

# Discipline Committee of the College of Optometrists of Ontario

Panel: Dr. Jim Hoover, Chair	Professional Member
Dr. Patrick Quaid	Professional Member of Council
Dr. Linda Bathe	Professional Member
Ms. Shoshana Gladstone	Public Member of Council
Mr. John Van Bastelaar	Public Member of Council

## **Between**

College of Optometrists	)	Ms. Julia Martin,
of Ontario	)	Counsel for College of
	)	Optometrists of Ontario
-and-	)	
	)	
Dr. Kar Man Cheung	)	
Dr. Suzan Sarkies	)	Mr. Neil Abramson,
Dr. Vivian Li	)	Counsel for Drs. Cheung, Sarkies,
Dr. Emad Eskander	)	Li, and Eskander.
(the “Members”)	)	
	)	Ms. Alexandra Wilbee,
	)	Independent Legal Counsel
	)	<b>Heard on April 5, 2016</b>

## DECISION AND REASONS

A panel of the Discipline Committee of the College of Optometrists of Ontario held a hearing on Tuesday, April 5, 2016 to consider allegations of professional misconduct against Drs. Suzan Sarkies, Kar Man Cheung, Vivian Li and Emad Eskander. This hearing began as scheduled at 10:00 a.m. The Chair introduced the panel members and our independent legal counsel to those present and also acknowledged the various members of the prosecution and defense in attendance.

The Chair indicated that the hearing was open to the public and neither prosecution nor defense requested that the hearing be closed.

Ms. Julia Martin, counsel for the College, filed the Notice of Hearing as Exhibit 1 and the Affidavits of Service as Exhibit 2. The allegations against the Defendants as stated in the Notice of Hearing were as follows:

That in or about 2014, you committed acts of professional misconduct under paragraphs 14 and 24 of section 1 of Ontario Regulation 119/94 made under the *Optometry Act 1991*, S.O. 1991, c. 35, as set out in the particulars which are contained in Appendix "A" to this Notice of Hearing.

Also, the following allegation about Dr. Cheung, Dr. Sarkies and Dr. Li:

That in or about 2014, you committed acts of professional misconduct under paragraph 39 of section 1 of Ontario Regulation 119/94 made under the *Optometry Act 1991*, S.O. 1991, c. 35, as set out in the particulars which are contained in Appendix "A" to this Notice of Hearing.

Ms. Martin explained that paragraph 19 of Appendix A to the Notice of Hearing is withdrawn with respect to Dr. Li only.

Mr. Neil Abramson, counsel for the Members, stated that the Members plead guilty to the allegations as set out in the Notice of Hearing. Their admissions of guilt were confirmed by the Chair to be voluntary, informed, and unequivocal by way of an oral plea inquiry.

Ms. Martin presented the panel with an Agreed Statement of Facts which was entered into evidence as Exhibit 3. The parties agreed that the following facts

constitute an accurate statement with respect to the allegations contained in the Notice of Hearing.

1. Dr. Emad Eskander, Dr. Kar Man Cheung, Dr. Suzan Sarkies, and Dr. Vivian Li hereby plead guilty to the allegations set out in the first paragraph of the Notice of Hearing dated, June 29, 2015, that they committed acts of professional misconduct under paragraph 14 and 24 of section 1 of Ontario Regulation 119/94 made under the *Optometry Act, 1991*, S.O. 1991, c. 35. A copy of the Notice of Hearing is attached to this Agreed Statement of Facts as Schedule "A".
2. Dr. Cheung, Dr. Sarkies and Dr. Li hereby plead guilty to the allegations set out in the second paragraph of the Notice of Hearing, that they committed acts of professional misconduct under paragraph 39 of section 1 of Ontario Regulation 119/94 made under the *Optometry Act, 1991*, S.O. 1991, c. 35.

### **Background**

3. Dr. Eskander, Dr. Cheung, Dr. Sarkies and Dr. Li (the "optometrists") are optometrists practising in the Province of Ontario and members of the College of Optometrists of Ontario.
4. In or about 2014, the optometrists provided eye examinations to school children in Ontario through the School Vision Care ("SVC") Program. SVC is a private corporation that offers and offered at the relevant time, OHIP insured eye examinations and free eye glasses to Ontario school children in selected school boards.

### **Dr. Emad Eskander**

5. Dr. Emad Eskander is an optometrist practising in Ontario who has been a member of the College of Optometrists of Ontario (the "College") since in or about January 1, 2007.

6. In or about 2014, Dr. Eskander examined and treated the following child patients through the SVC Program:

- a. [REDACTED]
- b. [REDACTED]
- c. [REDACTED]
- d. [REDACTED]
- e. [REDACTED]
- f. [REDACTED]
- g. [REDACTED]
- h. [REDACTED]
- i. [REDACTED]
- j. [REDACTED]

7. Dr. Eskander failed to maintain the standard of practice of the profession contrary to paragraph 1. 14 of Ontario Regulation 119/94 in his examination and treatment of the patients in paragraph 6 as follows:

- a. He conducted inadequate binocular vision assessments;
- b. The internal examinations were incomplete; and
- c. The refractive examinations were minimal and incomplete.

8. Dr. Eskander failed to make and maintain the records required by Part IV of Ontario Regulation 119/94 contrary to paragraph 1.24 for the patients referred to in paragraph 6 as follows:

- a. The patient history was inadequate;
- b. There were no patient addresses;
- c. The diagnosis was blank; and
- d. The records were not legible.

9. The College's expert, Dr. Paul Padfield, an optometrist practising in Ontario, reviewed Dr. Eskander's patient records for the ten patients referred to at paragraph 6, above, and if he were called to testify

would say that Dr. Eskander failed to maintain the standard of practice of the profession in his care for these patients.

10. Dr. Padfield would also say if called to testify that Dr. Eskander did not make or maintain records as set out at paragraph 8, above, as required for the ten patients above as required by Part IV of Ontario Regulation 119/94.

### **Dr. Kar Man Cheung**

11. Dr. Cheung is an optometrist practising in Ontario who has been a member of the College of Optometrists of Ontario since in or about October 21, 2013.

12. In or about 2014, Dr. Cheung examined and treated the following child patients through the SVC Program:

- a. [REDACTED]
- b. [REDACTED]
- c. [REDACTED]
- d. [REDACTED]
- e. [REDACTED]
- f. [REDACTED]
- g. [REDACTED]
- h. [REDACTED]
- i. [REDACTED]
- j. [REDACTED]

13. Dr. Cheung failed to maintain the standard of practice of the profession contrary to paragraph 1. 14 of Ontario Regulation 119/94 in her examination and treatment of the patients in paragraph 12 as follows:

- a. She conducted inadequate visual acuity assessments;
- b. She conducted inadequate binocular vision assessments;

- c. She failed to conduct or conducted inadequate external ocular examinations;
- d. The internal examinations were insufficient; and
- e. The refractive examinations were minimal and incomplete.

14. It is further alleged that Dr. Cheung failed to make and maintain the records required by Part IV of Ontario Regulation 119/94 contrary to paragraph 1.24 for the patients referred to in paragraph 12 as follows:

- a. The patient history was inadequate;
- b. The recording of the visual acuity was inadequate;
- c. The external examination findings were not adequately recorded; and
- d. The internal examination findings were not adequately recorded.

15. The College's expert, Dr. Paul Padfield, reviewed Dr. Cheung's patient records for the ten patients referred to at paragraph 12, above, and if he were called to testify would say that Dr. Cheung failed to maintain the standard of practice of the profession in her care for these patients.

16. Dr. Padfield would also say if called to testify that Dr. Cheung did not make or maintain records as set out at paragraph 14, above, as required for the ten patients as required by Part IV of Ontario Regulation 119/94.

### **Dr. Suzan Sarkies**

17. Dr. Suzan Sarkies is an optometrist practising in Ontario who has been a member of the College since in or about February 10, 2010.

18. In or about 2014, Dr. Sarkies examined and treated the following child patients through the SVC Program:

- a. [REDACTED]

- b. [REDACTED]
- c. [REDACTED]
- d. [REDACTED]
- e. [REDACTED]
- f. [REDACTED]
- g. [REDACTED]
- h. [REDACTED]
- i. [REDACTED]
- j. [REDACTED]
- k. [REDACTED]
- l. [REDACTED]

19. Dr. Sarkies failed to maintain the standard of practice of the profession contrary to paragraph 1.14 of Ontario Regulation 119/94 in her examination and treatment of the patients in paragraph 18 as follows:

- a. She conducted inadequate visual acuity assessments;
- b. She conducted inadequate binocular vision assessments;
- c. She failed to conduct or conducted inadequate external ocular examinations;
- d. The internal examinations were insufficient;
- e. The refractive examinations were minimal and incomplete; and
- f. Insufficient evaluation of pupillary function

20. Dr. Sarkies failed to make and maintain the records required by Part IV of Ontario Regulation 119/94 contrary to paragraph 1.24 for the patients referred to in paragraph 18 as follows:

- a. The diagnosis was not properly recorded;
- b. The recording of pharmaceutical agents used was insufficient;
- c. The recording of the visual acuity was inadequate;
- d. The external examination findings were not adequately recorded; and
- e. The internal examination findings were not adequately recorded.

21. The College's expert, Dr. Paul Padfield, reviewed Dr. Sarkies' patient records for the twelve patients referred to at paragraph 18, above, and if he were called to testify would say that Dr. Sarkies failed to maintain the standard of practice of the profession in her care for these patients.

22. Dr. Padfield also says if called to testify that Dr. Sarkies did not make or maintain records as set out at paragraph 20, above, as required for the twelve patients as required by Part IV of Ontario Regulation 119/94.

**Dr. Vivian Li**

23. Dr. Vivian Li is an optometrist practising in Ontario who has been a member of the College since in or about July 9, 2012.

24. In or about 2014, Dr. Li examined and treated the following child patients through the SVC Program:

- a. [REDACTED]
- b. [REDACTED]
- c. [REDACTED]
- d. [REDACTED]
- e. [REDACTED]
- f. [REDACTED]
- g. [REDACTED]
- h. [REDACTED]
- i. [REDACTED]
- j. [REDACTED]
- k. [REDACTED]

25. Dr. Li failed to maintain the standard of practice of the profession contrary to paragraph 1.14 of Ontario Regulation 119/94 in her examination and treatment of the patients in paragraph 24 as follows:

- a. She conducted inadequate binocular vision assessments;
- b. She failed to conduct or conducted inadequate external ocular examinations; and
- c. The internal examinations were insufficient;

26. Dr. Li failed to make and maintain the records required by Part IV of Ontario Regulation 119/94 contrary to paragraph 1.24 for the patients referred to in paragraph 24 as follows:

- a. The external examination findings were not adequately recorded; and
- b. The internal examination findings were not adequately recorded.

27. The College's expert, Dr. Paul Padfield, reviewed Dr. Li's patient records for the eleven patients referred to at paragraph 24, above, and if he were called to testify would say that Dr. Li failed to maintain the standard of practice of the profession in her care for these patients.

28. Dr. Padfield would also say if called to testify that Dr. Li did not make or maintain records as set out at paragraph 26, above, as required for the eleven patients as required by Part IV of Ontario Regulation 119/94.

### **Optometrists failed to allow for follow up**

29. Dr. Eskander, Dr. Cheung and Dr. Sarkies failed to schedule follow up assessments for their patients which is a failure to maintain the standard of practice of the profession contrary to paragraph 1.14 of Ontario Regulation 119/94.

30. Dr. Eskander, Dr. Cheung, Dr. Sarkies and Dr. Li failed to provide a mechanism or system for their patients (or their parent/guardian) to contact them with questions or when problems arose with their vision

or eye glasses which is a failure to maintain the standard of practice of the profession contrary to paragraph 1. 14 of Ontario Regulation 119/94.

31.If Dr. Padfield, the College's expert were called to testify he would say that the conduct in paragraphs 29 and 30 constitutes a failure to maintain the standard of practice of the profession.

### **Improper Record Storage - Drs. Cheung, Sarkies and Li**

32.Dr. Cheung, Dr. Sarkies, and Dr. Li stored or allowed their records to be stored in boxes on the floor at the office of SVC which was a unit in a strip mall.

33.The manner in which the records were stored:

- a. was not secure and exposed the records to breaches of patients' privacy; and
- b. did not allow for patients to readily access their records.

34.The conduct in paragraphs 32 and 33 constitutes professional misconduct under paragraph 1.39 of Ontario Regulation 119/94.

After reviewing the Agreed Statement of Facts and hearing submissions from counsel, and advice from Independent Legal Counsel, the panel retired to discuss our options. Taking all things into account including the Agreed Statement of Facts, the guilty pleas of the Members, and the explanations from both counsel, and ILC, the panel was convinced that professional misconduct as set out in the Notice of Hearing did in fact occur and announced that finding.

Ms. Martin submitted a Joint Submission on Penalty which was entered into the record as Exhibit 4. It read as follows:

1. The members shall attend before the Discipline Committee to be reprimanded.

2. The members shall pay \$5000 each to the College of Optometrists of Ontario (the "College") for its costs in investigating and prosecuting this matter. The costs shall be paid within six months of the date of the Order of the Discipline Committee by way of postdated cheques provided to the Registrar on or before April 5, 2016.
3. The members' certificates of registration shall be suspended for two weeks.
4. All of the two week suspension referred to in paragraph 3, above, will be suspended for each member who successfully completes the condition that he or she submit a written essay to the Registrar of the College ("Registrar") as follows:
  - a. The essay shall reflect:
    - (i) The appropriate documenting and maintaining of patient records with an emphasis on documenting patients' health and oculo-visual history;
    - (ii) For Drs. Cheung, Li and Sarkies only, the storing of records in a secure manner that protects patients' privacy and allows for an easy access to their records; and
    - (iii) Follow-up protocols including the importance of being accessible to patients following examination.
  - b. The essay shall be completed within six (6) months of the date of the Order of the Discipline Committee.
  - c. The Registrar shall determine whether or not each essay is acceptable, if it is not, the members will be required to correct it to the Registrar's satisfaction.

d. If a member fails to successfully complete the above condition within the six (6) months following the date of the Order of the Discipline Committee then his or her certificate of registration will be suspended for two weeks.

5. The imposition of a condition on the members' certificates of registration that they each complete a minimum of twenty (20) hours of continuing education (CE) activities as follows:
- a. A minimum of ten (10) hours must be in the management of patients with binocular vision disorders, including assessment and treatment;
  - b. A minimum of five (5) hours must be in ocular health assessment;
  - c. A minimum of five (5) hours must be in refraction; and
  - d. All CE shall be of category A (Continuing Education Equivalency is not acceptable), as per the *College of Optometrists of Ontario Continuing Education Policy January 1, 2015-December 31, 2017*;
  - e. All CE must be pre-approved by the Registrar;
  - f. The members shall be responsible for the cost of the CE;
  - g. The CE shall be completed within twelve (12) months of the date of the Order of the Discipline Committee and the members shall provide proof of completion of the CE to the Registrar; and
  - h. The CE shall be in addition to the mandatory CE requirements of the Quality Assurance Program.

6. The imposition of a condition on each member's certificate of registration that he or she shall undergo a practice inspection within fifteen (15) months of the date of the Order of the Discipline Committee. The details of which are as follows:
  - a. The Registrar shall assign an assessor to conduct an inspection of twenty-five (25) patient records for each member for patients whom the members treated following the completion of the CE referred to in paragraph 5: fifteen (15) of the patient records shall be for patients under the age of fourteen (14), and the other ten (10) shall be for patients over the age of fourteen (14);
  - b. The assessor shall review the records in the areas that are relevant to the allegations only and report the results of the inspection to the Registrar;
  - c. In the event that any deficiencies are noted in the report of the inspection, the Registrar shall make a report to the Inquires, Complaints and Reports Committee;
  - d. The members shall be given five (5) business days' notice prior to the College representative attending their respective practices to obtain the records; and
  - e. The practice inspection shall be conducted at no cost to the members.

Ms. Martin explained to the panel that the penalty aims to protect the public, rehabilitate the member, and balance specific and general deterrence. In regards to deterrence, the penalty must discourage the doctors from engaging in these activities again and must also send a message to the general membership of the College that such activity will not be tolerated. Ms. Martin outlined the various mitigating and aggravating factors that went into the drafting of the submitted penalty. Aggravating factors presented to the panel included the following:

- i) There were a number of patients affected.
- ii) The allegations were severe.

Mitigating factors presented to the panel included the following:

- i) Members had no previous discipline history.
- ii) Members cooperated with the investigation.
- iii) Members plead guilty.
- iv) There was an absence of dishonesty or moral turpitude.

Mr. Abramson submitted to the panel that there was an absence of aggravating factors and that the mitigating factors were that the Members did not own the SVC program, severed their ties long ago, and that they plead guilty. He stated that the penalty was significant and did indeed offer good specific and general deterrence. Mr. Abramson added that it was a significant penalty in itself for the doctors to go through this process and attend the Discipline Hearing.

Both counsel mentioned the need for the panel to accept the proposed penalty as written unless we determined the joint submission is contrary to the public interest and the sentence would bring the administration of justice into disrepute. Supportive case law was submitted to the panel in this regard (R. vs. Cerasuolo, 2001 CanLII 24172 (ON CA)).

Ms. Wilbee agreed with counsel that the test as to whether the penalty should be rejected is if we felt it was contrary to the public interest or brought the administration of justice into disrepute. She also stated that if we were inclined to reject the proposed penalty, we should return for further explanation from counsel.

The panel retired to consider the options. It was decided that taking all things into consideration, the proposed penalty was reasonable, meets the purpose of protecting the public, and offered a good balance between specific and general deterrence.

Of significant observation was the fact that the Members showed genuine remorse and understood the serious nature of their actions. It was also noted

that a significant part of the penalty is devoted to remediation and the panel was impressed with the emphasis on this component. A penalty should offer a chance for rehabilitation of behavior that is deemed inappropriate.

The panel announced their decision and indicated they were prepared to administer the reprimand if the Members were willing to waive their right to appeal this decision. The Chair received a verbal acknowledgement from each Member waiving their appeal rights and the reprimand was administered to them collectively. The wording of this reprimand is attached.

The Chair at this point adjourned the hearing.

(Signed)

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Dr. Jim Hoover, Chair

Signed this 26th day of April, 2016, in Kingston, Ontario.

**TEXT of PUBLIC REPRIMAND**  
**Delivered on April 5, 2016**  
**In the case of the**  
**College of Optometrists of Ontario and Drs. E. Eskander, S. Sarkies, K. M.**  
**Cheung, and V. Li**

“Drs. Eskander, Sarkies, Cheung, and Li; this panel of the Discipline Committee of the College of Optometrists of Ontario has found you guilty of professional misconduct as laid out in the Notice of Hearing. You have disregarded regulations that have been put in place to protect the public, not only in record keeping and storage, but also in patient care. 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 in this regard. Regulations are put in place to ensure best practices and protect the public when receiving optometry services, and when regulations are disregarded, we fail to ensure public safety. This panel of the Discipline Committee is hereby expressing its disappointment with your actions and we expect that you will review the regulations and expectations that this College has in place. We would hope that going through this experience will encourage you to review and improve your best practices model.”