THE DISCIPLINE COMMITTEE OF THE COLLEGE OF OPTOMETRISTS OF ONTARIO

Panel: Dr. Christopher Nicol, Chair
Dr. Vivian Habib
Dr. David White
Mr. Howard Kennedy
Ms. Winona Hutchinson

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. Ajay Chandail	)	Self-represented
	)	Ms. Julie Maciura Independent Legal Counsel
	)	**Heard on December 3, 2019**

DECISION AND REASONS

This matter came before a Panel of the Discipline Committee of the College of Optometrists of Ontario (the "College") on December 3, 2019, at the College, 65 St. Clair Avenue East, 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. Ajay Chandail (the "Member").

The five members of the Discipline Panel referred to above were in attendance, as well as the Member who was self-represented; Ms. Julia Martin, counsel for the College, accompanied by Ms. Maureen Boon, Registrar; and Ms. Julie Maciura, independent legal counsel to the Discipline Panel.

The hearing was called to order at 10:00 a.m. on December 3, 2019. The Chair introduced the Panel and the other people present in the room.

Publication Ban

On December 3, 2019, at the request of the College and on consent of the Member, the Panel made an order pursuant to subsection 45(3) of the *Regulated Health Professions Act, 1991* banning the publication, broadcasting or disclosure of the name of the patients referred to during the hearing or mentioned in any documentation filed at the hearing and/or any information that would disclose the identity of the patients.

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

Allegations and Evidence

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

The Notice of Hearing made the following allegations against the Member:

1. 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:

    a. paragraph 1.11 of Ontario Regulation 119/94, under the *Optometry Act, 1991*, S.O. 1991, c. 35, in that you failed to refer your patient, Patient A, to another professional when you recognized or should have recognized a condition of the eye or vision system that appeared to require such referral;

    b. paragraph 1.14 of Ontario Regulation 119/94, under the *Optometry Act, 1991*, S.O. 1991, c. 35, in that you failed to maintain the standards of practice of the profession with respect to the following:
        i. the oculo-visual assessment you performed on Patient A;
        ii. the oculo-visual assessments you performed on 23 pediatric patients;
        iii. the oculo-visual assessments of 101 patients who were students at XYZ University;
        iv. failing to notify the 101 patients at XYZ University as to where their patient records were located and failing to provide the patients with your contact information (telephone number or other means of contacting you) in the event that they had questions or problems with their vision or eyeglasses; and
        v. inputting inaccurate information on 17 patient records.

    c. paragraph 1.24 in that you failed to make and maintain records in accordance with

Part IV of Ontario Regulation 119/94, under the *Optometry Act, 1991*, S.O. 1991, c. 35, in that:

i. you made a referral to a pediatric ophthalmologist for your patient, Patient B, but failed to maintain a referral in the patient record;
ii. you failed to maintain an appointment book as required by section 8 of Ontario Regulation 119/94;
iii. you failed to maintain financial records for each patient as required by section 9 of Ontario Regulation respectively 119/94;
iv. you failed to record all of the information required by s. 10 of Ontario Regulation 119/94 in the patient records; and
v. you used equipment for recording, storing and the retrieval of records which permitted amendments, corrections, additions or deletions to be made to any record which obliterated the original record or did not show the date of the change contrary to paragraph 12(c) of Ontario Regulation 119/94.

d. paragraph 1.39 of Ontario Regulation 119/94, under the *Optometry Act, 1991*, S.O. 1991, in that 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 by adding information to the patient record of Patient C after the fact and not indicating that this is what you did.

Particulars of the allegations to the Notice of Hearing are as follows:

1. Dr. Ajay Chandail is an optometrist who has practised in Ontario since in or about June 6, 2016.

XYZ University Students

2. In or about October and November 2016, Dr. Chandail attended at XYZ University, in Ottawa to conduct eye clinics for the students.

3. Dr. Chandail conducted oculo-visual assessments of the 101 students listed at Appendix "B".

4. It is alleged that Dr. Chandail's oculo-visual assessments of the patients listed at Appendix "B" did not include the following and that he therefore failed to maintain the standard of practice:

i. a review of the patients' ocular or visual symptoms or experiences;
ii. the patients' occupational and avocational visual environment and demands;
iii. the patients' apparent and relevant physical, emotional and mental status;
iv. the patients' posterior segment;
v. the patients' intraocular pressure;
vi. the patients' refractive status and best-corrected monocular visual acuities;
vii. the patients' accommodative function; and
viii. the patients' oculomotor status.

5. It is further alleged that Dr. Chandail failed to do the following which constitutes a failure to maintain the standard of practice:

    i. provide his patients listed at Appendix "B" with his contact information (telephone number or other means of contacting him) in the event that they had questions or problems with their vision or eyeglasses; and
    ii. inform them of the location of their patient records when he left Ottawa.

6. Dr. Chandail did not maintain financial records for his patients listed at Appendix "B" as required by section 9 of Ontario Regulation 119/94.

7. Dr. Chandail failed to record the following information in the patients' records at Appendix "B" which is required by section 10 of Ontario Regulation 119/94:

    i. the patients' addresses;
    ii. the correct time and date of the appointment; and
    iii. the patients' correct date of birth.

Elementary School Children

8. On or about May 16, 2017, Dr. Chandail attended ABC Elementary School in Hamilton and conducted oculo-visual assessments on children who were students there.

9. Dr. Chandail conducted oculo-visual assessments of the children listed at Appendix "C" as well as a child that he saw at Spec Appeal Optical in Cambridge on or about March 22, 2018.

10. It is alleged that Dr. Chandail's oculo-visual assessments of the patients listed at Appendix "C" as well as, Patient D, did not include the following and that he therefore failed to maintain the standards of practice:

    i. the review of the patients' ocular or visual symptoms or experiences;
    ii. the patients' general health history;
    iii. the patients' apparent and relevant physical, emotional and mental status;
    iv. the examination of the patients' external eye and adnexa;
    v. the assessment of the patients' anterior segment;
    vi. the patients' presenting monocular acuities;
    vii. the patients' oculomotor status; and
    viii. the patients' stereoacuity.

11. Dr. Chandail noted on the record for his patient, Patient B that he was to be referred to a pediatric ophthalmologist for refraction under cycloplegia. However, he did not have a copy of the referral in the patient record.

12. Dr. Chandail therefore failed to maintain the records required by Part IV of Ontario Regulation 119/94.

13. Also, on or about May 16, 2017, Dr. Chandail conducted an oculo-visual assessment of Patient A, another student at ABC Elementary School in Hamilton.

14. Dr. Chandail concluded that Patient A's vision was normal.

15. Dr. Chandail did not refer Patient A to another health professional.

16. Patient A attended her family doctor on or about October 31, 2017, who noted upon examining her, that she had what appeared to be a "lazy eye".

17. Her guardians therefore took her to see another optometrist on or about November 20, 2017, who found a main diagnosis of "V pattern right eye exotropia", suspected as being congenital, with minor diagnoses of compound hyperopia astigmatism, receded near point of convergence, and reduced stereoacuity and had the patient return for cycloplegia.

18. Dr. Chandail failed to maintain the standard of practice of the profession in his oculo-visual assessment of Patient A as follows:
    i. he failed to complete the assessment of EOMs and refraction, including cycloplegic refraction;
    ii. his analysis of the data was deficient in that he did not consider the stereoacuity; and
    iii. given the foregoing, he failed to properly diagnose this patient.

19. In addition, Dr. Chandail failed to recognize, when he ought to have, that Patient A's condition of the eye required a referral to another professional whose profession is regulated under the *Regulated Health Professions Act*, contrary to paragraph 1.11 of Ontario Regulation 119/94.

Inaccurate Records

20. Other than the patient's name and health card number, Dr. Chandail input identical information, including the identical date and time of service, on the following groups of patient records for the patients at Appendix "B":
    a. 11/03/2016 – Patient E and Patient F;
    b. 11/03/2016 – Patient G, Patient H and Patient I;
    c. 11/03/2016 – Patient J, Patient K and Patient L;
    d. 10/25/2016 – Patient M, Patient N and Patient O; and
    e. 10/27/2016 – Patient P, Patient Q and Patient R.

21. Dr. Chandail input the same date of service and identical times for the measurement of intraocular pressure on the patient records for the following patients listed at Appendix "B":

a. 10/25/2016 11:05 – Patient S and Patient T; and
b. 11/03/2016 11:05 – Patient U and Patient V.

22. The conduct alleged in paragraphs 20 and 21 above, constitutes a failure to maintain the standard of practice.

23. For the Patient C listed at Appendix "B", the College previously obtained a copy of her patient record during the course of a related investigation. Dr. Chandail subsequently provided another patient record for this patient during the investigation into his conduct.

24. The original patient record contained very little information whereas the one obtained during the current investigation contained the following additional details regarding this patient:

i. health history (no health concerns);
ii. meds note (no meds);
iii. allergies (NKA);
iv. cover test @D (exophoria 6pd) @N (exophoria 6pd);
v. stereo (50 specs);
vi. colour vision (NORMAL);
vii. pupil size (4.00mm OD / 4.00mm OS); and
viii. retinoscopy (-450-100x035 OD / -450-100x095 OS);
ix. subjective (-400-075x045 20/20 OD / -450-075x110 20/20 OS);
x. IOP (refused); and
xi. and BV/OH (WNL).

25. In addition, there was a change in information for RX Diagnostic Recommendations from "spectacle rx released for full time wear" to "New spectacle RX released for full time wear / as needed".

26. Dr. Chandail did not indicate on the subsequent record that he had made any changes to the original one nor did he indicate any date of the changes.

27. Dr. Chandail therefore contravened paragraph 12(c) of Ontario Regulation 119/94 in that his computer, electronic or other equipment for recording, storing and the retrieval of records permitted him to make an amendment, correction, addition or deletion to Patient C's record which obliterated the original record and did not show the date of the change.

28. In addition regarding Patient C, it is alleged that by adding information in the patient record after the fact and not indicating that this is what he had done, Dr. Chandail 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.

AGREED STATEMENT OF FACTS

College counsel entered an Agreed Statement of Facts that was signed by the Member and a College representative and was marked as Exhibit 2.

The Agreed Statement of Facts provided as follows:

1. Dr. Ajay Chandail hereby pleads guilty to the allegations contained in the Notice of Hearing dated June 21, 2019, which is attached as Schedule 1 to this Agreed Statement of Facts.

2. Dr. Ajay Chandail is an optometrist who has practised in Ontario since in or about June 6, 2016.

XYZ University Students

3. In or about October and November 2016, Dr. Chandail attended at XYZ University, in Ottawa to conduct eye clinics for the students.

4. Dr. Chandail conducted oculo-visual assessments of the 101 students listed at Appendix "B" to the Notice of Hearing.

5. Dr. Chandail's oculo-visual assessments of the patients listed at Appendix "B" to the Notice of Hearing did not include the following and he therefore failed to maintain the standard of practice:

    i. a review of the patients' ocular or visual symptoms or experiences;
    ii. the patients' occupational and avocational visual environment and demands;
    iii. the patients' apparent and relevant physical, emotional and mental status;
    iv. the patients' posterior segment;
    v. the patients' intraocular pressure;
    vi. the patients' refractive status and best-corrected monocular visual acuities;
    vii. the patients' accommodative function; and
    viii. the patients' oculomotor status.

6. Dr. Chandail also failed to do the following which constitutes a failure to maintain the standard of practice:

    i. provide his patients listed at Appendix "B" to the Notice of Hearing with his contact information (telephone number or other means of contacting him) in the event that they had questions or problems with their vision or eyeglasses; and
    ii. inform them of the location of their patient records when he left Ottawa.

7. The parties agree that if the College of Optometrists of Ontario's expert witness, Dr.

Expert were called as a witness, he would testify that the conduct set out in paragraphs 5 and 6, above, constitutes a failure to maintain the standard of practice.

8. Dr. Chandail did not maintain financial records for his patients listed at Appendix "B" to the Notice of Hearing as required by section 9 of Ontario Regulation 119/94.

9. Dr. Chandail failed to record the following information in the patients' records at Appendix "B" to the Notice of Hearing which is required by section 10 of Ontario Regulation 119/94:

    i. the patients' addresses;
    ii. the correct time and date of the appointment; and
    iii. the patients' correct date of birth.

Elementary School Children

10. On or about May 16, 2017, Dr. Chandail attended ABC Elementary School in Hamilton and conducted oculo-visual assessments on children who were students there.

11. Dr. Chandail conducted oculo-visual assessments of the children listed at Appendix "C" to the Notice of Hearing as well as a child that he saw at Spec Appeal Optical, Patient D, in Cambridge on or about March 22, 2018.

12. Dr. Chandail's oculo-visual assessments of the patients listed at Appendix "C" to the Notice of Hearing as well as, Patient D, did not include the following and he therefore failed to maintain the standards of practice:

    i. the review of the patients' ocular or visual symptoms or experiences;
    ii. the patients' general health history;
    iii. the patients' apparent and relevant physical, emotional and mental status;
    iv. the examination of the patients' external eye and adnexa;
    v. the assessment of the patients' anterior segment;
    vi. the patients' presenting monocular acuities;
    vii. the patients' oculomotor status; and
    viii. the patients' stereoacuity.

13. The parties agree that if Dr. Expert were called as a witness he would testify that the conduct set out in in paragraph 12, above, constitutes a failure to maintain the standard of practice.

14. Dr. Chandail noted on the record for his patient Patient B that he was to be referred to a pediatric ophthalmologist for refraction under cycloplegia. However, he did not have a copy of the referral in the patient record.

15. Dr. Chandail therefore failed to maintain the records required by Part IV of Ontario Regulation 119/94.

16. Also, on or about May 16, 2017, Dr. Chandail conducted an oculo-visual assessment of Patient A, another student at ABC Elementary School in Hamilton.

17. Dr. Chandail concluded that Patient A's vision was normal.

18. Dr. Chandail did not refer Patient A to another health professional.

19. Patient A attended her family doctor on or about October 31, 2017, who noted upon examining her, that she had what appeared to be a "lazy eye".

20. Her guardians therefore took her to see another optometrist on or about November 20, 2017, who found a main diagnosis of "V pattern right eye exotropia", suspected as being congenital, with minor diagnoses of compound hyperopia astigmatism, receded near point of convergence, and reduced stereoacuity and had the patient return for cycloplegia.

21. Dr. Chandail failed to maintain the standard of practice of the profession in his oculo-visual assessment of Patient A as follows:

    i. he failed to complete the assessment of EOMs and refraction, including cycloplegic refraction;
    ii. his analysis of the data was deficient in that he did not consider the stereoacuity; and
    iii. given the foregoing, he failed to properly diagnose this patient.

22. The parties agree that if Dr. Expert were called as a witness, he would testify that the conduct in paragraph 21, above, constitutes a failure to maintain the standard of practice.

23. In addition, Dr. Chandail failed to recognize, when he ought to have, that Patient A's condition of the eye required a referral to another professional whose profession is regulated under the *Regulated Health Professions Act*, contrary to paragraph 1.11 of Ontario Regulation 119/94.

Inaccurate Records

24. Other than the patient's name and health card number, Dr. Chandail input identical information, including the identical date and time of service, on the following groups of patient records for the patients at Appendix "B" to the Notice of Hearing:

    a. 11/03/2016 – Patient E and Patient F;
    b. 11/03/2016 – Patient G, Patient H and Patient I;

c. 11/03/2016 – Patient J, Patient K and Patient L;
d. 10/25/2016 – Patient L, Patient N and Patient O; and
e. 10/27/2016 – Patient P, Patient Q, Patient R.

25. Dr. Chandail input the same date of service and identical times for the measurement of intraocular pressure on the patient records for the following patients listed at Appendix "B" to the Notice of Hearing:

a. 0/25/2016 11:05 – Patient S and Patient T; and
b. 11/03/2016 11:05 – Patient U and Patient V.

26. The conduct in paragraphs 24 and 25 above, constitutes a failure to maintain the standard of practice and the parties agree that if called as a witness, Dr. Expert would testify that it constitutes a failure to maintain the standard of practice.

27. For the patient Patient C listed at Appendix "B" to the Notice of Hearing, the College previously obtained a copy of her patient record during the course of a related investigation. Dr. Chandail subsequently provided another patient record for this patient during the investigation into his conduct.

28. The original patient record contained very little information whereas the one obtained during the current investigation contained the following additional details regarding this patient:

i. health history (no health concerns);
ii. meds note (no meds);
iii. allergies (NKA);
iv. cover test @D (exophoria 6pd) @N (exophoria 6pd);
v. stereo (50 specs);
vi. colour vision (NORMAL);
vii. pupil size (4.00mm OD / 4.00mm OS);
viii. retinoscopy (-450-100x035 OD / -450-100x095 OS);
ix. subjective (-400-075x045 20/20 OD / -450-075x110 20/20 OS);
x. IOP (refused); and
xi. BV/OH (WNL).

29. In addition, there was a change in information for RX Diagnostic Recommendations from "spectacle rx released for full time wear" to "New spectacle RX released for full time wear / as needed".

30. Dr. Chandail did not indicate on the subsequent record that he had made any changes to the original one nor did he indicate any date of the changes.

31. Dr. Chandail therefore contravened paragraph 12(c) of Ontario Regulation 119/94 in that his computer, electronic or other equipment for recording, storing and the retrieval of records permitted him to make an amendment, correction, addition or deletion to Patient C's record which obliterated the original record and did not show the date of the change.

32. In addition, regarding Patient C, by adding information in the patient record after the fact and not indicating that this is what he had done, Dr. Chandail engaged in conduct or performed an act, that having regard to all the circumstances, would reasonably be regarded by members as unprofessional.

Professional Misconduct

33. Dr. Chandail acknowledges and pleads guilty to committing 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:

    a. paragraph 1.11 of Ontario Regulation 119/94, under the *Optometry Act, 1991*, S.O. 1991, c. 35, in falling to refer his patient, Patient A, to another professional when he recognized or should have recognized a condition of the eye or vision system that appeared to require such referral;

    b. paragraph 1.14 of Ontario Regulation 119/94, under the *Optometry Act, 1991*, S.O. 1991, c. 35, in that he failed to maintain the standards of practice of the profession with respect to the following:

        i. the oculo-visual assessment he performed on Patient A;
        ii. the oculo-visual assessments he performed on 22 pediatric patients listed at Appendix C to the Notice of Hearing and Patient D;
        iii. the oculo-visual assessments of 101 patients who were students at XYZ University;
        iv. failing to notify the 101 patients at XYZ University as to where their patient records were located and failing to provide the patients with his contact information (telephone number or other means of contacting him) in the event that they had questions or problems with their vision or eyeglasses; and
        v. inputting inaccurate information on 17 patient records.

    c. paragraph 1.24 in that he failed to make and maintain records in accordance with Part IV of Ontario Regulation 119/94, under the *Optometry Act, 1991*, S.O. 1991, c. 35, in that:

        i. he made a referral to a pediatric ophthalmologist for his patient, Patient B, but failed to maintain a referral in the patient record;
        ii. he failed to maintain an appointment book as required by section 8 of

Ontario Regulation 119/94;

iii. he failed to maintain financial records for each patient as required by section 9 of Ontario Regulation respectively 119/94;

iv. he failed to record all of the information required by s. 10 of Ontario Regulation 119/94 in the patient records; and

v. he used equipment for recording, storing and the retrieval of records which permitted amendments, corrections, additions or deletions to be made to any record which obliterated the original record or did not show the date of the change contrary to paragraph 12(c) of Ontario Regulation 119/94.

d. paragraph 1.39 of Ontario Regulation 119/94, under the Optometry Act, 1991, S.O. 1991, in that he engaged in conduct or performed an act, that having regard to all the circumstances, would reasonably be regarded by members as unprofessional by adding information to the patient record of Patient C after the fact and not indicating that this is what he did.

Guilty Plea

The Member accepted the facts and allegations included in the Agreed Statement of Facts.

Submissions of the Parties on Finding

College counsel submitted that the allegations essentially related to three different groups of issues.

Allegations related to XYZ University

The first set of allegations relates to a two month span in 2016 when the Member was conducting an eye clinic at a university in Ottawa. Appendix B to the Notice of Hearing lists the names of 101 students about whose assessments the College identified concerns. The College was concerned about the manner in which oculo-visual assessments were done and paragraph 5 of the Agreed Statement of Facts sets out eight problems with those assessments that resulted in failure to meet the standards of practice of the profession.

The next allegation relates to the failure to provide contact information as set out in paragraph 6 of the Agreed Statement of Facts. The 101 university students were not given Dr. Chandail's contact information in case there was a problem with their prescription so they had no means of contacting him, nor did he advise them where their records were being kept.

Paragraph 7 demonstrates that if the College's expert witness, Dr. Expert, were called as a witness he would testify that the conduct set out in paragraphs 5 and 6 of the Agreed Statement of Facts constitutes a failure to maintain the standard of practice of the profession.

Paragraph 8 of the Agreed Statement of Facts relates to Dr. Chandail failing to maintain required financial records for the university students.

Paragraph 9 of the Agreed Statement of Facts relates to Dr. Chandai's failure to record required information in the patient's records in particular, the patient's names, addresses, the correct date and time of appointments and the patient's correct dates of birth.

Allegations related to ABC Elementary School

The second group of allegations relate to school children at an elementary school in Hamilton and these stem for the most part from one day where Dr. Chandail attended and did oculo-visual assessments of students there. Those 22 students were listed at Appendix C to the Notice of Hearing (plus one additional student seen at another location the same day).

Paragraph 12 of the Agreed Statement of Facts sets out the Member's failure to maintain the standards of practice of the profession with respect to the students at Appendix C, as well as the additional student. The failures to maintain the standards of the profession were similar to his failures with respect to the university students. Similarly, the College's expert, Dr. Expert, if called as witness, would testify that these allegations constitute a failure to maintain the standards.

The student referred to in paragraph 14 of the Agreed Statement of Facts was apparently referred to a paediatric ophthalmologist but no referral was found in the Member's records, which constitutes a failure to maintain records as required.

An additional student referred to in paragraphs 16 through 23 came to the College's attention by way of a complaint from her guardians. The Member had concluded that her vision was normal and she was not referred to another healthcare provider. Some months later her family doctor noticed she had a lazy eye and took her to another optometrist who found a "V pattern right eye exotropia" and other issues with her eye. As such the Member failed to maintain the standards when he assessed her because he failed to complete an appropriate assessment, analyse the data properly and as a result failed to properly diagnose. If called as a witness, the College's expert would say this was also a failure to maintain standards. Furthermore, the Member failed to refer the student to another health professional.

Allegations related to Record Keeping

The last set of allegations, starting at paragraph 24 of the Agreed Statement of Facts, relates to the Member's record keeping. This allegation relates to identical information being inputted into the records for the university students including identical dates and times for service which could not be correct because it is impossible to see two patients at the exact same time.

The last allegation relates to the chart of one student which came to the attention of the College through another investigation and during which it was apparent that there were two different

versions of the chart relating to the same client visit. The original record contained very little detail whereas the subsequent record included additional details regarding the student as listed at paragraphs 28 and 29 of the Agreed Statement of Facts. The Member did not indicate that additional information was added after the fact, which is inappropriate. As well, he failed to use a recordkeeping program that would make it apparent when any changes were made to a record. This was a breach of the record keeping requirements and also unprofessional conduct.

Finding on Misconduct

After considering the Agreed Statement of Facts and the submissions of College counsel and the Member, the Panel found that the facts supported the findings of professional misconduct as set out in the Agreed Statement of Facts, more particularly, pursuant to paragraphs 1.11, 1.14, 1. 24 and 1.39 (unprofessional only) of Ontario Regulation 119/94, under the *Optometry Act, 1991*, S.O. 1991.

Reasons for Finding of Misconduct

The Member was present at the hearing and he agreed with the College that the conduct set out in the Agreed Statement of Facts, which he admitted engaging in, constitutes professional misconduct. After considering the Agreed Statement of Facts and the submissions of counsel, the Panel found that the College proved the allegations on a balance of probabilities.

The Panel felt that the information included in the Agreed Statement of Facts and as presented by College counsel clearly showed that the facts constituted the various heads of misconduct to which the Member pled guilty.

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

Joint Submission on Penalty

College counsel provided to the Panel a Joint Submission on Order and Costs that was signed by the Member and a College representative and it was marked as Exhibit 3 on December 3, 2019.

The Joint Submission proposed the following Order:

1. That Dr. Chandail be reprimanded;

2. That Dr. Chandail pay the College's costs in the amount of $10,000 payable to the College of Optometrists of Ontario within six months of the date of the Order of the Discipline Committee;

3. That Dr. Chandail's certificate of registration be suspended for a period of four (4) weeks commencing on a date that is acceptable to the Registrar;

4. That a condition be imposed on Dr. Chandail's certificate of registration that he complete twelve hours of practice coaching within three (3) months of the date of the decision of the Discipline Committee as follows:

    a. The coaching shall be at Dr. Chandail's own expense;

    b. The practice coach and the coaching plan shall be approved by the Registrar;

    c. The coaching will focus on the issues that arose in the allegations including making and maintaining patient records, financial records and appointment books; conducting ocular-visual assessments; how to test for and identify the condition ultimately diagnosed in patient S. C's and when to refer such patient to an ophthalmologist.

    d. The coaching will take place primarily at the coach's office; however, the coach will also attend at Dr. Chandail's office to assist in developing the coaching plan and may attend again during the coaching period at his or her discretion.

    e. At the conclusion of the coaching period the practice coach will send a report to the Registrar indicating whether or not, in the opinion of the coach, Dr. Chandail understands the issues covered by the coaching and whether he has implemented improvements to his practice, as recommended by the coach.

    f. In the event of a report from the practice coach that is not acceptable to the Registrar, Dr. Chandail can repeat the practice coaching period once more under the same conditions as above. This is to be completed within twelve (12) months of the date of the Order of the Discipline Committee.

    g. If Dr. Chandail fails to successfully complete the practice coaching, the matter will be referred to the Inquiries, Complaints and Reports Committee.

5. [1]That a condition be imposed on Dr. Chandail's certificate of registration that he submit a written essay, which is in his own words, to the Registrar of at least 1,000 words 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;

[1] Note that the Joint Submission on Penalty mis-numbered this paragraph as 4 and the subsequent paragraph as 5.

ii. The fact that patient records must not be altered after the date that they are made unless a note is made indicating the date and reason for the alteration;

iii. The required steps involved in completing an appropriate oculo-visual assessment;

iv. How to test for and identify the condition ultimately diagnosed in patient S. C's and when to refer such patient to an ophthalmologist

v. Dr. Chandail's reflections on how the eye examinations provided to the patients at issue in his discipline hearing should have been handled differently.

b. The essay shall be completed within one month of the successful completion of his practice coaching.

c. The Registrar shall determine whether or not the essay is acceptable; if it is not, Dr. Chandail will be required to correct it to the Registrar's satisfaction.

6. That a condition be imposed on Dr. Chandail's certificate of registration that he shall undergo a practice inspection within twelve (12) 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 patients under the age of twenty-two, seen after the suspension has been served and the essay completed;

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. Dr. Chandail shall be given five (5) business days' notice prior to the College representative attending his practice to obtain the records; and

e. The practice inspection shall be conducted at Dr. Chandail's expense, to a maximum of $1,500.

College Submissions on Penalty

College counsel submitted that the purpose of penalty is threefold: to protect the public; to serve as a deterrent (both specific and general) and to rehabilitate the Member so that he does not engage in this conduct again.

She submitted that the panel was also required to take into account both the aggravating and mitigating factors in the case.

With respect to aggravating factors she submitted that there are quite a few different types of behaviour in this case and also a large number of patients affected. While the conduct is not the worst that has come before the College as it does not involve dishonesty or abuse, it is still relatively serious.

That said, College counsel submitted that there are more mitigating factors than aggravating in this case, including the fact that the Member has no previous complaints or findings against him. As well, the Member has been very cooperative in the investigation and in the prosecution of the matter and indicated very early on that he had made these errors and that he regretted them. Furthermore, the Member pled guilty, which is an acknowledgment of wrongdoing and which saves the College time and money. This would have been a very complicated and expensive hearing to prosecute and likely would have lasted a week or more.

College counsel submitted that the Joint Submission on Penalty met the principles of public protection and also meets the principle of specific deterrence to the Member as the period of suspension is not insignificant given that this is his first time before the Discipline Committee.

College counsel pointed out that the Joint Submission contained much in the way of rehabilitation, including a great deal of coaching, as well as an essay and finally the practice inspection after the first two elements have been completed, to ensure that the remediation has in fact been effective.

College counsel submitted that the penalty also sends a strong message to others who might think about engaging in similar conduct. She then provided two decisions from the Discipline Committee of the College dealing with similar conduct to demonstrate to the Panel that the Joint Submission was within the correct range and would not bring the administration of the discipline process into disrepute or otherwise be contrary to the public interest.

Member Submissions on Penalty

The Member made submissions on his own behalf, explaining that he had been an ophthalmologist for 30 years before immigrating to Canada. He came to Canada so his two sons could attend university here. He worked at different jobs for four or five years until he was lucky enough to get into the bridging program for optometry and he completed the program. In 2016 he (became) was registered as an optometrist in Ontario.

He explained that the university program (that led to the allegations contained in the Agreed Statement of Facts at paragraphs 3 through 9) was his initial opportunity to work as an optometrist in 2016 and that he was brought in to the program by another optometrist who had already done similar programs. So the Member followed what that other optometrist had done in the past. He stated that he left most of the things like providing the contact information and keeping financial

information to the other optometrist. The Member acknowledged that he should have taken care to make sure those things were done correctly but due to being new to the system he failed to do so and he regrets that decision. He has tried to correct his shortcomings so he doesn't repeat those mistakes.

Similarly, before the Member joined the other school vision program it was under the care of a paediatric ophthalmologist at Hamilton. The paperwork and record keeping was under the ophthalmologist's care and again, the Member thought that what was being done was sufficient. Later on he found out a lot of shortcomings in that record keeping and he acknowledges that he should have taken care of that himself rather than assume that others were doing it correctly. He submitted that the reason for the errors was being new to the systems and following what others had done but he further recognizes that the fault lies with him because it is his responsibility.

He regrets making those mistakes and he told the Panel that he has overcome all these shortcomings and as a result of the coaching he will be able to overcome any future deficiencies.

Decision on Penalty

The Panel accepted the Joint Submission on Penalty and made an order consistent with its terms.

Reasons for Penalty

After deliberating and considering the submissions of counsel for the College and the Member, the Panel determined the penalty was fair and reasonable, being neither too lenient nor too onerous and made the Order on penalty as jointly submitted by the parties, keeping in mind that the test for rejecting a Joint Submission on Penalty as articulated by the Supreme Court of Canada in *R v. Anthony-Cook* is very high.

College counsel provided two previous cases of this College in which similar conduct occurred resulting in penalties that included suspensions as well as terms, conditions and limitations. The *Cheung* et al as well as *Singh* decisions both resulted in a suspension of two weeks plus remedial components. Those members were also required to repay some costs to the College.

While the penalty being sought here is a longer suspension than in those other two cases, the Panel agrees with College Counsel that the conduct at issue here involved many more patients. The Panel also notes that the patients were vulnerable, as they included children and university students.

The College's standards of practice exist to ensure that the public is protected and failure to maintain those standards puts patients at risk. The Panel believes that the totality of the penalty order is such that it will act as a general deterrent to other members of the profession and that its focus on rehabilitation will also help to ensure that the Member himself does not repeat this

conduct in the future. The Panel was particularly comforted by the fact that there is a final practice inspection to ensure that the coaching has in fact been effective and that the Member is indeed meeting the standards of practice at that point.

The Panel was also of the view that the penalty appropriately took into consideration the mitigating factors in this case, including the fact that the Member had no previous complaints against him, he cooperated fully with the College and pled guilty, thereby saving time and resources and that he was sincere and remorseful and prepared to learn from this experience and improve his practice.

At the conclusion of the hearing the Panel administered the reprimand to the Member, a copy of which is attached to this decision.

Dated this 17th day of December, 2019, at Toronto, Ontario.

Dr. Christopher Nicol, Chair

On behalf of:

Dr. Vivian Habib
Dr. David White
Mr. Howard Kennedy
Ms. Winona Hutchinson

TEXT OF PUBLIC REPRIMAND

College of Optometrists of Ontario and Dr. Ajay Chandail

December 3, 2019

Dr. Chandail, please stand.

Dr. Chandail, this reprimand will be part of the public portion of the College register and will form part of your record with the College.

Dr. Chandail, 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 Statements of Facts.

The failure to maintain the standard of practice for the profession of optometry is serious misconduct.

Your patients and the public trust you to provide them with the same level of eye care that we expect of every optometrist.

You compromised that trust by providing substandard card, not only in your examination of patients but also in your records.

This panel is disappointed with your behaviour and we anticipate that you will learn from your mistakes and from the penalty that we impose. We also expect that you will welcome remediation efforts imposed by this panel and that you will immediately incorporate any recommendations into your practice routine.

Dr. Chandail, we trust that you will not find yourself before a panel of the Discipline Committee again. However, if you do, you can expect that the penalty you receive will be more severe.

Thank you, you may sit down.