**SUMMARY**

**DR. CHAIM JOSEPH GOLDBERG (CPSO# 29580)**

## 1. Disposition

On September 15, 2017, the Inquiries, Complaints and Reports Committee ("the Committee") ordered ophthalmologist Dr. Goldberg to appear before a panel of the Committee to be cautioned with respect to a repeated pattern of ordering unnecessary tests without informed consent of the patient, and the appropriateness of billing for those tests

The Committee also ordered Dr. Goldberg to complete a specified continuing education and remediation program ("SCERP"). The SCERP requires Dr. Goldberg to:

- complete six months of clinical supervision with monthly meetings and a chart review, to focus on indications and application of ancillary testing in ophthalmology (e.g. PAM, HRT); communication with patients that enhances patient understanding of recommended investigations; and clear communication with patients regarding the need for uninsured investigations and documentation of the discussion;
- complete one-on-one communications coaching;
- review the College's The Practice Guide, as well as relevant Clinical Practice Guidelines on efficient utilization of ancillary testing in ophthalmology. The review will include a written summary of the documents with reference to current standards of practice (where applicable), how it is applicable to Dr. Goldberg's situation, as well as how Dr. Goldberg has made---or plans to make---changes to his practice; and
- undergo a reassessment approximately six months after the end of the education program.

## 2. Introduction

A patient was concerned that Dr. Goldberg failed to perform an adequate assessment of his eyes; failed to provide a prescription, after noting he had "the wrong prescription," and instead

told him to book a follow-up appointment; had staff inform him that he would have to pay $260 for a follow-up appointment; and behaved in an unprofessional manner and did not answer his questions.

Dr. Goldberg responded that he performed a complete ophthalmic examination and confirmed the patient had dry eye syndrome. He did not provide a prescription for glasses, as the dryness impacts the refraction, and so it was not appropriate to do so unless this was corrected first. He explained the follow-up appointment and testing was optional, and that the testing was not covered by OHIP. He believes he answered all of the patient's questions.

## 3. Committee Process

A Surgical Panel of the Committee, consisting of public and physician members, met to review the relevant records and documents related to the complaint. The Committee always has before it applicable legislation and regulations, along with policies that the College has developed, which reflect the College's professional expectations for physicians practising in Ontario. Current versions of these documents are available on the College's website at www.cpso.on.ca, under the heading "Policies & Publications."

## 4. Committee's Analysis

The Committee found that Dr. Goldberg completed an appropriate initial assessment of the patient and that it was reasonable not to provide a prescription at this stage, since the cause of the patient 's vision problems was not yet clear.

The Committee was concerned, however, that Dr. Goldberg recommended the patient undergo additional testing (including a visual field test, PAM, HRT, and macular OCT). These tests were either not indicated, or Dr. Goldberg did not provide and/or document his rationale for testing or his consent discussion with the patient.

The Committee is limited to a documentary review of information before it, and generally cannot determine exactly what the parties said to one another or in this case whether Dr. Goldberg answered the patient's questions. However, the Committee did note that Dr. Goldberg has had several past complaints to the College in which patients found Dr. Goldberg's explanations to be inadequate. This information suggested to the Committee that Dr. Goldberg's communication with patients could be improved.

Dr. Goldberg's history of complaints and investigations at the College of a similar nature (including ordering unnecessary tests that were uninsured, recommending surgery that was not medically indicated, poor record-keeping, and inappropriately charging patients for cancelled appointments) elevated the Committee's concern in this case, and suggested a concerning pattern of practice. It troubled the Committee that in spite of Dr. Goldberg's history of similar complaints with the College, and particularly the education ordered just five years ago, the issues in this case had arisen again.