DISCIPLINE COMMITTEE
OF THE COLLEGE OF CHIROPODISTS OF ONTARIO

PANEL[i]: Peter Stavropoulos, Chair (Professional Member)
Ramesh Bhandari (Public Member)
Irv Luftig (Professional Member)

BETWEEN:

COLLEGE OF CHIROPODISTS OF ONTARIO (the "College")	)	DEBRA McKENNA for the College
-and-	)	MATTHEW WILTON, for the Member,
EDDIE K. CHAN	)	LUISA RITACCA, Independent Legal Counsel
	)	Heard: December 21, 2022

Decision and Reasons on Penalty and Costs
(original decision issued on September 19, 2022)

1. This matter came on for the continuation of a hearing before this panel of the Discipline Committee on December 21, 2022, by way of videoconference hosted by Victory Verbatim in Toronto.

2. On September 19, 2022, the Panel released its decision finding that the Member, Eddie Chan, engaged in professional misconduct as alleged in the Notice of

[i] Sasha Kozera (professional member) was originally on this panel. She took part in the decision regarding liability. Ms. Kozera is no longer a member of council. She did not take part in the remainder of these proceedings.

Hearing, dated May 19, 2020. Attached hereto is a copy of the Panel's September 19th decision.

3. The parties returned before the Panel to provide submissions regarding penalty and costs. At the outset of the hearing, the Panel was advised that the parties had reached an agreement on the issue of penalty and costs. As such, this stage of the hearing proceeded on an uncontested basis.

Joint Submission on Penalty and Costs

4. The Joint Submission on Penalty and Costs provides as follows:

THE PARTIES agree and jointly submit that the Discipline Committee make the following orders with respect to this matter:

1. An oral reprimand;

2. An order suspending the Member's certification of registration for a period of nine (9) months,[ii] two (2) months of which will be remitted upon the Member completing the Probe ethics course and the University of Toronto record-keeping course as outlined in paragraph 3(a) below;

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

   (a) Prior to returning to practice, the Member shall successfully complete the Probe ethics course and the University of Toronto record-keeping course at his own expense and provide documentary evidence to the College of his successful completion of those courses to the satisfaction of the Registrar.

[ii] During the period of suspension, the Member is not permitted to practise chiropody and shall comply with the College's Guideline for Suspension: www.cocoo.on.ca/pdf/guidelines/suspension_guideline.pdf. For the sake of clarity, this includes, among other things, the Member is not permitted to use the restricted title of chiropodist, or hold himself out as being able to practise, or hold himself out as a member of the College. The Member is not permitted to invoice or earn any income from the practice of chiropody (directly or through a health profession corporation) or be present at the Member's primary practice location or any secondary practice location or attend at a practice setting where chiropody patients are in attendance, to be involved in or participate in any of the chiropody care to be provided to chiropody patients.

(b) Upon returning to practice after his suspension, the Member is prohibited from imaging, casting, prescribing, constructing, fitting, dispensing and/or ordering the fabrication of orthotics for a period of six (6) months ("**Orthotics Restricted Period**"). For the purpose of clarity, the Member is not entitled to assign his patients to anyone else practising in his clinics during the Orthotics Restricted Period, regardless of whether or not he receives a fee, but shall refer such patients seeking orthotic assessment and treatment to another member of the College in good standing at a clinic unaffiliated with the Member's clinics.

(c) Upon returning to practice after his suspension, the Member is prohibited from prescribing, fabricating, fitting, dispensing and/or ordering prescription footwear modifications for a period of twelve (12) months ("**Modifications Restricted Period**"). For the purpose of clarity, the Member is not entitled to assign his patients to anyone else practising in his clinics during the Modifications Restricted Period, regardless of whether or not he receives a fee, but shall refer such patients seeking prescription footwear modifications to another member of the College in good standing at a clinic unaffiliated with the Member's clinics.

(d) At his own expense, the Member will receive supervision of his chiropody practice with a supervisor selected by the Registrar for a period of one (1) year from the date on which the Member returns to practise from the suspension. The terms of the supervision are as follows:

- The supervisor shall visit with the Member in person on at least four (4) occasions – twice in the first six months and twice in the last six months;
- Two of the visits with the supervisor will be unannounced;
- The supervisor shall determine the length of each visit;
- In conducting the supervision, the supervisor shall discuss ethics, practice management, record-keeping and compliance with the College's standards with the Member;
- The supervisor shall prepare a report to the Registrar after the second (2) visit and after the fourth (4) visit;
- The Member shall provide the supervisor with the Discipline Committee's decision and then provide written confirmation to the Registrar, signed by the supervisor, that the supervisor has received and reviewed the final decision;

(e) In the event that the Member obtains employment to provide chiropody services during the twelve (12) months following the date that the Member returns to practise after his suspension, the

Member shall:

- notify any current or new employers of the Discipline Committee's Decisions;
- ensure the Registrar is notified of the name, address, and telephone number of all employer(s) within fifteen (15) days of commencing employment;
- provide his employer(s) with a copy of:
  - the Discipline Committee's Misconduct Decision;
  - the Discipline Committee's Penalty Decision;
  - the Notice of Hearing; and
  - have his employer forward a report to the Registrar within fifteen (15) days of commencing employment confirming that the employer has received the documents noted above and agrees to notify the Registrar immediately upon receipt of any information that the Member is not complying with the College's standards;

4. An order directing the Member to pay costs to the College in the amount of $85,000.00, which amount will be paid by the Member on the following schedule:
   - $25,000.00 – December 21, 2022;
   - $10,000.00 – June 1, 2023;
   - $10,000.00 – December 1, 2023;
   - $10,000.00 – June 1, 2024;
   - $10,000.00 – December 1, 2024;
   - $10,000.00 – June 1, 2025; and
   - $10,000.00 – December 1, 2025.

5. An order that the Discipline Committee's Penalty Decision will be published, in detail with the Member's name, in the College's official publications, on the College's website, on the College's public register, and on CanLII.

6. The College and the Member agree that if the Discipline Committee accepts this Joint Submission on Penalty and Costs, there will be no appeal or judicial review of the decision to any forum.

Decision and Reasons

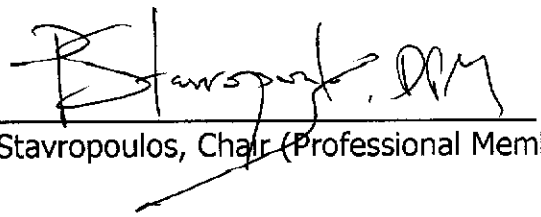
5. The Panel reviewed the Joint Submission and received submissions from counsel. The Panel accepted the Joint Submission and made an order consistent with its terms before the conclusion of the hearing.

6. The Panel is satisfied that the terms contained in the Joint Submission are reasonable, proportionate, and will maintain public confidence in the Discipline Committee.

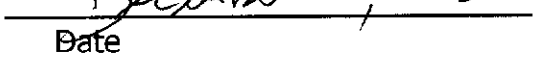
7. In coming to its decision, the panel weighed a number of mitigating factors. Firstly, this was the first time that the member had been referred to Discipline in his 15 years of practice. Secondly, the panel was informed by the member's counsel that he was directed by the member to work toward a joint settlement. This signalled to the panel that the member was eager to put this unfortunate chapter behind him, looking forward now to his rehabilitation. Third, the panel believed the penalty and costs, jointly agreed to, were fair and proportionate when considering the misconduct that had occurred. Lastly, since the agreed to settlement for costs was derived at by joint submission, and given the aforementioned views of the panel, the panel was in no way compelled to go against what they believed to be an adequate specific and general deterrent as reflected by the penalty and costs.

8. At the conclusion of the hearing, the Member confirmed that he waived his appeal rights and was prepared to receive his reprimand. The Panel delivered its reprimand, a copy of which is attached as Appendix A.

I, Peter Stavropoulos, sign this Decision and Reasons for the decision as Chairperson of this Discipline panel and on behalf of the members of the Discipline panel as listed below:



Peter Stavropoulos, Chair (Professional Member)



Date

Ramesh Bhandari (Public Member)
Irv Luftig (Professional Member)

Appendix A

Reprimand

As you know, Mr. Chan, as part of its penalty, this Discipline panel has ordered you be given an oral reprimand.

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

Although you will be given an opportunity to make a statement at the end of the reprimand, this is not an opportunity for you to review the decision made by the Discipline panel, nor a time for you to debate the merits of our decision.

The panel has found that you have engaged in professional misconduct in the following ways:

1. You failed to meet and/or contravened the standards of practice of the profession, including the standards regarding Patient Relations, Assessment and Management, Records, Prescription Footwear and Prescription Custom Foot Orthoses;

2. You practiced the profession while in a conflict of interest

3. You failed to keep records as required by the regulations

4. You signed or issued documents you knew or ought to have known contained false or misleading statements

5. You charged excessive fees for products and/or services

The fact that you engaged in professional misconduct is a matter of profound concern. Virtually every aspect of your practice was found to be problematic. You appeared to put profit ahead of patient care.

You have brought discredit to the entire chiropody profession and to yourself. Patients who come to see the members of this profession, often rely on insurance. Your actions put in jeopardy the good relationship the membership has with insurance companies. Further, public confidence in this profession has been put at risk. The result of your misconduct is that you have let down the public, the chiropody profession, and yourself.

Your conduct is totally unacceptable to your fellow chiropodists and to the public. Of special concern to us is the fact that the professional misconduct in which you engaged has involved misleading and deceptive billing practices, improper foot assessments and practices which put your business interest ahead of the well-being of your patients.

We also want to make it clear to you that while the penalty that this panel has imposed upon you is a fair penalty, a more significant penalty will likely be imposed by another Discipline panel in the event that you are ever found to have engaged in professional misconduct again.

As you heard earlier, you will now be given an opportunity to respond if you wish. Remember this is not an opportunity for you to review the decision or debate its correctness. Do you wish to make any comments?

Thank you for attending today. We are adjourned.

DISCIPLINE COMMITTEE OF THE COLLEGE OF CHIROPODISTS OF ONTARIO

THE DISCIPLINE COMMITTEE OF THE COLLEGE OF CHIROPODISTS OF ONTARIO

IN THE MATTER OF a Hearing directed by the Inquiries, Complaints and Reports Committee of the College of Chiropodists of Ontario pursuant to Section 26(1) of the **Health Professions Procedural Code** being Schedule 2 of the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

BETWEEN:

COLLEGE OF CHIROPODISTS OF ONTARIO

- and –

EDDIE K. CHAN

PANEL MEMBERS:

Peter Stavropoulos	Chair, Professional Member
Sasha Kozera	Professional Member
Irv Luftig	Professional Member
Ramesh Bhandari	Public Member

COUNSEL FOR THE COLLEGE:	**Debra McKenna**
COUNSEL FOR THE MEMBER:	**Matthew Wilton**
INDEPENDENT LEGAL COUNSEL:	**Luisa Ritacca**
Hearing Date:	**January 17-18, 2022** **May 2-5, 2022**
Decision Date:	**September 19, 2022**
Release of Written Reasons:	**September 19, 2022**

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee on January 17 and 18, 2022 and on May 2, 3 and 5, 2022. This matter was heard via video conference.

The Allegations

1. The allegations against the Member as stated in the Notice of Hearing, dated May 19, 2020, are as follows:

STATEMENT OF ALLEGATIONS

1. Eddie K. Chan ("**Mr. Chan**" or the "**Member**") was at all material times a registered member of the College.

2. During the period in or about November 2014 to November 2018 (the "**Relevant Period**"), the Member engaged in professional misconduct within the meaning of the following paragraphs of section 1 of the Professional Misconduct Regulation,

3. O. Reg. 750/93 under the *Chiropody Act*, 1991:
   a. paragraph 2 (failing to meet or contravening a standard of practice of the profession), and, in particular, the College's standards pertaining to:
      i. Assessment and Management;
      ii. Patient Relations;
      iii. Records;
      iv. Prescription Footwear;
      v. Prescription Custom Foot Orthoses;
   b. paragraph 10 (practising the profession while the member is in a conflict of interest);
   c. paragraph 17 (failing to keep records as required by the regulations);
   d. paragraph 20 (signing or issuing, in the member's professional capacity, a document that contains a false or misleading statement);
   e. paragraph 21 (submitting an account or charge for services that the member knows is false or misleading);
   f. paragraph 22 (charging a fee that is excessive in relation to the services or devices charged for);
   g. paragraph 30 (contravening the *Chiropody Act*, 1991, the *Regulated Health Professions Act*, 1991, or the regulations under either of those Acts), specifically:
      i. Ontario Regulation 750/93 (Professional Misconduct) under the *Chiropody Act, 1991*, as specified in this Notice of Hearing;
      ii. Ontario Regulation 203/94 (General) under the *Chiropody Act, 1991;*

iii. section 51(1)(c) of the *Health Professions Procedural Code*, beingSchedule 2 to the *Regulated Health Professions Act, 1991*; and/or

h. paragraph 33 (engaging in conduct or performing an act, in the course of practising the profession that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, or unprofessional).

PARTICULARS OF THE ALLEGATIONS

A. Background

1. At all material times, the Member was a chiropodist registered with the College to practise chiropody in Ontario.

2. During the Relevant Period defined above, the Member was engaged in the practice of chiropody at EC Orthotics, which operates at two clinic locations in Toronto, Ontario: 1 Queen Street East, Toronto, Ontario, M5C 2W5 and 77 King Street West, Toronto, Ontario (collectively, the "**Clinic**").

3. In addition to his clinical practice, the Member is also the owner of the Clinic and manages the Clinic's operations.

4. During the Relevant Period, the Member also practiced at the following locations:

- Downtown Foot Clinic
  123 Queen Street West,
  Toronto, Ontario
  M5H 3M9

- Toronto Laser Nail
  20 Richmond Street East
  Toronto, Ontario
  M5C 2R9

B. The Complaint

5. On or about June 18, 2018, the College received a complaint from Sun Life Insurance ("**Sun Life**") with respect to the Member (the "**Complaint**").

6. As set out in the Complaint, Sun Life regularly conducts reviews with respect to the services and/or products that are provided to its plan members and/or their dependents, including claims with respect to orthotics and/or orthopaedic shoes.

7. During the Relevant Period, Sun Life conducted a review in relation to the Member and the various clinics that he owns and/or operates.
8. As indicated in the Complaint, Sun Life raised concerns about the Member over- prescribing medical products for financial benefit and/or charging for services not rendered.
9. In particular, among other concerns, the Member had issued and/or submitted benefit claims to Sun Life for orthopaedic shoes and/or shoe modifications that were, in essence, an off-the-shelf shoe in which the Member and/or his staff had placed a temporary foot pad inside of the shoe.
10. The insurance claims issued and/or submitted to Sun Life by the Member had no permanent modifications made to the off-the-shelf shoe.
11. The Member was aware or ought to have been aware that the cost of the shoes and/or the "shoe modifications" were not an appropriate charge to be covered by Sun Life's insurance benefits.
12. The Member was aware or ought to have been aware that the documentation issued and/or submitted by the Member for the insurance claims was false and/or misleading. The Member was also aware or ought to have been aware that the costs chargedby the Member for the "shoe modifications" were excessive in the circumstances.
13. In addition to claims for "shoe modifications", the Member also prescribed, issued and/or submitted claims to Sun Life for custom-made orthotics for his patients.
14. At the time of prescribing the orthotics and/or submitting those claims to Sun Life,the Member was practising in a conflict of interest.
15. During the Relevant Period, the Member was a shareholder, officer, or director of Paragon Orthotic Laboratory ("Paragon").
16. Paragon is a business incorporated in British Columbia and a manufacturer of orthotics.
17. The Clinic was a customer of Paragon and purchased orthotics from Paragon for the Member's patients.
18. In addition to prescribing and selling orthotics manufactured by Paragon, the Member was also

offering and/or paying an incentive commission to the other chiropodists working at the Clinic to prescribe and sell orthotics made by Paragon.

19. Attached as Schedule “A” is a list of the patients for whom the Member issued invoices and/or submitted benefit claims for “shoe modifications” and/or custom made orthotics.

SCHEDULE "A"

SUMMARY OF FEES FOR PRODUCTS

Patient	Date of Appointment	Fees
Y.Z.	11/21/2014	Shoes - $50.00 Bunion modification - $100.00 Metatarsal pad - $150.00[1]
Y.Z.	10/02/2015	Shoes - $50.00 Bunion modification - $150.00 Metatarsal pad - $100.00
F.Y.	12/30/2015	Shoes - $300.00
S.K.	12/21/2016	Shoes - $300.00
D.K.	04/13/2017	Shoes - $250.00
S.K.	12/29/2017	Shoes - $150.00 Heel lift - $75.00 Valgus pad - $75.00
C.C.	12/30/2017	Orthotics - $650.00 Shoes - $100.00 Metatarsal pad - $75.00Valgus pad - $75.00
D.K	01/23/2018	Orthotics - $400.00 Shoes - $250.00
S.A.	03/27/2018	Orthotics - $300.00 Shoes - $150.00 (x2) Metatarsal pad - $100.00Valgus pad - $100.00
J.N.	11/20/2018	Shoes - $250.00
G.G.	11/23/2018	Orthotics - $400.00 Orthotics - $300.00

[1] In the course of the hearing, counsel for the member noted that the costs listed here were incorrect. The patient was charged $100 for metatarsal pads and $150.00 for bunion modifications

Overview

As outlined in the Notice of Hearing, the College alleges that Mr. Chan engaged in various acts of professional misconduct between November 2014 and November 2018. The alleged acts involved multiple patients and various categories of professional misconduct, including failing to meet the standard of practice of the profession. The alleged conduct is said to have taken place while the Member was engaged in the practice of chiropody at EC Orthotics (hereinafter, the "Clinic").

For the reasons set out below, the Panel finds that Mr. Chan engaged in professional misconduct as alleged. The Member engaged in a practice of charging excessive fees for shoe and orthotic modifications, practising in a conflict of interest, and poor record keeping as it related to virtually all the patients listed in Schedule A of the Notice of Hearing. The Panel reached its decision primarily on the patient records filed into evidence. While Mr. Chan provided the Panel with his explanation for some of the discrepancies found in his chart entries and for the manner in which he charged for certain services, the patient records provided the Panel with sufficient evidence to find professional misconduct in the circumstances.

Summary of Evidence and Factual Findings

In addition to receiving the patient records into evidence, the Panel heard from a representative of Sun Life Insurance, the complainant in this matter, an investigator retained by the College prior to the referral of this matter to the Discipline Committee and from Anthony Merendino, Podiatrist, and former member of the College's Council. Mr. Merendino was called to provide an expert opinion regarding the College's standards relevant to the allegations in this case. The Member also testified on his own behalf.

From the witnesses and the records available, the Panel learned that at all material times, the Member was engaged in the practice of chiropody at EC Orthotics, which itself operates in two locations in Toronto, Ontario. The Member was and continues to be the owner of EC Orthotics and at the relevant time managed its operations.

As described by Tiffany Secours, a representative from Sun Life Insurance, on or about July 2018, Sun Life Insurance filed a complaint with the College regarding Mr. Chan's billing practices. Ms. Secours explained that this complaint was filed after Sun Life Insurance conducted its own internal billing reporting review of Mr. Chan's patients, who were Sun Life Insurance plan members. Ms. Secours described that the insurer asked plan members for photos of the products being claimed, proof of payment and receipts. She said it was strange for Sun Life Insurance to see that the photos were taken at EC Orthotics. The insurer ultimately delisted Mr. Chan and filed its complaint with the College.

As part of its investigation process, the College collected records from EC Orthotics relating to eight specific patients. The records, coupled with the Member's testimony, revealed that the Member prescribed footwear and footwear modifications without taking (or properly documenting) a patient history or thorough assessment. Further, as the Member explained to the Panel, many of the "modifications" he charged patients for consisted of gluing or affixing foot pads inside a shoe or orthotic and also included shoe stretching on occasion. The foot pads used by the Member cost less than $20.00, however the Member charged patients anywhere between $75.00 and $150.00 for these modifications. The Member explained that these fees included the cost of the visit and follow-up, however the Member's records did not support such an assertion.

There was no follow-up noted and in many instances the patient was charged both the fee for the modification and a separate assessment fee.

The evidence also revealed that during the relevant time, the Member was a shareholder, officer or director of Paragon Orthotic Laboratory ("Paragon"). The Member purchased orthotics from Paragon for his patients CC, DK, SA, and GG. The Member explained to the Panel that he disclosed his business/financial interest in Paragon to his patients, however there was nothing in the patients' records to confirm such disclosure had taken place. The Member acknowledged that this disclosure was made verbally, but that he had recently changed his practice to ensure that his interest in Paragon is disclosed both verbally and in writing. He also testified that his associates would not receive any different or increased commission for selling a Paragon product. It is also important to note, that it appears from the patient records reviewed that no patient, who purchased orthotics, had their orthotics ordered from another lab.

With respect to the orthotics, the Member admitted that he charged fees that ranged from $300.00 to $650.00 per device, for what appeared to be the same product and treatment. Mr. Chan testified that he charged more for a patient receiving orthotics for the first time, rather than for a repeat patient. He also testified that in the case of patient CC, he charged her $650.00 because he anticipated that, as a first time orthotic user, she would need more adjustments and follow-up. He noted that with patient GG, for example, he did not anticipate the same follow-up care because GG used orthotics previously. The records suggest that GG had orthotics made for him by someone other than Mr. Chan sometime in 2015. Mr. Chan said that is why he only charged GG $400.00 for the product and service.

Expert Evidence and the Standards of Practice

Mr. Merendino graduated as a doctor of podiatric medicine in 1993. Since 2019, he has worked as a professor at the University of Florida. Before that, he was an instructor at the Michener Institute, in Toronto. He was a member of council of the College from 2016 until he left Ontario in 2019. During his tenure with the College, Mr. Merendino was involved in the development of and revisions to the various College Standards of Practice, Guidelines, and Policies. While not currently practising in Ontario, Mr. Merendino confirmed that as a result of his time on council and his teaching role at the Michener Institute, he was knowledgeable and well aware of the College's policies regarding prescription footwear, orthotics, assessment and management standards and patient relations.

The Member raised an objection as to Mr. Merendino's qualifications on the basis that his prior connection to the College council raised a reasonable apprehension of bias such that it would be inappropriate for the Panel to qualify Mr. Merendino to provide his opinion evidence in this instance.

The Panel received submissions from the parties and advice from its independent legal counsel on the issue. The Panel concluded that qualifying Mr. Merendino to provide his opinion evidence would not give rise to a reasonable apprehension of bias or otherwise be improper. Mr. Merendino had not been involved with the council since 2019. While there was some overlap between Mr. Merendino's involvement with the College and some of the members of the Panel, there had been no contact with any Panel members and Mr. Merendino since at least 2019. Further, the Panel members were satisfied that, despite their prior dealings with Mr. Merendino, they could consider his evidence fairly and objectively.

Based on Mr. Merendino's experience and knowledge of the College's standards, policies and guidelines, the Panel qualified him to provide his opinion evidence as to the standards required of a chiropodist in Ontario during the relevant period.

Mr. Merendino identified the College's written standards relevant to the misconduct alleged in this case, including the Assessment and Management Standard, the Patient Relations Standard, the Records Standard, the Prescription Footwear Standard and the Custom Foot Orthoses Standard. He confirmed that these written standards reflected the standards of practice of the profession at the materials time and explained that in his view the standards reflect what is required.

With regard to the Assessment and Management Standard, Mr. Merendino testified that he would expect to see clearly set out in a patient record, the reason for the patient's attendance, notes regarding the pathology, and an explanation of what treatment has been prescribed. He said that a member should not provide treatment that has no benefit to their patient.

Mr. Merendino explained that the Patient Relations Standard sets out the importance of and the requirements to obtain proper informed consent.

Further, Mr. Merendino testified that pursuant to the Record Keeping Standard, a member's records should include assessment and diagnosis, as well as instructions provided to the patient, together with a summary of any other communications with the patient.

The Prescription Footwear Standard and Prescription Custom Orthoses Standard require members to properly document why the prescription is necessary for the patient's care, that the patient has made an informed choice about receiving the footwear or orthotic, and that the product has been properly dispensed. Over prescription of footwear and/or orthotics is not in the best interest of patients or the profession. Mr. Merendino explained that over prescription is unethical and can result in extended benefit providers deciding to eliminate coverage for the service.

Mr. Merendino also identified the College's Conflict of Interest Policy, which prohibits the sale of any product that is not medically necessary. Further, he explained that it is a conflict of interest for a member to recommend or make a referral to a supplier of any service, device or product in which they have a financial interest, unless the member discloses that financial interest, and also offers the patient suitable alternative provision options.

Finally, Mr. Merendino provided the Panel with his opinion regarding the fees charged by the Member for modifications. Mr. Merendino noted that metatarsal and valgus pads could be purchased by a member for $1.00 to $5.00 and that in his view charging a patient $10.00 to $25.00 in the circumstances would be reasonable.

In cross examination, Mr. Merendino acknowledged that he was not asked to, nor did he review any of the patient records collected by the College as part of its investigation. Further, he acknowledged that while he was not familiar with the fee guide published by the Pedorthic Association of Canada (2018) (the "Guide"), the Guide did suggest that prices for shoe modifications could range from $70.00 to $175.00, and that when assessing the price, one needs to understand how long it takes to create and fit the product. Mr. Merendino further acknowledged that if the fees charged by the Member for the various shoe modifications performed were a blended rate, which included the examination fee, diagnosis, and shoe modification then the fee might be reasonable. In answer to a question from the Panel, however,

Mr. Merendino explained that while it would be appropriate for a member to bill an insurer for a temporary modification (like a metatarsal pad), the fact that the modification was temporary, should nonetheless have been clearly set out in the bill.

Decision and Reasons on Liability

The Panel finds that the Member engaged in professional misconduct as alleged in the Notice of Hearing. The Panel's decision is based primarily on the Member's records and his own admissions. The Member's practice as it related to the eight patients presented in this hearing was problematic. His records were wholly deficient, he charged excessive fees for low-cost, easy labour footwear modifications, he did not properly disclose (or document the disclosure) of his interest in Paragon, and he prescribed orthotics and other footwear without documenting a proper assessment or treatment plan.

Credibility of the Member

The Panel carefully considered the Member's version of events and in particular, his explanations for the gaps in his patient records. The Panel did not find the Member's testimony, where it was contradicted by his own records, to be credible. The Member sought to convince the Panel that in virtually every instance where he appeared to fail to take appropriate steps in his assessment of or communications with his patients, that he simply failed to record what in fact had happened orally. While the Panel was prepared to consider that the Member might have missed documenting a few discussions or assessment notes, given the number of gaps in the records, across all eight patients, the Panel concluded that the Member failed to meet his obligations to his patients and to the College in both his record keeping and in the manner he provided care.

Failing to Meet or Contravened a Standard of Practice of the Profession

The Member argued that the College failed to provide the Panel with opinion evidence to support a finding that he had contravened a standard of practice of the profession. The Member argued that the College ought to have had Mr. Merendino review the patient records at issue so that he could specifically opine on whether the Member had contravened any of the College's standards.

The Panel rejects the Member's position regarding the Standards of Practice. There is no issue that the College put into evidence the relevant Standards of Practice and College guidelines. Mr. Merendino identified the Standards and testified that in his opinion, the Standards set out what is required of a member in the province. There was no need for Mr. Merendino to opine on whether in this case, based on his reading of the records, the Member met or failed to meet the Standards. That is a decision the Panel makes based on the records and the evidence confirming the Standards. This is not a situation where there could be doubt about what is required by the Standards and whether those requirements were met. There was no suggestion by the Member that the Standards are ambiguous or open to interpretation. In the circumstances, the Panel was satisfied that the College had discharged its burden of establishing the relevant Standards of Practice and that it was not necessary for the College to ask Mr. Merendino or another expert to provide an opinion on the ultimate issue as to the Member's records or conduct specifically.

Assessment and Management Standard

The Panel concluded that at least with respect to two patients, the Member contravened the requirements of the Assessment and Management Standards. Among other things, the Assessment and Management Standard in place at the relevant time, required members, on the

initial assessment, to record pertinent information gathered from the patient's history and relevant clinical findings; and state a differential diagnosis, as well as a treatment plan with anticipated prognosis. With respect to patient YZ, Mr. Chang's original records contained a blank patient history form. Mr. Chan admitted that no medical history was recorded, and that no differential diagnosis was provided. He also acknowledged that he did not discuss the risks and benefits of the footwear modifications provided to YZ with him, and that he did not include a signed consent form in the record. Further, there is no notation in the chart as to any specific findings Mr. Chan observed following his physical examination of the patient. He recorded, "bunion", but did not indicate whether he found the bunion on one or both feet. If there were two bunions, he did not note whether one was worse or more painful than the other. Further, he did not note whether the patient was experiencing pain within a range of motion or on palpation. He did not note whether there was any evidence of skin irritation, blistering or callus. He did note "metatarsalgia" but failed to reference in the physical exam which foot or joints that diagnosis referred to. Finally, Mr. Chan did not record any observations of edema to justify prescribing compression stockings to YZ.

Patient SK was diagnosed by Mr. Chan with a Haglund's deformity, but there is nothing in the record to indicate that Mr. Chan performed a physical exam to confirm whether the deformity was found on one or both feet. Similarly, Mr. Chan diagnosed SK with Achilles tendonitis, but the record does not indicate, for example, whether Mr. Chan completed range of motion examination of the lower extremities, or palpated the affected structures, noted any swelling or visible abnormality, or whether SK was experiencing pain or limitation in functioning. Finally, it does not appear that Mr. Chan considered the differential diagnosis for these patients, the risks, or benefits of the proposed treatment or that any alternative treatment options were offered.

A review of the other patient records reveals similar deficiencies in the Member's assessment and management of their care. In many instances, there are blank or incomplete patient history forms in the files and in several instances there is little to no information to justify Mr. Chan's diagnosis or treatment plan. The Panel is satisfied based on the records and Mr. Chan's admissions that he failed to meet the standard in relation to assessment and management of his patients listed in the Notice of Hearing.

Patient Relations Standard

The Patient Relations Standard requires practitioners to ensure that patients are informed of the risks and benefits of a proposed treatment plan. Patients must also be informed of alternative treatment plans. Without any record of a physical examination or specific record of the patient's reason for attending (i.e right toe pain, uncomfortable in work shoes) and without any record of a discussion regarding treatment options, the Panel finds that Mr. Chan failed to meet the Patient Relations Standards.

The Standard, as well as the *Health Care Consent Act* Guideline sets out that one of the principles of consent to treatment can only be met where the consent is informed. The Panel finds, based on its review of Mr. Chan's records, the Member failed to obtain informed consent with respect to the eight patients listed in the Notice of Hearing.

Records Standard

Mr. Chan's records fall well-short of what is expected of a practitioner in Ontario and of what is required by the Records Standard. In several instances, Mr. Chan failed to record any medical

history for his patients, including no reference to the patient's weight or height, which are often important considerations in the treatment of foot conditions. Further, as set out above, Mr. Chan failed to record sufficient information about the examination he performed on his patients or even to make note of which foot the patient was complaining about. Similarly, it appears from the records that he did not conduct vascular examinations for patients, even where he went on to prescribe them with compression stockings. Patient, DK, for example, received several prescriptions for compression stockings, but there is nothing in the patient record to explain why. In addition, in several instances, important medical information, like the patient's allergies, medications, and other medical conditions, is not listed on the Patient Intake Form. For example, in patient SK's intake form, Mr. Chan identified "L heel wart + dryness" as the foot complaint, but his clinic note does not record any dermatological specifics as to the exact location of the wart on the foot, its size, shape or depth or any other distinguishing characteristics. There is also no mention in the record as to whether the wart was painful or whether the lesion could be anything other than a wart.

Similarly, patient JN's record indicates that they presented with "foot pain". Mr. Chan appears to have diagnosed JN with Achilles tendonitis and plantar fasciitis, in the absence of any record of the findings of any physical examination. Finally, the Panel noted that the invoice, prescription document and the exam notes for SK dated December 29, 2017, fail to identify the specific orthopedic shoe that was dispensed.

The Panel acknowledges that in certain other instances, it appears that Mr. Chan did take the time to complete thorough Patient Intake Forms (see for example the forms completed for patients JN, GG, SA and DK). However, these instances do not diminish the deficiencies found in the majority of the records.

The deficiencies in Mr. Chan's patient records are significant. Without proper records, Mr. Chan cannot provide adequate and ongoing care to his patients. Further, without proper records, it is difficult for the Panel to be satisfied that Mr. Chan conducted proper assessments or discussed treatment options with his patients. For these reasons, the Panel finds that Mr. Chan contravened the Records Standards as alleged.

Prescription Footwear Standards

In reviewing the patient records, the Panel concluded that in several instances the Member failed to demonstrate and/or document the medical necessity of the footwear he prescribed. The Member failed to conduct (or chart having conducted) a thorough medical history or physical examination. Without a history or examination, the Member could not have reached a justifiable decision that prescription footwear was necessary in every instance he prescribed it to the patients listed in the Notice of Hearing.

The Panel reviewed the Member's records for patient YZ. On October 2, 2015, the Member dispensed modified orthopedic shoes to YZ. He did so without taking a proper medical history, as required by the Standard and without establishing or setting out in his records the medical necessity for the product. The Standard in place at the relevant time, specifically required members to take a medical history, including the recording of the condition/diagnosis that necessitates the prescription footwear. It also required members to perform a foot exam with appropriate measurements taken and record and to perform a gait analysis where possible. The

Standard in place at the time also required members to assess and record any pertinent activities and environmental requirements of use and to record whether any orthopaedic modification are required. YZ's Patient History Form is entirely blank. The chart notes state that the patient presented at the Clinic for orthopaedic shoes and modifications. There is a reference to modifications for the patient's bunions and abnormal lesion/calluses and metatarsalgia. The notes contain no details regarding the patient's foot conditions, including the nature or location of the metatarsalgia (pain) or how the orthopaedic footwear will assist.

The Member dispensed a similar product to YZ in May 2016. During his testimony, the Member explained that he did not need to obtain an updated medical history because the second prescription was made within one-year of the first. The Panel does not agree with the Member's rationale for failing to take an updated medical history in the circumstances. With respect, the Member seems to miss the point of the Standard. Had the Member taken a thorough medical history in October 2015, then a new complete medical history would not have been necessary in May 2016. However, the Panel found that the Member failed to obtain a proper medical history initially and so it was not appropriate for him to rely on that history again in May 2016. Similarly, Mr. Chan relied on an inadequate initial medical history when prescribing orthopedic footwear to patient SK in January and December 2016.

The Standard provides that when prescribing off-the-shelf orthopedic footwear, a member should conduct and record a gait analysis "where possible". Mr. Chan admitted that with respect to the eight patients at issue in this matter he did not always conduct a gait analysis, because he did not think it was necessary to do so. He explained that since he deals primarily with healthy and active patients, he did not believe it was necessary to conduct a gait analysis. He said that he would conduct such an analysis on a patient in a wheelchair and only "in the most extreme circumstances". The Panel did not accept Mr. Chan's explanation. It is inconsistent with the plain reading of the Standard to suggest that a gait analysis in only required where a patient presents with a visible infirmity or walking condition. Failing to include a gait analysis as a routine part of his assessment is a clear breach of both the plain language and spirit of the Standard.

The Panel also found that contrary to the requirements set out in the Standard, it does not appear from Mr. Chan's records that he scheduled follow-up in any form with his patients after dispensing the footwear prescribed. There was nothing in the records before the Panel to suggest that any of the patients received follow-up phone calls or an opportunity for a follow-up appointment once the products were dispensed.

Prescription Custom Foot Orthoses Standard

The Panel reviewed records of four patients who received orthotics from Mr. Chan during the relevant period. As with the prescription footwear, the Panel concluded that the patient records did not demonstrate that Mr. Chan took a thorough medical history or make clinical findings as a result of a physical examination prior to prescribing orthotics for any of the four patients. The Standard requires members to demonstrate the medical necessity for the orthotics. It does not appear in the records that alternate treatment options were attempted or even discussed with the patients. Without a history or physical examination, the Panel concludes that Mr. Chan failed to demonstrate the medical necessity for these prescriptions.

Further and similar to the Panel's findings above, the Panel finds that Mr. Chan failed to meet his obligations as set out in the Standard in failing to provide follow-up appointments after dispensing the orthotics.

Practised the Profession while the Member is in a Conflict of Interest

The Panel finds that in failing to disclose his business and financial interest in Paragon to his patients, the Member practised while in a conflict of interest and as a result engaged in professional misconduct as alleged.

The Member conceded that he has a financial interest in and became an officer of Paragon in November 2017. The College's Conflict of Interest Policy requires that a member must declare any potential financial conflict to their patients. Given that Mr. Chan had (and continues to have) a financial interest in Paragon, the orthotic laboratory he uses for his patients' orthotics, he was obliged to advise his patients of the interest and to offer them alternative laboratory options. This should have been documented in his patient records. The records before the Panel indicate that Mr. Chan dispensed three orthotics to three patients after November 2017. There is nothing in any of their records to indicate that Mr. Chan disclosed his financial interest in Paragon to any of these patients. While Mr. Chan testified that he did have a conversation about his ownership in Paragon with his patients – as it was something he was proud of – the fact that there is no notation of the conversation or any reference to his interest in the record and the fact that no orthotics were fabricated by another lab, makes it difficult for the Panel to accept Mr. Chan's explanation. In the circumstances, the Panel finds that it is more likely than not that Mr. Chan did not disclose or fully explain his interest in Paragon to his patients and that he did not provide them with an alternative orthotic supplier as required by the Policy.

Failed to Keep Records as Required by the Regulations

For the same reasons that the Panel concluded that the Member failed to meet the Records Standard, the Panel finds that the Member failed to keep records as required by the Regulations. Mr. Chan failed to record clinical findings, differential diagnosis, or any significant discussions with his patients regarding treatment options.

Signing or issuing, in the Member's Professional Capacity, a Document that Contains a False or Misleading Statement

Submitted an Account or Charge for Services that the Member knew was False or Misleading

The Panel considered these heads of misconduct together. As found above, the Member prescribed orthotics and footwear, in circumstances where he failed to take an adequate history or to conduct an assessment as required by the relevant Standards. Having failed to perform the steps one would expect prior to prescribing such medical devices, it was misleading for the Member to nonetheless issue prescriptions and invoices as though he had done a proper assessment and concluded that the medical devices were necessary.

It is reasonable for a patient and their insurer to assume that if a member prescribes and charges for a medical device, the member is doing so because they are satisfied that the device is medically necessary and appropriate in all of the circumstances. Here, given the Member's failure to perform or record the assessments necessary to justify the medical devices for his various patients, his issuing prescriptions and invoices for such devices is misleading and thus professional misconduct.

Charged a Fee that is Excessive in Relation to the Services or Devices Charged For

The Member acknowledged charging different prices for the same orthotics; and occasionally charging $75-$100.00 for a "blended fee", which included an assessment and modification and other times charging a separate assessment fee. The patient records provide little insight into how the Member set his fee or charged his patients.

It appears from the records that in some instances, the Member charged assessment, dispensing and follow-up fees within his blended rate for each separate shoe modification. For example, for the patient YZ, the Member charged them $100.00 for metatarsal pads, plus $150.00 for a bunion modification, which he explained included charges for labour, materials, and assessment. The Panel could not rationalize why a separate assessment fee, blended or otherwise, should be applied for two sets of footwear modifications for the same patient within a given pair of shoes. It is not clear whether YZ had any follow-up care and so the Panel finds that to charge $250.00 for minor modifications performed on the same shoes is excessive.

In addition, the Panel notes that many of the modifications performed essentially involved gluing padding or other materials into a shoe. The Member admitted that many of these modifications could be moved around or removed and put back in the shoe as needed. The modifications involved the use of inexpensive products and were not labour intensive. In the circumstances, it was excessive for the Member to be charging $100.00 or more for these minor (and sometimes temporary) adjustments.

Finally, the Panel notes that it appears from the records that the Member charged different rates for orthotics without a reasonable justification for the difference. As set out above, in his testimony, Mr. Chan explained that he charged different rates for patients receiving a first pair of orthotics versus those receiving repeat pairs. He also explained that in certain instances, he expected that a first time user would require more follow-up and care, for which additional time would be required, so he would build that into the price of the orthotics. The Member's explanation is simply not borne out in the patient records reviewed. In the case of CC, a patient who was charged $650.00 for a first pair of orthotics, there is nothing to indicate that the patient required extensive follow-up or that adjustments were needed. By comparison, patient SA was charged $300.00 for what appears to be the same orthotics and patient JN was charged $375.00 for theirs. Given the paucity of detail in the patient records, the Panel simply cannot accept the Member's explanation for the price difference. It is inappropriate and excessive to charge a patient at a higher rate for the same product.

Engaged in Conduct that having Regard to All of the Circumstances would reasonably be regarded by Members as Disgraceful, Dishonourable or Unprofessional

For the reasons described above, the Panel finds that Mr. Chan's deficient record keeping, billing practices and failure to maintain the standards in several aspects of his practice would reasonably be regarded by other members of this profession as disgraceful, dishonourable or unprofessional.

It appeared to the Panel that the Member conducted his practice in a manner to maximise his insurance billings rather than to provide appropriate and reasonable care to his patients. He employed a cookie-cutter approach to his assessments and the treatments provided to his patients, seemingly with the intent of maximizing his billings. This formulaic approach to providing medical care is problematic. In the absence of verifiable medical need and in the absence of having attempted less expensive interventions, it appears from the records the Panel

reviewed that the Member was quick to prescribing orthotics, orthopaedic shoes and/or other costly interventions. This behaviour is contrary to what is expected of a member of this College, as it is not grounded in what is best for the patient, but rather in what is most profitable for the Member

Summary

In summary, the Panel finds that the Member engaged in professional misconduct under each of the heads of misconduct listed in the Notice of Hearing.

I, Peter Stavropoulos sign this Decision and Reasons as Chairperson of this Discipline Panel and on behalf of the members of the Discipline Panel as listed below:

September 19, 2022

Peter Stavropoulos , Chairperson

Sasha Kozera
Irv Luftig
Ramesh Bhandari