29, 2015 in which the insurance company denied the treatment plan relating to vision therapy with Dr. C was entered as Exhibit 8.

Cross-Examination of Ms. X

In response to Dr. Miller's questions, Ms. X reiterated that Dr. Miller made the statements about vision therapy being a scam.

She testified that she wears glasses now but takes them on and off as she needs them.

Dr. Miller took Ms. X to the quote from Dr. D that is in Dr. Miller's report at page 2 of Tab 1 of Exhibit 2. Ms. X said that this was only an excerpt and not the whole report and that Dr. D said she had sustained a head injury related to the motor vehicle accident. Because Belair Direct didn't like Dr. D's conclusion, they referred Ms. X to Dr. E.

Ms. X agreed that Dr. Miller told her during the assessment that he was not her doctor.

Re-examination of Ms. X

In response to College counsel, Ms. X agreed that during the assessment by Dr. Miller he asked her if she was still in the neuro-ophthalmologist's care and that she told Dr. Miller that the neuro-ophthalmologist monitored her eye.

Assessment of Ms. X's Evidence

Ms. X was able to directly observe all material events as she was present for the examinations and had direct interaction with the doctors who examined her, including Dr. Miller, Dr. A and Dr. B.

Ms. X demonstrated exceptional recall of the medical treatment she has received following her motor vehicle accident. Due to her background and training as a physiotherapist, she demonstrated a high degree of understanding of her injury condition and related medical terminology. She was also able to describe her symptoms clearly and in great detail. She had taken care to document her symptoms with dated photographs and accompanying notes. She was confident and articulate about her recollection of her appointment with Dr. Miller.

The witness has an interest in the outcome that might cloud her recollection. As the complainant in this matter, she is unhappy that the outcome of her exam with Dr. Miller resulted in her being denied insurance coverage for the vision therapy treatment she was seeking. At one point in her testimony, she stated that she was doing this because Dr. Miller had commented on her weight and age. At other points in her testimony she stated that her main goal was public protection.

Despite her interest in the outcome of the hearing, her evidence is generally plausible and reasonable. Much of her evidence is supported by the photographs taken of her eyes at the relevant times.

Her recollection is generally consistent with the evidence of other witnesses, although it is not consistent with Dr. Miller's record of their interaction. His record states that he administered two drops to dilate her eyes.

Exhibit 9

The Attending Physician's Statement for Ms. X was entered on consent as Exhibit 9. It was a document sent to College counsel by Ms. X after she had testified.

Evidence of the College expert, Dr. F

Dr. F was tendered as an expert witness. Dr. F's *curriculum vitae* was entered as Exhibit 10 and his independent expert opinion (dated February 22, 2017) regarding Dr. Miller's assessment of Ms. X, was entered as Exhibit 11.

College counsel reviewed his *curriculum vitae* and his experience. Dr. Miller did not object to Dr. F being qualified to give opinion evidence as an expert in optometry and to give opinion evidence with respect to the performance of comprehensive oculo-visual assessments of the eye and vision which includes diagnosing, treating and managing refractive errors, binocular vision anomalies and diseases of the eye. The Panel accepted Dr. F as an expert qualified to give opinion evidence.

College counsel asked Dr. F to assume that the evidence given by Ms. X and Dr. A was true and that the observations of Dr. A in his patient record at Exhibit 2, Tab 5 accurately reflect Dr. A's observations and findings. College counsel asked Dr. F to assume that Dr. A took the retinal images that are Exhibits 3-6.

She further asked Dr. F to assume that Dr. B would testify that on January 21, 2015, shortly after Ms. X saw Dr. Miller, Dr. B observed optic disc swelling in Ms. X's left eye. Dr. F was also asked to assume that Dr. B took the retinal images at Exhibit 2, Tab 7, pages 115 and 116.

He was also asked to assume that Ms. X saw the neuro-ophthalmologist for over a year and that the neuro-ophthalmologist's patient records at Tab 6 of Exhibit 2 accurately reflect his observations and findings.

Dr. F was also asked to assume that Dr. Miller did an independent optometric examination of Ms. X in 2015 and that his report of that examination appears at Tab 1 of Exhibit 2 and that Dr. Miller's patient record appears at Tab 4 of Exhibit 2.

Based on those assumptions, Dr. F testified that in his opinion Ms. X had persistent disc swelling. Dr. F's description of Ms. X's eye accorded with the description given by Dr. A. College counsel asked Dr. F if this condition was serious or not serious, to which Dr. F replied that it was serious.

When asked whether it would be possible for Ms. X to have optic nerve swelling when she saw Dr. A in January, August and October 2014 and Dr. B on January 21, 2015, but not when she saw Dr. Miller on January 5, 2015, Dr. F said it was not possible. The optic nerve swelling was not something that would wax and wane.

The College's Optometric Practice Reference ("OPR"), 2014, was entered as Exhibit 12. Dr. Miller saw Ms. X in 2015 and so this version of the OPR was in effect at the time. Dr. F testified that the OPR reflects the standards of practice of the profession.

Dr. F testified that Dr. Miller's chart shows that he had indicated that Ms. X's left (and right) eye is normal and healthy with no swelling. His charting shows that both eyes are the same in relation to colour, depth of cup, and C/D ratio.

Based on Ms. X's evidence that she did not feel any stinging after the drops were put in her eyes and that her eyes were not blurry afterwards, Dr. F's opinion is that Dr. Miller did not give her tropicamide.

In Dr. F's opinion, Dr. Miller should have given Ms. X the Humphrey visual field test.

In his opinion the comment on the top left of Dr. Miller's chart indicating that Ms. X's last eye exam was with the neuro-ophthalmologist was not sufficient to meet the requirement that he ensure that Ms. X is under someone's care for her optic nerve swelling.

Based on Dr. Miller's charting, it is Dr. F's opinion that Dr. Miller did not actually examine Ms. X's optic disc. Dr. Miller's chart says he did a dilated fundus examination with a bio microscope that revealed that her lens, vitreous and fundus were normal in both eyes. Given the condition of her eye as demonstrated by Dr. A's and Dr. B's images of her eye, it was Dr. F's opinion that it was not possible to make this conclusion if Dr. Miller had in fact performed a dilated fundus examination.

In Dr. F's opinion, the fact that Dr. Miller was not her treating optometrist when he saw Ms. X did not change Dr. Miller's obligation in relation to the standards of practice. It is indicated in the independent examiner guidelines that he has to follow the regulations of his College. It was Dr. F's opinion that as the disc swelling is a suspicious finding, it was Dr. Miller's responsibility to ensure that Ms. X knew she had the condition and was being treated for it. There is no indication in the record that this was discussed.

Cross-Examination of Dr. F

Dr. Miller directed Dr. F to the Canadian Society of Medical Evaluators Guide to Independent Examinations, which was entered as Exhibit 13.

Dr. Miller read out a definition of mild traumatic brain injury and asked Dr. F if he was aware of that definition. Dr. F said he was not. Dr. F said he did not use that definition when he came to the determination that this Patient A's visual symptoms seem to be related to her traumatic brain injury. Dr. F said he got the definition of traumatic brain injury from the references appended to Dr. F's report relating to Dr. Miller's assessment of Ms. X.

The College of Physician and Surgeons of Ontario's ("CPSO") Policy Statement #2-12 – Third Party Reports: Reports by Treating Physicians and Independent Medical Examiners Guide to Third Party Medical Reports was entered as Exhibit 14.

Dr. Miller entered into evidence one page of Ms. X's original complaint to the College and it was marked as Exhibit 15.

Regulation 34/10 under the *Insurance Act*, the Statutory Accident Benefits Schedule ("SABS"), was entered as Exhibit 16. Dr. Miller asked Dr. F if he had ever done an examination under section 44 of the SABS and Dr. F said he had not. Dr. Miller then pointed Dr. F to the three types of examinations that can be done under that schedule – a paper review, an in-person medical assessment (which is the kind of examination Dr. Miller did of Ms. X) and the catastrophic impairment examination.

Dr. Miller entered into evidence the Guide to the Evaluation of Permanent Impairment: Chapter 8, The Visual System" and it was marked as Exhibit 17. He asked Dr. F if he had ever been involved in a multi-disciplinary examination for catastrophic impairment and Dr. F had not. Dr. Miller pointed to the fact that this type of assessment by an optometrist would only assess for permanent impairment, which is described in the document as occurring in the presence of a

deviation from normal in one or more of the functions of the eye which include: 1) corrected visual acuity for near and far objects; 2) visual field perception and 3) ocular motility with diplopia. The document lists the following equipment as being necessary to test the functions of the visual system: visual acuity test charts, visual field testing and refraction equipment. Dr. Miller asked Dr. F if that would satisfy the College's position with regard to an examination as listed in the OPR. Dr. F said that it would not because it doesn't include an assessment of the health of the eye.

Dr. Miller then asked Dr. F if a paper review of a client's charts would satisfy the OPR requirements for an oculo-visual assessment. Dr. F said that he expected it would not, since the optometrist does not see the patient in that case.

Dr. Miller then entered into evidence some dictionary definitions of the word "patient" as Exhibit 18. Dr. F agreed that the dictionary definitions defined what a patient is.

Dr. Miller then asked Dr. F if the label of misconduct "failing to refer a patient to another professional" referred to an optometric patient and Dr. F agreed that it did.

Dr. Miller asked Dr. F if it was professional misconduct to recommend unnecessary diagnostic or treatment services and Dr. F agreed that if the services were unnecessary then it would be.

Dr. F agreed with the proposition that the stated purpose of the OPR and the professional misconduct provisions under the *Optometry Act* were to regulate the profession of optometry with their patients.

Re-Examination of Dr. F

On re-examination Dr. F agreed that Ms. X was not Dr. Miller's patient but said that even though she was not his patient in the traditional sense that did not take away from the fact that Dr. Miller still had to meet the standards of practice of the profession when he assessed her.

Dr. F was asked if a paper review of charts constituted an oculo-visual assessment. He said it did not because it doesn't include an assessment of the person.

In relation to the line of questioning by Dr. Miller about unnecessary testing, Dr. F said that the tests of Ms. X's optic nerve that he indicated were missing from Dr. Miller's chart were not unnecessary – they were necessary. Where a condition has already been diagnosed, it must be recorded. Dr. F indicated that patients with serious conditions are frequently co-managed, which requires mutual understanding between practitioners as to who is providing testing to avoid unnecessary testing while ensuring that necessary testing gets done. Dr. F advised that Dr. Miller's record simply indicates that Ms. X had her last appointment with the neuro-ophthalmologist but does not indicate that the reason Dr. Miller is not cross-referring is because she is under the neuro-ophthalmologist's continuing care.

Assessment of Dr. F's Evidence

Dr. F was not present at any of Ms. X's appointments. He is an expert witness and his observations were appropriately limited to the examination records that were presented to him for opinion. He was able to understand and clearly and thoroughly explain the chart that Dr. Miller prepared in relation to Ms. X.

Dr. F did not examine Ms. X, so he has no direct recollection of events involving her health. However, this is not required for Dr. F to fulfill his role as an expert witness.

Dr. F does not have a direct interest in the outcome of this case. He was not involved in the clinical care or evaluation of Ms. X at any time and his services are not at issue. As with any expert witness he is retained by one of the parties; in this case, the College. He is also a member of the College of Optometrists' Quality Assurance Committee, which gives him both a higher level of in-depth knowledge of the College's quality assurance program and professional expectations as well as a stronger connection to the College than the average optometrist. The Panel noted that College counsel disclosed the fact of Dr. F's relationship to the College and its Quality Assurance Committee while qualifying him as an expert witness, and Dr. Miller had no objection to Dr. F qualifying and testifying as an expert witness.

The panel found that Dr. F's evidence is generally plausible but not always completely reasonable. His assessment of Ms. X's health records and his opinion regarding the presence of optic nerve swelling in the left eye at the time Dr. Miller saw her was plausible and reasonable. Dr. F's evidence was internally consistent and is externally consistent with the evidence of the neuro-ophthalmologist [in Tab 6 of Exhibit 2] and Dr. B [in Tab 7of Exhibit 2] that Ms. X's left eye showed a swollen optic nerve head.

However, the Panel found that Dr. F's evidence was not externally consistent with the OPR and the requirement therein for additional testing given that Dr. Miller's Independent Optometrist Assessment report specifically documents the fact that Ms. X was attending the neuro-opthalmologist "for her left eye and has high intracranial pressure". As such, Dr. Miller knew Ms. X's condition was being monitored. The Panel does not believe it was reasonable to require Dr. Miller to perform additional testing in those circumstances.

Evidence of Dr. B

Dr. B is an optometrist practising in Guelph. He practices vision therapy. Dr. B first saw Ms. X on January 21, 2015; she was referred to him by Dr. A. She had had a motor vehicle accident in 2013 and her left eye was blurred, she had headaches and difficulty with reading. Dr. B also noticed that she had problems with her gait and that she would drift to the left when walking.

Dr. B reviewed his assessment of Ms. X. His assessment findings were similar to that of Dr. A as Dr. B also noticed that Ms. X had a swollen left optic nerve. Dr. B noted a splinter hemorrhage on the optic nerve. There was not enough blood supply getting to her optic

nerve. In relation to the cup to disc ration, the cup should be about 30% of the disc but in Ms. X's left eye there was hardly any cup at all. He noted the C/D ratio as .05.

The margin of Ms. X's optic nerve was indistinct. One could not tell where the optic nerve ended and the retina began. Dr. B took the image of Ms. X's retina found on page 115 of Exhibit 2 (Tab 7) on January 21, 2015. There are also black spots near the bottom, at the 7, 8 and 9 o'clock positions.

Dr. B compared the image of her left eye to the image of her healthy right eye, the latter of which showed a distinct margin between the optic nerve and where the retina starts, as well as no sign of hemorrhaging.

To examine Ms. X's eye, Dr. B dilated her pupils and examined the optic nerve with a slit lamp. He did not see any retinal tears or retinal detachment, but he did see optic disc swelling in her left eye.

He noticed that Ms. X had trouble turning to the right and that the muscles on the left side of her neck where very restricted. He thought perhaps the restricted blood flow in her neck was impacting her optic nerve. Dr. B sent her to see a neuro-muscular specialist, who works with physiotherapists at his clinic, to look at her neck and try to get it more flexible.

After Ms. X start to work with the neuro-muscular specialist, her optic nerve started to improve. At page 120 of Exhibit 2 there is a description of Dr. B's assessment from March 20, 2015 – Ms. X's optic nerve was still elevated but her neck felt better. She had only been for about three or four rehabilitation sessions at this point.

By May 29, 2015 (still at page 120 of Exhibit 2), after Ms. X had about 10-15 session with the neuro-muscular specialist, Dr. B could see a huge difference in her eye. Ms. X told him that the left eye fogginess was down about 80% by now and Dr. B could see that the swelling had markedly improved.

Pages 120 and 116 of Exhibit 2 are photographs of Ms. X's eye taken in August 2015. There is still some indistinctness but the vessels are clearer. The neuro-muscular specialist's work suggested that by relaxing the muscles in her neck, it improved the blood flow to her left eye. Even Dr. B was surprised by how much it helped.

As some of the writing on Dr. B's chart in Exhibit 2 was cut off, a better copy of his records for Ms. X was entered as Exhibit 19.

Dr. B's Binocular Vision Report relating to Ms. X was entered as Exhibit 20.

Cross-Examination of Dr. B

Dr. Miller took Dr. B to the photographs that Dr. A had taken in 2014 and compared them to the photographs at page 115 and 116 of Tab 2, which were from 2015. Dr. Miller asked Dr. B if he agreed that there seemed to be quite a bit of variation and fluctuation in the condition of Ms. X's left eye. Dr. B said that he could not comment on her eye before January 2015 when he first saw Ms. X but that from his perspective the swelling was relatively consistent the first few times he saw her and only improved after she had about 12 or 13 sessions with the neuro-muscular specialist.

When asked to comment on the neuro-ophthalmologist's January 26, 2015 chart note (at page 60 of Exhibit 2) where he reported "diffuse edema of the left optic nerve" and his note of July 14, 2014 (page 81 of Exhibit 2) that reported "mild blurring at her disc margins", Dr. B said that it is difficult to interpret words and it is easier to look at pictures. Without pictures it is difficult to say what someone means. Dr. B said there was still swelling of the left optic nerve when the neuro-ophthalmologist saw Ms. X on January 26, 2015.

Dr. B agreed that at page 81 of Exhibit 2, the neuro-ophthalmologist said that in July 2014 her left eye appeared to be much better than it was in January 2014. Dr. B agreed that between January and July 2014 there seemed to be some pattern of improvement but from the time Ms. X saw Dr. B on January 21, 2015, the swelling in her left optic nerve was present and stable.

Re-examination of Dr. B

In response to questions from College counsel, Dr. B said that there would have been some fluctuation of her optic nerve over time but he would expect that if you had asked four different doctors, they all would have said that the nerve did not look normal.

Assessment of Dr. B's Evidence

The Panel carefully assessed the evidence given by Dr. B.

Dr. B made detailed and direct personal observations of Ms. X when he examined her during her visits to his office. He had a very clear recollection of her appointments with him. He was guided by his records, including charts and photographs, which he created during and immediately after her examination. He was able to clearly and thoroughly explain the findings and photographs. Dr. B has no interest in the outcome of this case.

Dr. B's evidence is reasonable and plausible. He gave a clear and reasonable explanation of the swelling of the left optic disc, which was consistent with the documentary evidence including the images of her optic disc that he took. Dr. B's evidence was internally consistent with itself and externally consistent with the evidence given by Dr. A.

On this basis, the Panel concluded that Dr. B was a reliable witness, and the evidence given by Dr. Bwas given substantial weight.

Defense Case

Dr. Miller did not call any witnesses or testify on his own behalf.

The Chair of the Panel advised Dr. Miller that if he wanted to tell his version of events, then his opportunity to do that was by taking the stand and testifying on his own behalf. She explained to him the difference between submissions/argument and evidence. After considering his options over the lunch break, Dr. Miller confirmed that he did not wish to take the stand to testify.

Submissions of the Parties on Finding

College Counsel Closing Submissions

College counsel submitted that the onus of proving the allegations is on the College. The standard of proof is a balance of probabilities. Another way of saying that is whether it is more likely than not that the conduct occurred.

College counsel submitted that the case was not about a brain injury or vision therapy or whether the treatment plan was or was not approved; instead it was about Dr. Miller failing to see optic nerve swelling, failing to record it, failing to investigate it and failing to ensure that Ms. X was seen by another professional with respect to the condition.

College counsel submitted that the image taken by Dr. A of Ms. X's left optic nerve in January 2014 showed optic nerve swelling. Dr. A observed it with equipment that is readily available in any optometry practice. The condition was still present on September 11, 2014 when the neuro-ophthalmologist saw her and noticed persistent left optic disc edema. On December 1, 2014, the neuro-ophthalmologist again noted 360 degree swelling of the left optic nerve. And yet, Dr. Miller saw her one month and four days later (January 5, 2015) and he concluded that she had a normal left optic nerve.

Dr. B then saw Ms. X on January 21, 2015 and he observed left optic disc swelling. Dr. F said Ms. X's condition would not wax and wane. In his opinion it could not be absent when Dr. Miller saw her and yet present a month before Dr. Miller saw her and again 16 days after Dr. Miller saw her.

College counsel suggested that since Dr. Miller did not take the stand, this is not a case where credibility is as crucial as in some cases, and emphasized that no one has given evidence that contradicts any of the College witnesses. However, counsel submitted that the Panel still had to make a credibility assessment about the witnesses they heard. She reviewed the *Pitts and Director of Family Benefits*, 1985 CanLII 2053 (ONSC) which sets out the factors that should be considered when assessing credibility.

College counsel suggested that the records of Dr. A and Dr. B speak for themselves. Their evidence was not shaken on cross-examination. She submitted that Ms. X was a very credible witness. She had a good recollection of the events that happened and because of her

healthcare background she could articulate what happened. Her evidence was probable, consistent and credible. She was forthright and honest and had nothing to gain by coming to testify. She wanted to ensure that this did not happen to anyone else.

Ms. X was the only witness who testified about the comments made by Dr. Miller about the lack of value of vision therapy in relation to the third allegation of unprofessional conduct. Dr. Miller did not take the stand to contradict her and as such, the evidence on that point was uncontroverted.

College counsel reviewed the expert testimony that Dr. F gave. Her submission was that Dr. F clearly testified that Dr. Miller did not meet the standards of practice of the profession. With respect to the fact that Dr. Miller was doing an independent optometric assessment, she submitted that it cannot be the case that the context changes his responsibility as an optometrist in the situation. He is conducting an optometric examination because he has a licence to practice optometry. Dr. Miller looked into Ms. X's eyes and once he ventured down the path of conducting an examination then he had an obligation to do it properly.

College counsel referred to Exhibits 13 and 14, upon which Dr. Miller was relying. Section 1.1 of Exhibit 13 (the Canadian Society of Medical Evaluators Guide to Third Party Medical Evaluations) sets out the general duties of a practitioner undertaking an independent examination. It says that the practitioner "shall conform to the Code of Ethics, scope of practice and regulations of their professional college." The very first duty for practitioners conducting independent examinations is to obey the rules of one's regulatory college.

College counsel then referred to the CPSO document, Exhibit 14 – page 6, clause iv in regard to independent medical examinations. It says that "If, however, in the context of an examination, the independent medical examiner discovers a suspicious finding, such as an unexpected significant clinical finding, a condition which raises serious concern or a symptom or condition which requires essential intervention, he or she should advise the examinee of this fact. The goal in doing so is to enable examinees to obtain timely medical attention. The College recommends that independent medical examiners seek the examinee's consent to share the results with his or her treating physician. It is recommended that the findings be conveyed in written form as soon as possible to that treating physician."

While the College of Optometrists does not have a similar guideline or policy about independent examinations, the CPSO document was provided by Dr. Miller. He asked Dr. F about it, and Dr. Fsaid the standards of the profession would require that Dr. Miller refer Ms. X or ensure that she had a follow-up appointment and also chart that fact.

The evidence of Dr. F is that Dr. Miller did not perform the examinations that he recorded because he could not possibly have achieved those results with respect to Ms. X's left eye if he had done the testing that the chart indicates that he performed. The only other conclusion that can be drawn is that the information in Dr. Miller's patient record for Ms. X is incorrect and recorded incorrectly. Either way, Dr Miller failed to identify Ms. X's condition.

College counsel submitted that it was inappropriate that the appendices to Dr. Miller's report, purporting to be references relating to Ms. X's assessment, actually applied to another patient.

College counsel submitted that the evidence that Dr. Miller made comments referring to vision therapy as a useless scam stands uncontradicted and that such comments are disgraceful, dishonourable and unprofessional.

College counsel asked the Panel to find Dr. Miller guilty of the three allegations set out in the Notice of Hearing.

Dr. Miller Closing Submissions

Dr. Miller submitted that his problems arose when the College tried to reconcile his report of an independent medical assessment with the OPR. His position is that the purpose of the SABS is different than the purpose of the OPR. The OPR was written for the purpose of regulating the relationship and responsibilities between an optometrist and a patient. He referred the Panel to the definition of patient in Exhibit 18 as being someone who seeks out advice or treatment. Dr. Miller also pointed out that the various professional misconduct provisions under the *Optometry Act, 1991* also refer to "patient" and that Ms. X was not a patient.

Dr. Miller also pointed out that the OPR continually refers to patients because the document relates to the optometrist-patient relationship.

In contrast, the in-person medical evaluation under the *Insurance Act* and SABS regime does not create a doctor-patient relationship as no treatment or advice will be given. The report at the end of the process is called a "third-party report". The third-party report process is not for the purpose of providing health care.

Dr. Miller submitted that Dr. F agreed that the College did not have a published guide regarding third party assessments. The CPSO has a guide (Exhibit 14) and the independent medical examiner is defined as a physician who provides a third party report about an individual with whom he or she does not have a treating relationship. So the examinee, like Ms. X, is not in a treating relationship with the independent medical examiner.

An independent medical examination is done strictly for the third-party report. The third-party report should only include relevant and necessary information. The independent examiner process does not obligate the examiner to treat or provide health care to the examinee.

This is distinct from a regular optometrist – patient relationship. Dr. Miller agreed that if a suspicious finding was noted then that had to be brought to the attention of the examinee. Dr. Miller argued that he knew that Patient A was being followed by the neuro-ophthalmologist.

There is a difference between patients and claimants under the SABS. Dr. Miller submitted that the SABS system is distinct from the regular treating relationship with patients. He worked under both systems and they are not compatible with each other.

Ms. X was a claimant referred by an insurance company and Dr. Miller had to work within the restrictions set out by the *Insurance Act* and SABS. He completed the OCF 18 form the insurance company had sent to him. Dr. Miller said that he performed the task as required by the insurance company to answer the narrow question they asked of him. In doing so, he adhered to all the rules that applied to him.

Dr. Miller also argued that if the standards of practice of optometry all apply to independent medical assessments then anyone doing a paper (rather than in-person) independent optometric assessment would never be able to meet the standards of practice if the standards of practice require that an oculo-visual assessment always be done.

Dr. Miller submitted that Ms. X acknowledged that she was under the care of the neuro-ophthamologist during her appointment. His report to the insurance company on page 3 of Exhibit 2 notes that "she says that she attends an ophthalmologist at St. Josephs [sic] Hospital [sic], for her left eye, and has high intracranial pressure." Dr. Miller submitted to the Panel that further referral of Ms. X was unnecessary, because she was under the care of the neuro-ophthamologist.

College Reply

Ms. Martin referred to page 2 of the excerpt from the SABS (Exhibit 16) and pointed out that Dr. Miller was involved in the independent examination process because he is an optometrist. He is authorized by law and the *Regulated Health Professions Act* to practice optometry and that is how he came to do the assessment. In the College's view, that fact completely negates Dr. Miller's argument that he exists outside of the laws governing optometry when he does independent assessments.

While the College does not have a policy on independent optometric examinations, the College called an expert, Dr. F, who testified as to what the standards of practice were that applied to Dr. Miller while he carried out the independent assessment. There was no expert evidence provided to the panel other than Dr. F's.

Dr. Miller examined Ms. X's eyes and he said her fundus was normal and he did not record optic disc swelling in her left eye. Nor did Dr. Miller document that she was under the care of the neuro-ophthalmologist for optic disc swelling. There was no assurance from his record that Dr. Miller knew that her optic disc swelling was being treated by anyone.

College counsel also pointed out that in relation to Exhibit 16 and its descriptions of the different kinds of SABS assessments, the assessment at issue is not one to which the paper review rules would have applied. As such Dr. Miller's argument that an optometrist could not meet the standards of practice when doing an independent paper review is irrelevant to this scenario. Dr. Miller did an oculo-visual assessment of Ms. X and the standards of practice applicable to such assessments applied.

Finding on Misconduct

After considering the evidence tendered at the hearing as well as the submissions of College counsel and Dr. Miller, the Panel found that the facts are sufficient for the College to discharge its onus and prove the first and third allegations and related particulars in the Notice of Hearing.

The Panel found on a balance of probabilities that Dr. Miller either failed to perform the assessment of Ms. X's optic nerve, or he failed to identify her swollen optic nerve. Either one of those things is a failure to maintain the standards of practice of the profession. As such, the Panel found that Dr. Miller failed to maintain the standards of practice of the profession as set out at paragraph 1.14 of Ontario Regulation 119/94 in that he did not identify or document Ms. X's optic disc swelling.

The Panel found that Dr. Miller made unprofessional remarks to Ms. X regarding vision therapy and as such, Dr. Miller engaged in conduct or performed an act that, having regard to all the circumstances, would reasonably be regarded by members as unprofessional as set out in paragraph 1.39 of Ontario Regulation 119/94 for making unprofessional remarks regarding vision therapy.

The Panel found that the remarks were unprofessional (but not disgraceful, dishonourable or unethical).

The Panel did not find that the College had proven the allegation that Dr. Miller failed to refer Ms. X to another professional regulated under the *Regulated Health Professions Act, 1991* when he recognized or should have recognized that she had a condition of the eye or vision system that appears to require such referral contrary to paragraph 1.11 of Ontario Regulation 119/94. The Panel did not find in the circumstances (the circumstances being that Dr. Miller knew Ms. X was seeing the neuro-ophthalmologist, who was monitoring her condition) that Dr. Miller was required to conduct further examination of her optic disc swelling but given that he did an oculo-visual assessment of her eye, he should have identified and documented the optic nerve swelling.

Reasons for Finding of Misconduct

The Panel carefully reviewed the evidence it heard as well as the submissions made. In assessing the credibility of Ms. X, Dr. A and Dr. B, the Panel carefully considered the factors set out in the *Pitts* decision as well as the guidance from the Supreme Court of Canada in *FH v McDougall.*

A) Failure to maintain the standards of practice of the profession as set out at paragraph 1.14 of Ontario Regulation 119/94 in that Dr. Miller did not identify, document or conduct further examination of Ms. X's optic disc swelling.

The Panel accepted the evidence of Dr. A and Dr. B that Ms. X suffered from left optic disc swelling both before and after the time that she saw Dr. Miller. The panel further accepts the evidence of Dr. F that Ms. X's left optic disc swelling is a condition that would not have waxed and waned such that it would be undetectable when Dr. Miller saw her in between her appointments with Dr. aand Dr. B. The Panel further accepts their collective evidence that this condition should have been readily identifiable by an optometrist using equipment ordinarily available in an optometric office. Dr. Miller's patient record does not identify or document Ms. X's left optic disc swelling and in fact indicates that her eyes are normal in this respect.

The Panel therefore concludes that Dr. Miller did not perform the tests that are documented in his chart, or if he did, he did them incompetently or he did not chart them properly. In any of these situations, the College has discharged its duty of proving the first allegation that he failed to maintain the standards of practice of the profession because he failed to identify or document Ms. X's optic disc swelling.

Dr. F acknowledged in his testimony that the type of independent medical exam that Dr. Miller was providing did not create an optometrist / patient relationship with Ms. X. Ms. X also acknowledged advising Dr. Miller that she was under the care of the neuro-ophthalmologist, who was monitoring her eye. Based on this testimony, the Panel concluded that Dr. Miller's misconduct was failure to identify and document Ms. X's optic disc swelling, but the Panel finds that Dr. Miller had no obligation to conduct a further examination of Ms. X's optic disc swelling because she had advised him that she was already being monitored by the neuro-ophthalmologist, which fact is documented in Dr. Miller's Independent Optometric Assessment report.

B) Failure to refer Ms. X to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when Dr. Miller recognized or should have recognized that she had a condition of the eye or vision system that appears to require such referral as set out at paragraph 1.11 of Ontario Regulation 119/94.

The Panel finds as a fact that Dr. Miller did not refer Ms. X to another professional in relation to her left optic disc swelling. However, the Panel considered whether there was a responsibility on him to refer Ms. X to another professional such that failing to do so would constitute professional misconduct. Ms. X acknowledged in her testimony that she told Dr. Miller that she was under the care of the neuro-ophthalmologist for her left eye. Dr. Miller's chart merely refers to the neuro-ophthalmologist as being the doctor she saw for her last eye examination, but Dr. Miller's Independent Optometric Assessment report at page 3 of Exhibit 2 states that "She says that she attends an ophthalmologist at St. Josephs [sic] Hospital [sic], for her left eye . . . "

The Panel acknowledges that Dr. Miller's documentation is inadequate, but finds that Ms. X had informed him that she was seeing the neuro-ophthalmologist for her left eye such that it would have been unnecessary – and in fact duplicative – for Dr. Miller to refer her to yet another eye specialist.

Dr. Miller's failure to document properly is not equivalent to a failure to refer. The Panel finds that the College has not discharged its onus of proof in relation to the second allegation.

C) Dr. Miller 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 as set out in paragraph 1.39 of Ontario Regulation 119/94 for making unprofessional remarks regarding vision therapy.

Ms. X's testimony is uncontested that Dr. Miller made a range of comments about vision therapy being useless, a scam and a waste of money. The panel considered whether Ms. X's anger towards Dr. Miller might cloud her memory of events, but ultimately decided that on a balance of probabilities it was more likely than not that Dr. Miller made the comments as related by Ms. X. The evidence in this regard was uncontradicted because Dr. Miller did not testify. Dr. [redacted] testified that such comments are unprofessional and conversations about vision therapy could have been held in a more objective manner. On that basis, the Panel concluded that Dr. Miller's comments were unprofessional. However, the panel felt that the gravity and nature of the comments stopped short of disgraceful, dishonourable or unethical conduct.

Conclusion

For the reasons set out above, the Panel finds that the College has proven its case on a balance of probabilities based on clear, cogent and convincing evidence in relation to the first and third allegations (although only finds that the comments were "unprofessional"). It makes no finding with respect to the second allegation and in relation to the first allegation it does not find that Dr. Miller had an obligation to conduct further examination.

The Panel finds that the actions of Dr. Miller constitute professional misconduct pursuant to clause 51(1)(c) of the *Health Professions Procedural Code*, being Schedule 2 to the *Regulated Health Professions Act, 1991*, more particularly contrary to paragraphs 1.14 and 1.39 of Ontario Regulation 119/94.

The Panel is ready to convene the penalty phase of the hearing.

Dated this 27th day of August, 2019, at Toronto, Ontario.

signed

Ms. Ellen Pekilis, Chair