NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Andrew Winston Taylor, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the names or any information that could disclose the identity of the patients referred to orally or in the exhibits filed at the hearing under subsection 45(3) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

Subsection 93(1) of the Code, which is concerned with failure to comply with these orders, reads:

> Every person who contravenes an order made under … section 45 or 47… is guilty of an offence and on conviction is liable,
>
> > (a) in the case of an individual to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence; or
> >
> > (b) in the case of a corporation to a fine of not more than $50,000 for a first offence and not more than $200,000 for a second or subsequent offence.

Indexed as: **Ontario (College of Physicians and Surgeons of Ontario) v. Taylor, 2016 ONCPSD 22**

THE DISCIPLINE COMMITTEE OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

IN THE MATTER OF a Hearing directed by the Inquiries, Complaints and Reports Committee of the College of Physicians and Surgeons 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.

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. ANDREW WINSTON TAYLOR

PANEL MEMBERS:

DR. C. CLAPPERTON (CHAIR)
MR. S. BERI
DR. P. POLDRE
MS. D. DOHERTY
DR. P. TADROS

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PUBLICATION BAN

Hearing Dates: September 15 to 18, 2014; December 16 to 17, 2014; November 4 to 5 and 16 to 17, 2015; December 2 and 8, 2015
Decision Date: July 29, 2016
Release of Written Reasons: July 29, 2016

DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on September 15 to 18, 2014; December 16 to 17, 2014; November 4 to 5 and 16 to 17, 2015; and December 2 and 8, 2015. At the conclusion of the hearing, the Committee reserved its decision on finding.

ALLEGATION

The Notice of Hearing alleged that Dr. Andrew Winston Taylor committed an act of professional misconduct:

1. under paragraph 1(1)33 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* ("O. Reg. 856/93"), in that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

RESPONSE TO THE ALLEGATION

Dr. Taylor denied the allegation in the Notice of Hearing.

BRIEF OVERVIEW

Dr. Taylor, an ophthalmologist, operated a laser eye surgery clinic in Niagara Falls which offered at least two types of laser eye surgery – Planoscan and Zyoptix. The Zyoptix procedure was the newer, more intricate procedure and required more resources. The Zyoptix procedure was more expensive than the Planoscan procedure.

Dr. Taylor first performed the Zyoptix procedure at the clinic in the summer of 2002. From the summer of 2002 until May 2003 (the "Material Time"), over 120 patients were billed for the Zyoptix procedure when in fact they had received the less expensive

Planoscan procedure. On April 30, 2003, the clinic issued refund cheques to 53 patients who had their procedures in 2002 and on May 7, 2005, to 70 patients who had their procedures between January and April 2003.

The College alleged that the overbilling was deliberate and intentional and that Dr. Taylor altered or directed the altering of records to make it look as if they had received the Zyoptix, rather than the Planoscan, procedure.

Dr. Taylor submitted that the overbilling and failure to refund was inadvertent and caused by a gap in communications between the clinic's operating room staff and the administrative staff. Dr. Taylor also submitted that he did not alter or direct the altering of records. Rather, he suggested that the office manager had instigated these practices.

ISSUES

1. Did Dr. Taylor bill for medical procedures that were not performed? Specifically, did Dr. Taylor intentionally bill patients for the more expensive Zyoptix procedure when he had not performed it, but had performed the less expensive Planoscan procedure?

2. Did Dr. Taylor create, alter, or otherwise manipulate medical records relating to such procedures, including billing records and / or instruct others to create, alter, or otherwise manipulate such records?

   Specifically,

   a) Did Dr. Taylor alter, or direct the altering of patient records by cutting and pasting, to support inappropriate billing?

      It was uncontested that such cutting and pasting occurred.

   b) Did Dr. Taylor carry out, or direct others to carry out, blank firings of the laser (meaning no patient was present but the laser was operated), on numerous occasions in April and May 2003 to support inappropriate billing?

It was uncontested that such blank firings occurred.

BACKGROUND

Dr. Taylor graduated from the University of Toronto Medical School in 1991. He completed an ophthalmology residency in Toronto in 1995 and received a Royal College fellowship in the specialty that year. In January 1996, Dr. Taylor accepted a position at the Greater Niagara General Hospital and took over a retiring ophthalmologist's practice in Niagara Falls, Ontario. He billed OHIP for patients he saw in this general ophthalmology office.

LASIK Surgery

In 1998, Dr. Taylor began a refractive laser surgery practice at a separate location in Niagara Falls under a Vancouver-based corporation's brand, LASIK Vision. Refractive laser eye surgery utilizes a laser to change the cornea's shape so that the patient no longer needs glasses or contact lenses. The LASIK brand's innovation in refractive laser surgery was the creation of a flap which reduced healing time, improved patient comfort, and enhanced predictability of surgery results. LASIK Vision had a direct-to-market approach with patients.

Dr. Taylor was both the medical director and the director of the Niagara Falls LASIK centre. He also served as co-medical director of a clinic in Toronto. Dr. Taylor devoted approximately 80 percent of his time in the laser clinic and 20 percent in his OHIP office because of the very high demand for laser eye surgery. There was also an influx of American patients because this type of surgery was slow to be adopted in the United States.

LASIK MD

Although LASIK Vision went bankrupt in April 2001, Dr. Taylor founded a new corporation called LASIK MD in May 2001 with two other ophthalmologists, Drs. Cohen and Wallerstein. LASIK MD took over the facilities of the bankrupt corporation.

LASIK MD's partnership structure included a holding company and wholly-owned subsidiaries for each of the clinics in Niagara Falls, Toronto, and Montreal. Drs. Taylor, Cohen, and Wallerstein equally owned the holding company. The local clinics had variable shareholders. In Niagara Falls, the office manager and the optometrists held minor shares in the corporation.

Dr. Taylor's Schedule

Dr. Taylor's typical schedule was very busy. On Mondays, he would practise at the general ophthalmology (OHIP) office. He would operate at the LASIK MD clinic all day Tuesday, Wednesday, and Thursday, as well as on Friday evenings. Dr. Taylor also devoted two Saturdays per month to the LASIK MD clinic.

On Friday mornings, Dr. Taylor would perform ophthalmic surgery at the Greater Niagara General Hospital. Dr. Taylor would see his Greater Niagara General Hospital patients who had had surgery on Friday mornings at the LASIK MD clinic later on that day for post-operative follow-up. Besides this, there was no other crossover of patients between Dr. Taylor's practice sites. There was no crossover of staff between the OHIP office and the laser clinic.

On a typical day, Dr. Taylor would perform 40 eye surgeries (20 patients, both eyes) at the LASIK MD clinic. Ninety percent of the patients were American, while ten percent were Canadian.

Personnel, Process and Surgical Offerings at the Laser Clinic

Office Manager

Milena Yerich (then Milena Dancuo) was LASIK MD's office manager during the Material Time and beyond. Ms. Yerich had been hired and trained by LASIK Vision. Her duties included accounting, payroll, staff bonuses, staffing, procurement of supplies, contracts for equipment, maintenance schedules, advertising, and liaison between different clinics in the LASIK MD system.

The roles of Dr. Taylor's laser clinic personnel are described below in relation to a typical patient's journey through the centre.

Receptionist

A receptionist would greet the patient, obtain basic demographic information, and ask the patient to complete a medical and ocular history questionnaire.

Pre-op Technician

Next, a pre-clinical or pre-op technician would perform pre-operative testing, including corneal topography, pupilometry, auto-refraction, and the spectacle correction of the patient's glasses. From 2002 onward, the pre-op technician would also perform special testing (Zywave) in preparation for the innovative Zyoptix procedure, which is described in detail below.

Optometrist

The optometrist would see the patient next. Five optometrists, who were independent contractors, worked at the LASIK MD clinic during the Material Time. The optometrist on duty would perform a complete ophthalmic examination to determine the patient's refractive requirement, assess the general health of the eye, and determine whether the patient was a candidate for laser surgery. The optometrist would then discuss the recommended surgery and pertinent risk factors with the patient. The optometrist would inform patients that the final decision regarding their procedure would be made by Dr. Taylor.

Laser Surgeries - PRK Surgery and LASIK Surgery

Two of the laser surgeries available at the clinic were photo-refractive keratectomy ("PRK") and LASIK surgery. PRK involved surface-based ablation of corneal tissue. LASIK surgery was distinguished from PRK by the creation of a flap. There are two kinds of LASIK surgery performed at the clinic: Planoscan and Zyoptix.

Planoscan Procedure

LASIK surgery's basic procedure, Planoscan, required more corneal tissue than the newer procedure, called Zyoptix. Planoscan, the less-expensive procedure of the two, was performed with the same laser beam for both eyes, and no special cards were required to operate the laser. The laser beam did not need to be re-calibrated after each eye. The patient remained seated during the procedure.

Zyoptix Procedure

The Zyoptix procedure was first performed in Dr. Taylor's laser centre in the summer of 2002. It was a custom procedure which saved corneal tissue and gave more predictable results. However, Zyoptix was only possible for patients who were near-sighted (myopic). Zyoptix was able to correct higher order corneal aberrations and required more complicated Zywave pre-operative testing. A special Zyoptix card, which created a smaller beam, was inserted into the laser for each patient. The laser was re-calibrated between each eye, meaning that the patient had to leave the operating seat between each eye surgery. Zyoptix was the more expensive procedure, costing an additional $600 per eye compared to Planoscan.

Surgical Counsellor and Patient Payment prior to Surgery

If the patient wished to proceed with surgery, he or she would see the surgical counsellor next. The surgical counsellor would discuss the financial aspects of the patient's recommended surgery as well as review a lengthy consent form concerning potential risks and complications. The surgical counsellor would then schedule the surgery and take payment from the patient for the procedure. Laser eye surgery was not covered by OHIP. The Committee did not hear testimony from any surgical counsellors.

Scrub and Flow Person

Following a four-hour wait for the pre-operative dilation to wear off, a scrub-and-flow person would then bring the patient into the operating room, typically on the same day. The scrub-and-flow person would also prepare and clean the instruments, escort the

patient out of the operating room after the surgery, and explain the post-op instructions to the patient.

Laser Technician

A laser technician would assist Dr. Taylor in the operating room. The laser technician would perform calibration and tuning of the laser every morning. In addition, the gas level in the laser would be monitored. Fluence was a calibration that determined if the laser was performing in the zone that would provide optimal results. The laser technician would enter patient demographic data, certain corneal curvature readings, and the refraction prescription into the laser. If Zyoptix was being performed, the laser technician would insert a special card into the laser. The Zyoptix card cost between $125 and $150 for each eye.

Dr. Taylor

Dr. Taylor would meet the patient for the first time in the operating room. He would examine the patient in the examination chair, review the chart, and answer any patient questions. Dr. Taylor would conduct the ophthalmic examination with an emphasis on refraction and the proposed treatment. Dr. Taylor would make modifications to the prescription provided by the optometrist based on the tolerability unique to each patient. Dr. Taylor would review the consent form with the patient and have the patient sign the consent form. Before the operation, Dr. Taylor also would write the refractions on the pre-operative sheet and fill out the operative report.

If needed, Dr. Taylor had the option to change the prescription based on various assessments, including the amount of corneal tissue that could be safely removed. This process was referred to as “running the numbers.” Even if the pre-operative assessment suggested that the patient was a candidate for Zyoptix, Dr. Taylor could change the procedure to Planoscan at the time of the operation based on medical considerations.

After the patient was appropriately prepared, Dr. Taylor would then perform the surgery. He would create the corneal flap, centre the focus of the laser, and pedal-activate the laser. The Zyoptix procedure would take longer than the Planoscan procedure because the

laser would have to be re-calibrated for each eye. Zyoptix patients were typically in the operating room for between 20 and 30 minutes.

The laser would generate a printout for each patient with information verifying the procedure that had been performed. "Zyoptix Eye Tr" indicated Zyoptix and "PRK(Lasik) Eye Tr" indicated Planoscan surgery.[1]

Dr. Taylor would then examine the patient, review the drops schedule with the patient, and advise the patient to wear protective eyewear after the operation.

Refund Request Form

If a refund was required, the surgical counselor was supposed to complete a refund/rebate request form and send it to the centre manager for authorization and payment.

Post-Operative Visits

Post-operatively, the LASIK patient would be seen again the day after operation, and again after one week, then one month, and then either after six months or a year. If a patient lived far away from the laser centre, they could be seen by a co-managing physician, typically in the United States.

Staff Remuneration

During the Material Time, optometrists received $50 per patient who had the Zyoptix surgery (10-43). Surgical counsellors received $5 per patient. (8-70-71). The evidence

[1] On both page 9 and on page 15 of the Agreed Statement of Facts it is indicated that "Zyoptix Eye Tr" meant that it was the Zyoptix procedure that was performed. However, the Planoscan procedure was labelled as "PRK(Lasik) Eye Tr" which clearly is an error in labelling by the clinic. When one looks at Consent form and the LASIK MD Post-Operative Evaluation under "Procedure" there are 3 choices: LASIK, ZYOPTIX and PRK. This same trio of procedure names is used on the OR report. It would appear that PRK(Lasik) actually means Planoscan. We cannot hypothesize why the forms do not have uniform names for the procedures, but what is clear is that PRK is not the same as LASIK.

was that these additional payments were due to the fact that the Zyoptix procedure was more time consuming.

Other clinic staff received a bonus based on the total volume of eye surgeries performed per month, irrespective of the type of surgery performed. Dr. Taylor's surgical professional fee was $150 per eye, irrespective of the type of surgery.

Dr. Taylor ceased to be a partner in Lasik MD in May 2005. He subsequently operated the Niagara Falls laser centre under the name Lasik Provision.

OVERVIEW OF THE EVIDENCE AND WITNESSES

The Committee admitted numerous documents into evidence, including patient charts, surgery appointment lists, a thank-you card, an employment contract, a payroll book, a list created by one of the witnesses, numerous cheques and their stubs, a preliminary shareholder agreement, a financial reconciliation sheet, an income tax return, calendars for two months in 2003, a copy of email correspondence, a police report, and copies of both the Nursing Act and the Optometry Act, 1991. Agreed Statements of Fact with respect to refunds and the laser firings were also filed.

Milena Yerich

Milena Yerich had a romantic relationship with Dr. Taylor that began in 1997 (8-83). She began working as office manager for Dr. Taylor in 2001. Dr. Taylor's accounting office trained Ms. Yerich for various aspects of the manager role. She had earned a Bachelor of Science degree from Brock University in the mid-1990s.

In addition to drawing a salary from her job at the laser center, Ms. Yerich had a $25,000 personal investment in the laser center in the early 2000s.

In 2005, Ms. Yerich's romantic relationship with Dr. Taylor ceased. The same year, her management roles diminished as Adrienne Furney assumed several office manager responsibilities. (7-124)

In 2009, Ms. Yerich accepted a salary reduction instituted by Dr. Taylor. She left Dr. Taylor's employ in August 2010, just prior to her maternity leave.

Dena Perdikis

Dena Perdikis started working for Dr. Taylor in 1999 as both a laser technician and in the scrub-and-flow role. She had previously worked in the optometric field and had received training in both Montreal and Toronto for the laser technician and scrub-and-flow roles. Ms. Perdikis subsequently trained Marina Savic, Adrienne Furney, and others for these positions. (2/101-102) Ms. Perdikis left the laser clinic in January 2003. She subsequently worked for an optometrist, but eventually left the field.

Marina Savic

Marina Savic started working at Dr. Taylor's laser clinic as a laser technician in February 2000. Milena Yerich, her cousin, had recommended the position to her. Dena Perdikis trained Ms. Savic for the role.

Ms. Savic took maternity leaves from January 1, 2002 until January 1, 2003 and again from April 1, 2004 until April 1, 2005.

Ms. Savic resigned from the laser clinic at the end of September 2008. She subsequently received her nursing degree from Brock University and currently works as a registered nurse.

Adrienne Furney

Adrienne Furney began working at the laser center at the end of August 2002 as a scrub-and-flow. She subsequently completed a certificate program through Centennial College for ophthalmic medical personnel in 2004. She was also certified through Bausch and Lomb with respect to the laser for eye surgery and the micro-keratome between 2004 and 2005. Ms. Furney was trained in part by Ms. Perdikis for the scrub-and-flow role. She began to assist with laser eye surgery as a laser technician in April 2003. By 2007, Ms. Furney was co-managing the office with Ms. Yerich. (9-12) Ms. Furney became the sole office manager in 2010, after Ms. Yerich's departure.

Ms. Taylor

Ms. Taylor is Dr. Taylor's mother and had several roles in Dr. Taylor's general ophthalmology (OHIP) office in the early 2000s. She earned a nursing degree from the Toronto General Hospital in 1959 and worked in a variety of nursing and health care roles for many decades. She has homes in both Brantford and Niagara-on-the-Lake.

Ms. A

Ms. A is one of Dr. Taylor's patients from his OHIP office. She has also been a friend of Dr. Taylor's mother since the 1970s.

Ms. B

Ms. B is another one of Dr. Taylor's patients from his OHIP office. She has been friends with Dr. Taylor's mother since high school.

Christian Nanini

Christian Nanini is an optometrist who worked for Dr. Taylor at his laser clinic from 2000 to 2010. He graduated from the University of Montreal in 1996 with a Doctorate of Optometry.

Laurie Capogna

Laurie Capogna is an optometrist who has worked at Dr. Taylor's OHIP office since August 1998. Dr. Capogna is an associate at Peninsula Eye Associates and is a partner with Dr. Taylor at Peninsula Vision Associates, which dispenses glasses. She also worked at Dr. Taylor's laser clinic from 1999 to 2011. She graduated with a Doctorate of Optometry from the University of Waterloo in 1998.

LEGAL PRINCIPLES

The onus and standard of proof

The College must prove the allegations of disgraceful, dishonourable, or unprofessional conduct on a balance of probabilities on the basis of evidence that is clear, convincing and cogent.

The assessment of credibility and reliability of witnesses

In *R v. Sanichar*, 2012 ONCA 117, the Court explains the difference between the concepts of credibility and reliability. Credibility has to do with the honesty or veracity of a witness' testimony. Reliability relates to the accuracy of the testimony, based on the ability of the witness to make observations, to recall what was observed or said and to communicate accurately.

The Committee recognized that demeanour alone is not a reliable predictor of credibility or reliability. During this hearing, the Committee was careful not to rely on demeanour alone in its assessments of the witnesses.

The Committee understands that inconsistencies of various degrees are to be expected, especially when there has been a significant passage of time between the events in dispute, the time when statements were made to various investigators, and the time of the testimony at the hearing itself.

In the current matter, there were numerous technical details involved in the processes under scrutiny, and several of the key witnesses had not been involved in the field for many years. Thus, the Committee was mindful that it could accept some of a witness' evidence while not accepting other aspects.

The Committee is also aware that the presence or absence of a motive to fabricate evidence is only one factor to be considered in assessing credibility.

The interaction of the above legal principles leaves the Committee with the task of weighing the balance of a complex puzzle of evidence, with variations in witness reliability and credibility that must ultimately be resolved.

FACTS AND EVIDENCE

Agreed Statements of Fact

The following Agreed Statement of Facts, with respect to refunds, was filed as an exhibit, and presented to the Committee:

Refunds

1. On August 26, 2010, Dr. Taylor provided cheques and cheque stubs to Ian Held, College investigator, that reflect refunds prepared in respect of one hundred and twenty three (123) patients. The parties agree that the cheques and/or cheque stubs confirm the following facts:

(a) Fifty-three (53) cheques and/or cheque stubs are dated April 30, 2003.

(b) Seventy (70) cheques and/or cheque stubs are dated March 7, 2005.

(c) Of the fifty-three (53) cheques and/or cheque stubs dated April 30, 2003, five (5) cheques are made out in the names of five patients for a total of $9,984.00 in Canadian Dollars. The remaining forty-eight (48) cheques and/or cheque stubs dated April 30, 2003, are made out in the names of forty-eight (48) patients for a total of $63,935.00 in U.S. Dollars. The fifty-three (53) cheques and/or cheque stubs are made out in varying amounts.

(d) Of the seventy (70) cheques and/or cheque stubs dated March 7, 2005, sixty-nine (69) cheques are made out in the names of sixty-nine (69) patients for a total of $93,394.00 in U.S. Dollars. The remaining one (1) cheque stub is dated March 7, 2005, is made out in the name of one (1) patient for a total of $1,960 in Canadian Dollars. Of the seventy (70) cheques and/or cheque stubs dated March 7, 2005, nine (9) cheque stubs record nine patient names and are marked “void” for a total

amount of $11,200 in U.S. Dollars. The seventy cheques and/or cheque stubs are made out in varying amounts.

(e) The total amount reflected in the cheques and cheque stubs for April 30, 2003 and March 7, 2005 is USD $157,329.00 and CAD $11,944.00.

In addition, the following Agreed Statement of Facts with respect to laser was filed as an exhibit and presented to the Committee:

The Laser Hard Drive

1. Based on a forensic examination of the laser hard drive in use in Dr. Taylor's office in the years 2000 to 2005, the parties agree to the following facts for the purpose of this hearing only:
2. The term "blank-fired" means that a firing of the laser is recorded but no patient was present. The laser hard drive indicates blank firings on the following occasions:
    - Between approximately April 25, 2003 and April 29, 2003, on one hundred and twenty five (125) occasions in respect of sixty three (63) patients;
    - Between approximately April 29, 2003 and April, 30, 2003, on seven (7) occasions in respect of four (4) patients;
    - Between approximately May 17, 2003 and May 20, 2003, on one hundred and thirteen (113) occasions in respect of fifty eight(58) patients;
    - Between approximately May 22, 2003 and May 23, 2003, on three (3) occasions in respect of one (1) patient;
    - Between approximately May 23, 2003 and May 24, 2003, on thirteen (13) occasions in respect of seven (7) patients;
    - Between approximately May 27, 2003 and May 28, 2003, on six (6) occasions in respect of three (3) patients.
3. In total, there were two hundred and sixty seven (267) blank firings in respect of one hundred and thirty six (136) patients. In respect of almost all of the blank

firings, the date manually entered for each blank firing corresponded to the patient's original surgery date.

4. Of the two hundred and sixty seven (267) blank firings, one hundred and forty four (144) were Zyoptix blank firings in respect of patients who originally received PRK (Lasik). The remainder were PRK (Lasik) blank firings in respect of patients who originally received PRK (Lasik).[2]

5. Records for patient procedures prior to January 2, 2003, were deleted from the laser eye program from the user's perspective but are still present on the hard drive.

ANALYSIS AND FINDINGS

ISSUE #1 – DID DR. TAYLOR BILL FOR MEDICAL PROCEDURES NOT PERFORMED?

It is uncontested that during the Material Time, in over 120 instances, patients were billed for the more expensive Zyoptix procedure when they actually had the Planoscan procedure.

Dr. Taylor, Marina Savic, and Milena Yerich provided uncontested testimony that refunds were made to patients in 2003 and 2005. The Agreed Statement of Facts provides details of these refunds.

What is in dispute is whether this overbilling was deliberate and intentional, as the College alleged, or inadvertent and caused by a communication gap in the clinic, as Dr. Taylor submitted.

Dr. Taylor testified that the overbilling was inadvertent and the result of a communication gap between the operating room staff, where he made the decision to switch from the Zyoptix to Planoscan procedure, and the administrative staff, specifically, the office manager Ms. Yerich, who should have made the refund.

[2] The Committee believes there is an error in this paragraph of the Agreed Statement of Facts as the last sentence does not make sense. It is the Committee understanding that PRK is not a form of Lasik.

FINDING

The Committee finds that Dr. Taylor deliberately billed for medical procedures that were not performed. Specifically, the Committee finds that he billed for the more expensive Zyoptix procedure when he had actually performed the less expensive Planoscan procedure.

ANALYSIS

The Committee's assessment of this issue turned in large part on an assessment of the credibility of the witnesses. As discussed below, in many instances, Dr. Taylor's account of the facts was simply implausible given the evidence before the Committee.

Did Dr. Taylor inform his patients that they would be receiving a cheaper procedure?

The standard process at the clinic, as outlined above, was that the optometrist would recommend a procedure and the surgical counselor would request payment for the recommended procedure. It was unclear to the Committee based on the evidence whether or not the patients were ever informed, by either the optometrist or the surgical counsellor, of the actual names of the surgical procedures or the fact that each had a different cost. Dr. Taylor testified that the surgical counselor discussed with patients only the cost of the procedure that was recommended to them by the optometrist.

After the patients had paid the surgical counselor, Dr. Taylor would meet patients for the first time in the operating room. He would review the consent form with the patient and have the patient sign the consent form. The Committee reviewed a consent form (exhibit 6). On the first page of the form, the patient is asked to initial the consent which distinguishes between LASIK surgery and PRK surgery. The two different kinds of LASIK surgery, Zyoptix and Planoscan, are not mentioned in the consent form. Costs of the surgery are not mentioned on the consent form.

There was inconsistent testimony regarding whether patients were aware of which procedure was actually performed on them. Ms. Savic, one of the laser technicians,

testified that, “on some occasions [Dr. Taylor] did inform some patients that they were not going to receive Zyoptix, but others, he did not.” (1-107/8)

On the other hand, Ms. Furney and Dr. Taylor testified that patients were always told. Dr. Taylor’s testimony, however, was inconsistent on this point. Initially, he claimed that he never discussed pricing issues with the patient. On cross-examination (8-105), he was asked whether “your 123 patients did not understand they were being switched to a *cheaper* procedure.” Dr. Taylor’s response was, “I told every one of them.”

It is clear to the Committee that patients knew how much the procedure recommended by the optometrist cost because they had to make payment to the surgical counselor prior to the surgery. If Zyoptix was recommended (by name or otherwise), they would pay for it. Conversely, patients may not have known about the cost of the less expensive Planoscan procedure, as it was not recommended to them.

The Committee did not believe Dr. Taylor’s testimony that he told every patient, including the more than 120 patients who were charged for the wrong procedure, that they received a different and cheaper procedure than that initially recommended by the optometrist and paid for. The Committee found it utterly inconceivable that this number of patients would have left the laser clinic without asking for their refund, or follow up sometime afterwards, if Dr. Taylor, or any other member of the clinical team, had so informed them; or, if the optometrist had discussed with them the price difference between the Zyoptix and Planoscan procedures.

The sums involved, as illustrated by the subsequent refunds, were considerable, ranging from $660.00 USD to $1,620.00 USD and $2,040.00 CDN. By far, the single most-common refunded amount was $1,320 USD.

In the Committee’s view, an informed patient would have inquired prior to leaving the clinic, or sometime afterwards, about the anticipated refund. The Committee finds that these more than 120 patients were not informed about the cost differential between the Zyoptix and Planoscan procedures and the possibility of a refund.

Was the failure to refund the result of a communications gap at the clinic?

Dr. Taylor's assertion that the failure to refund was due to a communications gap between clinic staff was not plausible. If the failure to refund was the result of a communications gap between the operating room and the administrative office, there would have been no reason for the patient charts to be contemporaneously altered by cutting and pasting and blank firings, as discussed later in these reasons.

Did the overbilling stop at Dr. Taylor's request due to rumours in April 2003 of a police investigation?

In April 2003, Ms. Yerich learned about rumours of a police investigation into overcharging patients from a former scrub-and-flow person who had worked in the laser clinic until the end of 2002. This former scrub-and-flow person did not testify at the hearing.

Dr. Taylor testified that he had a meeting with Ms. Yerich and Ms. Savic about this rumour. According to Dr. Taylor, Ms. Yerich admitted to him that there was a communications gap. Specifically, he said Ms. Yerich told him that she was not aware of which procedure, Zyoptix or Planoscan, was ultimately performed in the operating room.

Dr. Taylor testified that Ms. Savic was visibly upset about the rumour (7-89). According to Dr. Taylor, Ms. Savic claimed that she was unaware of any issues with overcharging (7-92) since January 2003, when she returned from maternity leave.

In contrast, Ms. Yerich testified that it was the rumour of a police investigation that caused Dr. Taylor to finally accept her requests to stop the "zipping" (3-41).[3] Prior to the alleged police involvement, Ms. Yerich testified that her attempts to have the "zipping" stopped were rejected by Dr. Taylor, though she could not recall how many times she had tried to have him stop the practice (3-42).

[3] As discussed later in these reasons, "zipping" referred to the deliberate decision to change a procedure from Zyoptic to Planoscan and not to inform the patient.

Ms. Savic corroborated that the rumour of the police investigation resulted in the cessation of the "zipping" and the cutting and pasting of charts (1-149).

The Committee finds that Dr. Taylor's reaction to the rumoured police investigation was striking because he did not seek any information from the police about the investigation. He did not even attempt to confirm whether in fact there was an investigation. Instead, as will be discussed further below, Dr. Taylor sought the advice of a trusted friend with communications expertise while instructing Ms. Yerich and Ms. Savic to conduct a chart and financial review.

Further, the Committee found it implausible that Dr. Taylor would have assigned the administrative task of a chart and financial review to the very person he believed had made an administrative error – namely, Ms. Yerich.

The Committee found that the extraordinary assistance of Dr. Taylor's trusted friend would not have been needed if Dr. Taylor genuinely believed that the overbilling was a mere administrative error. As will be discussed later in reference to the letter that accompanied the refund, Dr. Taylor's friend's expert advice yielded a letter to patients that was misleading.

The Committee believed Ms. Yerich's testimony that she had tried unsuccessfully in the past to have Dr. Taylor cease the overbilling despite the fact she was unable to recall details of her attempts. The Committee found that the rumoured police investigation was the reason Dr. Taylor finally heeded Ms. Yerich's advice and stopped overbilling his patients.

Continued Employments of Ms. Yerich and Ms. Savic

Dr. Taylor testified that he delegated the responsibility of investigating the matter of overbilling to Ms. Yerich after the police rumours came to his attention, because "I trusted her implicitly" (7-96) and to Ms. Savic because "my trust in [Ms. Savic] was also very, very high" (7-96).

The Committee found it inconceivable that Dr. Taylor would continue to employ Ms. Yerich with her higher salary for four additional years if he had in fact discovered that she was responsible for very significant financial errors and chart alterations. Likewise, Ms. Savic remained in Dr. Taylor's employ until 2008.

The Committee concluded that a more plausible reason for Dr. Taylor's continued employment of and trust in both Ms. Yerich and Ms. Savic was the involvement of all three in the over-billing and related chart alterations throughout the Material Time

The Letter Accompanying the Refunds

While Ms. Savic and Ms. Yerich were conducting the chart review, Dr. Taylor's next step was "to take counsel with a family business friend, knowing full well that refunds needed to be done…I sought his advice to relay the situation and to make sure that he was in agreement with the steps that I was going to propose to remedy it."

The refund cheques (discussed below) were accompanied by a letter of explanation that was drafted by Dr. Taylor and this friend, who was noted by Dr. Taylor to be an "expert communicator [who] did work in the marketing area" (8-106).

He testified that this letter was intended "to explain what had gone on surrounding their change in procedures and why they were receiving a cheque." The letter stated, "A routine fiscal audit of all our patient records has indicated that, notwithstanding preoperative tests, when the final examination in the operating room occurred, one of the planned processes was deemed to be unessential. Regrettably this change was not reflected in our charge to you." (Exhibit 2, p 403)

The letter asked patients to acknowledge receipt of the letter and invited patients to direct any questions to Dr. Taylor. "Many, many phone calls" resulted (7-106). Dr. Taylor reported that the patients who called "were very happy with their vision and they were, frankly, surprised that they were receiving money back."

Although the letter submitted in evidence was from 2005, Dr. Taylor acknowledged that the content of his 2003 letter was similar.

The Committee found that the refund letter accompanying refunds was a deliberate attempt by Dr. Taylor to deceive patients about the reason for the refund.

The Committee was troubled by the evasive and untruthful content of the letter. In no way could the reason for these refunds be described as "a routine fiscal audit of all of our patient records." Nothing in Dr. Taylor's testimony indicated anything "routine" about the rumoured police investigation that allegedly brought the matter to Dr. Taylor's attention. Furthermore, not all of the patient records were audited.

Dr. Taylor testified that the conversion from Zyoptix to Planoscan was based on medical considerations. The Committee accepts this testimony. In contrast, the letter stated "one of the planned processes was deemed to be unessential." The Committee found that this phrase conveys the impression to patients that they were scheduled for two (or more) processes, one of which was not performed because it was not needed. The letter suggested that it was this "unessential" process was charged for initially, hence requiring the refund. The letter does not contain any reference to Dr. Taylor's claim that he told all patients that they had received the cheaper procedure at the time of the operation.

Furthermore, Dr. Taylor's need to consult with an "expert communicator" in drafting the refund letters suggests that he had a level of concern beyond what would have been required if a simple clerical or communications error had been involved.

Did Dr. Taylor direct staff in 2003 not to refund patients who had been overbilled between January and April 2003?

It is uncontested that refund cheques, dated April 30, 2003, were sent to 53 patients who had had their converted operations in 2002. It is also uncontested that on March 7, 2005, refund cheques were sent to 70 patients who had their converted operations between January and April 2003.

The reason for the difference in timing of the two sets of refunds is a matter of dispute.

Both Ms. Yerich (6-90) and Ms. Savic (1-233) testified that Dr. Taylor had specifically told them not to refund any 2003 patients during the first round of refunds that were dated April 30, 2003.

Ms. Yerich testified that Dr. Taylor had instructed her to refund only patients who paid for Zyoptix but received Planoscan in 2002. Ms. Savic stated that she was also present when Dr. Taylor gave these directions. Refunds were based on the surgical daily lists, with an asterisk indicating those patients whose Zyoptix procedure had been changed to Planoscan.

Ms. Savic noted that she wrote out most of the cheques with the date, patient name, and the amount of refund in numbers and in words, while Ms. Yerich, who had signing authority in the clinic, signed the cheques.

Ms. Savic further testified that Dr. Taylor gave instructions that refunds should not be provided to patients who were medical doctors or lawyers (as determined from the patient demographic sheet), for the reason that those patients might potentially be more suspicious and initiate a lawsuit. Dr. Taylor was not asked whether he gave this instruction in either direct or cross-examination.

Early in 2005, (7-118) Dr. Taylor met with his corporate partners, who confronted Dr. Taylor with allegations of cutting and pasting (7-126) and failure to refund all patients who had been converted from Zyoptix to Planoscan in 2003. Dr. Taylor denied the failure to refund all converted patients in 2003 and testified (7-119) that he "took charge to do all the auditing and reconciliation myself.…all of the charts from the first chart of Zyoptix through to the end of April were again pulled and reconciled against operative reports and financial records."

According to Dr. Taylor, this audit led to the discovery that patients from January 2003 to April 2003 had not been refunded. Dr. Taylor testified that this discovery left him disillusioned and angry with Ms. Yerich (7-124) and led to the diminution of her administrative roles at the laser clinic. Dr. Taylor did not testify about the exact timing or

nature of these diminutions. Ms. Furney then began to assume various administrative roles.

The romantic relationship between Dr. Taylor and Ms. Yerich ended within a few months of the March 2005 refunds (7-123). Ms. Furney testified (9-12) that her office role became equal to that of Ms. Yerich by 2007. However, Dr. Taylor did not initiate a salary reduction for Ms. Yerich until 2009 (3-94), four years after Dr. Taylor testified becoming disillusioned and angry with her administrative skills surrounding the need for a second round of refunds in 2005.

In early 2005, Dr. Taylor's corporate partners interviewed Ms. Yerich because of their concerns about overbilling during the Material Time. Ms. Yerich testified that Dr. Taylor directed her not to discuss the Zyoptix to Planoscan conversions, or the corresponding lack of refunds, during the interview (3-85). Ms. Yerich admitted that she did not tell the truth to Drs. Cohen and Wallerstein because she was "protecting myself and protecting Dr. Taylor."

Drs. Cohen and Wallerstein did not testify at the hearing.

The Committee found that Dr. Taylor deliberately ordered his employees in April 2003 not to refund patients who had been converted from Zyoptic to Planoscan between January and April 2003. Furthermore, the Committee found that Dr. Taylor directed his two employees to not tell the truth to his corporate partners in 2005 about the lack of refunds for converted patients between January and April 2003.

There is no evidence that Dr. Taylor made any effort to verify whether other patients converted from Zyoptix to Planoscan after 2002 may have required refunds when the initial set of refunds was made in April 2003. On the evidence before the Committee, it was inquiries in early 2005 by his corporate partners regarding billing errors that were the impetus for Dr. Taylor to initiate those refunds.

Furthermore, Dr. Taylor's personal auditing of all the records in 2005 was not very thorough. He testified that he had "never seen any alterations of patient records, other than testimony that I have heard in this courtroom vis-a-vis the issue of cutting and

pasting." (7-126) His personal auditing failed to note the May 2003 blank firings, which he claimed to have knowledge of only from Ms. Savic's testimony at this hearing (7-105/6) as will be discussed below. The Committee found it difficult to believe that he would not have discovered that the charts had been altered if he had in fact conducted this review in 2005.

Defence submission that amount overbilled relative to Dr. Taylor's income was not sufficiently gainful and therefore not deliberate

Defence counsel led evidence that Dr. Taylor, between his OHIP practice and his laser clinic, had earnings of over $1,000,000.00 in 2003. The defence estimated that after profit-sharing, taxes and dividends, the net value of any deliberate fraud to Dr. Taylor would have been only approximately $30,000 for the Material Time (approximately eight months from the late summer of 2002 until April 2003). Dr. Taylor testified that such a small amount of money "was not of interest to me" (8-124).

The Committee rejected the argument that the amount of improper gain relative to total earnings can be used to exonerate an individual based on protestation of a lack of a motive of financial benefit.

The Committee noted that, on a pro-rated basis, the personal gain to Dr. Taylor would have been greater if a full 12 months of over-billing had occurred.

Second, the over-billing could have continued for years if the police investigation rumours had not interrupted the activity.

Third, although information about 123 refunds was entered into evidence and formed the basis for the defence calculations above and these reasons, it is possible that more patients were overbilled over the Material Time and were not refunded.

Fourth, Dr. Taylor was the only one who had a defined personal financial gain as a result of the over-billing. The Committee noted that the same cannot be said for any of the staff Dr. Taylor suggested played a role in creating this scheme behind his back.

Ms. Yerich, during her brief time as a very small shareholder in the corporation, could have realized a very small financial gain. However, she would have had to secure the cooperation of laser technicians such as Ms. Perdikis and Ms. Savic to engage in the time-consuming and illegal activity of cutting and pasting for no personal financial gain. Furthermore, such activity on their part would have risked their employment with Dr. Taylor.

$30,000 is not an inconsequential amount of money. The Committee does not accept the argument that Dr. Taylor's income was such that he would have no motive to overbill clients. The precise reason why Dr. Taylor engaged in such a scheme is unknown to the Committee.

CONCLUSION

For all of the above reasons, the Committee concludes that Dr. Taylor's denial that he knowingly billed patients for services they did not receive is not credible. The Committee finds he intentionally billed patients for the more expensive Zyoptix procedure when he had not performed it.

ISSUE #2 - DID DR. TAYLOR ALTER AND / OR INSTRUCT OTHERS TO ALTER RECORDS RELATING TO THESE PROCEDURES?

2(a) Did Dr. Taylor alter or instruct staff to alter patient records by cutting and pasting?

During the Material Time, it is uncontested that the charts of patients, who had agreed to the Zyoptix procedure but were subsequently converted to the Planoscan procedure, were improperly altered at the end of the surgical day by a process of cutting, pasting, and photocopying. The charts were improperly altered to make it appear as if the patients had received the Zyoptix procedure when in fact they had received the less-expensive Planoscan procedure.

To achieve this, the laser technician would cut out a section of a random Zyoptix patient's chart – specifically, the section labeled "Zyoptix Eye Tr" – and paste it onto the

Planoscan's print-out, covering the section labeled "PRK(Lasik) Eye Tr." A photocopy of the pasted-over printout would be placed in the now-altered patient chart.

Dr. Taylor did not contest that that this improper "cut and paste" chart alteration occurred. However, Dr. Taylor denied that he participated in or directed the cut and paste or that he had any knowledge of it at the Material Time.

Ms. Perdikis was the laser technician between the summer of 2002, when Zyoptix was introduced, and January 2003, when she left the laser clinic. She testified that she kept a daily surgical list and made a mark beside the names of patients who were converted from Zyoptix to Planoscan. Ms. Perdikis' list was used at the end of each surgical day to determine which patient charts needed to be altered using the cut-and-paste method. These lists were ultimately provided to Dr. Taylor's corporate partners in 2005 during their investigations into Dr. Taylor's laser clinic operations. Ms. Perdikis testified that she provided her personal patient lists to Dr. Wallerstein for his investigations since she was aware of the improper nature of cutting and pasting.

Ms. Perdikis testified in chief that Dr. Taylor told her to cut and paste (2-108), but in cross-examination she testified that she could not recall the specific time that Dr. Taylor gave these instructions. Ms. Perdikis agreed that it could have been Ms. Yerich that gave her the instructions and she assumed the instructions were coming from Dr. Taylor.

Ms. Savic returned to the laser clinic in January 2003 following a one-year maternity leave. She testified that Ms. Perdikis told her to alter charts during the brief period of time that Ms. Perdikis was at the laser clinic in early 2003 until Ms. Perdikis resigned.

Ms. Savic testified that Ms. Perdikis told her that Dr. Taylor had given the cutting and pasting directions to Ms. Perdikis (1-98). Ms. Savic did not seek confirmation from Dr. Taylor regarding the cutting and pasting instructions (1-103).

Ms. Savic testified that she also saw another laser technician, Ms. Furney, engaged in cutting and pasting. Ms. Furney denied cutting and pasting (9-100). During examination-in-chief, Ms. Perdikis testified that she saw a number of other clinic employees altering

charts, including Ms. Furney (2-117-118), but on cross-examination, Ms. Perdikis testified that she could not recall seeing Ms. Furney cutting and pasting (2-179).

Ms. Yerich testified that she saw Ms. Perdikis and others, but she could not recall the names of the others, cutting and pasting at the end of the surgical day (3-30). Ms. Yerich denied that she had instructed employees about cutting and pasting (3-32). Ms. Yerich acknowledged that based on a conversation with Dr. Taylor she understood why cutting and pasting was occurring (3-35). She testified that she went along with "zipping" because "I was just doing my job". (3-54). Furthermore, Ms. Yerich testified that she would not have questioned the employees about cutting and pasting "if a directive came from our boss". (5-141)

Ms. Savic and Ms. Yerich testified that Dr. Taylor used the term "zipping" to refer to those patients who paid for Zyoptix, received Planoscan, were not told of the procedure switch, and were not offered a refund (1-109-110). Ms. Perdikis was not familiar with the use of the word "zipping", but clearly described the same process and its purpose.

Ms. Furney and Dr. Taylor both denied any knowledge of cutting and pasting and of the use of the term "zipping."

Ms. Perdikis, Ms. Savic, and Ms. Yerich all testified that they were aware that the purpose of the cut-and-paste process was to alter the charts of those patients who would not be offered a refund of the difference between the more expensive Zyoptix procedure and the less expensive Planoscan procedure. All of the staff who acknowledged their role in the cutting and pasting testified that they were aware that this activity was wrong.

FINDING

The Committee finds that Dr. Taylor directed his staff to alter patient charts using the cut-and-paste method. This was to support the deliberate billing for the more expensive Zyoptix procedure when the less expensive Planoscan procedure was actually performed.

ANALYSIS

Who directed the cutting and pasting?

The Committee heard conflicting testimony regarding cutting and pasting, especially regarding who precisely provided the directions to do so. It is clear that this activity was deliberate and intentionally deceitful from the outset and that it occurred throughout the Material Time.

Cutting and pasting took place after each busy surgical day whenever Zyoptix-to-Planoscan conversions occurred. The altered medical records were vital to covering up the deliberate overbilling. The vast majority of patients during the Material Time were from the United States. These altered records would have been especially necessary for patients whose follow-up was to be co-managed by a different physician who was closer to where the patient lived.

The Committee concluded that all who were taught the scrub and flow role during the summer of 2002 were taught the chart alteration at the same time.

Ms. Perdikis admitted on several occasions that she could not remember details (2-113 and 2-123/124). The Committee found that the payroll entry for Ms. Perdikis in January 2003 demonstrated that she did spend a few weeks at the laser clinic training before her ultimate departure, despite her recollection that she did not return to work after her December 2002 minor surgery. In addition, Ms. Perdikis testified that she trained Ms. Savic, which only could have occurred upon Ms. Savic's return from maternity leave in January 2003. The Committee concluded that Ms. Perdikis' failure to recall returning to the clinic after her December surgery was a failure of memory and not a deliberate falsehood.

The Committee was not concerned about Ms. Perdikis' lack of familiarity with the term "zipping". It was unclear when this term began to be employed in the laser clinic. The Committee found that Ms. Perdikis was able to fully describe the process and purpose of what others may have labeled as "zipping," even without knowing the term.

Ms. Perdikis did not receive any financial gain from the overbilling, as the bonus structure in place for laser technicians was based only on the monthly number of procedures performed at the clinic, irrespective of whether the procedure was Planoscan or Zyoptix.

The Committee concluded that Ms. Perdikis had no clear memory as to who instructed her to alter the charts. Although she originally testified that Dr. Taylor has instructed her, on cross-examination she agreed that it could have been Ms. Yerich and she assumed the instructions were coming from Dr. Taylor. Ms. Yerich testified that she did not instruct the staff to alter the charts, but she was aware this was occurring and had discussed it with Dr. Taylor. Dr. Taylor denied having any knowledge that the charts were being altered.

Ms. Perdikis' testimony about the threatening work environment is a believable explanation for why the chart altering continued. She felt that her job was as risk because "I had to do what I was told" (1-115). At the time, she was supporting two children and paying for a mortgage by herself. The Committee found Ms. Perdikis' testimony compelling regarding the stress she was under, in that she sought medical attention for stress caused because she "couldn't deal with that, with the falseness of the whole - you know, the whole procedure" (2-117).

The Committee found the testimony of Ms. Savic to be credible regarding her role in cutting and pasting. Ms. Savic was trained by Ms. Perdikis in January 2003, before Ms. Perdikis' departure. Ms. Savic testified that Ms. Perdikis was very upset about "things happening in the clinic that are not right"(1-96). This was consistent with Ms. Perdikis' testimony regarding her mental state at the time of departure.

The Committee found it difficult to believe that Ms. Yerich would not have discussed the chart alterations with the staff, since it was Ms. Yerich who normally provided instructions to the staff on behalf of Dr. Taylor. The Committee finds, however, that it does not matter if Dr. Taylor told Ms. Perdikis directly or through Ms. Yerich to alter the charts. In either case, the Committee believes the instructions came from Dr. Taylor. The

Committee does not believe Dr. Taylor's evidence that he had no knowledge of the chart alterations at the time.

Dr. Taylor was the only party to derive financial gain from withholding the patient refunds for the difference in cost between the procedures. Cutting and pasting was the method used to make it appear as if the more expensive procedure had been performed.

Conversely, had the chart alterations been instigated by the laser technicians who worked for Dr. Taylor – starting chronologically with Ms. Perdikis – those technicians would have risked severe repercussions had the deceit been discovered by Dr. Taylor.

In addition, the Committee noted that the laser technicians who altered the charts did not derive any personal financial benefit from the overbilling. Indeed, the cutting and pasting only added extra time to their already long surgical day.

The Committee considered the defence allegation that Ms. Yerich was the instigator of the chart alterations (and the associated failure to refund converted patients). Ms. Yerich lacks a clinical background, and the Committee concluded that she could not have provided sufficiently detailed instruction regarding the cutting and pasting procedure to successfully alter a chart to withstand the scrutiny of Dr. Taylor and other eye specialists when reviewing the chart in the future. Further, Ms. Yerich would have had to coerce all laser technicians into the scheme, something that the Committee found highly unlikely since there was no financial gain for laser technicians and a very minor potential gain for Ms. Yerich given her very minor financial interest in the clinic. The laser technicians would have instead been risking termination had they been caught.

Although the Committee recognized the fact that Ms. Yerich and Ms. Savic are cousins, Ms. Savic was not involved in the cutting and pasting until many months after this activity had started. The absence of a personal relationship between Ms. Yerich and Ms. Perdikis, who would have had to be recruited for such a scheme, makes the suggestion that Ms. Yerich instigated the cutting and pasting with her relative implausible.

Alleged involvement of certain optometrists in chart alteration

Ms. Savic testified that, in either 2005 or 2008, she witnessed Dr. Taylor and Dr. Nanini altering the operating report sheet (1-184). She said that this occurred in Dr. Taylor's office and that she witnessed it happening on only one occasion, for about 15 minutes. Ms. Savic could not recall the exact year, but thought that the event that she witnessed related temporally to either the investigation by Drs. Cohen and Wallerstein in 2005 or to the College investigation in 2008.

According to Ms. Savic, Dr. Taylor's explanation at the time was that he was trying to create an operating room report that did not look messy. Dr. Taylor denied this to be true.

Ms. Savic conceded that Dr. Nanini may have been copying what was on the original report to a new sheet (2-9). On cross-examination, Ms. Savic confirmed that these observations were not reported to College investigators in 2010 or 2013 but only were noted by her one month before the hearing.

Dr. Nanini testified that he would on occasion re-write a chart by copying it (10-58). He denied that he altered charts and specifically denied the allegation that he had altered charts in Dr. Taylor's office (10-47). Furthermore, Dr. Nanini testified that he had no knowledge of the overbilling issue or of the refunds that were sent to patients.

Ms. Savic testified that Dr. Capogna agreed with her in a 2008 conversation that included Bill Thom (an individual who did not testify) and Ms. Yerich. Ms. Savic also testified that Dr. Capogna knew about the overcharging of patients (1-202), that the "zipping" activity was motivated by financial gain (2-40).

Dr. Capogna denied having the 2008 conversation (11-9) and further denied that she knew anything about the overbilling issues starting in 2003 and continuing with the 2005 dispute with Drs. Cohen and Wallerstein (11-16).

The testimony regarding the chart alteration that Ms. Savic allegedly observed on one occasion by Drs. Taylor and Nanini was scant and the Committee concluded she was mistaken with respect to her observations. Ms. Savic was not in a position to directly

observe what either Drs. Taylor or Nanini were writing in the chart. It is quite believable that messy charts were being re-written by Dr. Taylor and that Dr. Nanini was simply copying his post-operative section onto the newly written report. Dr. Nanini conceded that he did occasionally copy his reports onto a new sheet.

The Committee found that the account that Ms. Savic provided with respect to her memory of the conversation in 2008 with Dr. Capogna, including the detail and identity of the four participants, was reliable and that this conversation did occur. Dr. Capogna has had a long professional relationship with Dr. Taylor, both at the laser center and at his OHIP practice. It is hard to believe that Dr. Capogna would have no knowledge of the overbilling accusations that first surfaced in 2003 (with the rumoured police investigation), then again in 2005 (with the dispute involving Drs. Cohen and Wallerstein) and finally in 2008 (with the beginning of the College investigation).

Issue 2 b) - Did Dr. Taylor alter, or instruct others to alter records by carrying out, or instructing others to carry out, blank firings of the laser in April and May 2003?

After rumours of a police investigation into overbilling began to circulate at the laser clinic in April 2003, it is not contested that some charts were altered using a second method. The laser was "blank fired" (meaning no patient was present and the laser was operated) on numerous occasions in April and May 2003. The "blank fired" false records included patient information and the original date of surgery. These records conveyed the false impression that the more expensive surgery had been performed instead of the less expensive procedure.

Dr. Taylor did not contest that blank firings occurred. However, Dr. Taylor denied that he participated in the blank firings and/or that he instructed the staff to carry them out. The matters of who gave the instructions to conduct blank firings and who was involved in carrying them out were in dispute.

Ms. Yerich and Ms. Savic both testified that Dr. Taylor stopped the process of failing to refund patients who had been converted to the less expensive procedure. They also

testified that Dr. Taylor instructed that refunds were to be sent to only those patients who had not been refunded up to Ms. Perdikis' January 2003 departure.

Ms. Savic testified that Dr. Taylor instructed her to "blank fire" the laser with the data of the patients who had not been given refunds between January 2003 and April 2003 (2-12). She testified that this initial round of blank firings occurred over two weekend days in late April 2003 and extended to the Monday.

Ms. Savic testified that she agreed to blank fire the laser because she was a coward and did not have the courage to say no, even though she knew it was morally wrong. She was paid for the weekend hours but did not get any other compensation for the blank firing.

According to Ms. Savic, Dr. Taylor was also present during the blank firings on one of those weekend days. Ms. Yerich testified that she was present during the blank firing on all three days (3-57).

Ms. Savic and Ms. Yerich also testified that Ms. Taylor, Dr. Taylor's mother, was present on the Monday to help with the blank firings. Ms. Taylor took the blank-fired laser printouts with her on that Monday (1-167).

Ms. Taylor testified that she was called to the laser clinic on a Sunday in late April 2003. The phone invitation came from either Ms. Yerich or Ms. Savic. Ms. Taylor noted that this Sunday was Serbian Easter. She was told "they wanted to talk to me about something" (10-18). When Ms. Taylor arrived at the laser clinic and asked what they were doing, she recalled that Ms. Yerich and Ms. Savic answered that they were "altering charts" (10-18). Ms. Taylor testified that she told Ms. Savic and Ms. Yerich what they were doing was illegal (10-19), using her nursing background to support her assertion. Ms. Taylor then phoned Dr. Taylor and said, "You had better deal with this. These girls are altering your charts" (10-19).

Ms. Taylor testified that she handed the phone to Ms. Yerich so that Dr. Taylor could speak to her. Ms. Taylor left after a total of only two minutes in the laser clinic. She denied taking any printouts with her. Ms. Taylor denied hearing anything further about the incident.

Dr. Taylor denied instructing Ms. Savic to blank fire the laser for the purpose of creating false patient records. Dr. Taylor's testimony regarding the April 2003 weekend was that his mother reported that she had discovered Ms. Savic and Ms. Yerich blank firing. Dr. Taylor testified that he spoke to Ms. Yerich by phone and ordered her to stop. He testified that he spoke to Ms. Savic the next day and informed her that "this is not the course and direction that we are going to proceed in."

Dr. Taylor admitted that he did not investigate what happened to the false printouts. He testified that Ms. Savic "assured me they did not go in the charts. That was enough for me."

At the same time of the blank firings, Ms. Savic testified that Dr. Taylor had also instructed her to delete all the patient files from the laser for patients who had surgery starting in September 2002. This was irrespective of the type of laser surgery the patients had received. Ms. Savic testified that she was unable to delete the files from the hard drive because she did not know where the hard drive was located. Dr. Taylor denied giving instructions to delete patient files from the laser.

In addition to the April blank firings, the Agreed Statement of Facts stated that between Saturday, May 17 and Tuesday, May 20, 2003, there were 113 blank firings of the laser (58 patients). Between Thursday, May 22 and Friday May 23, 2003, there were 3 blank firings (one patient). Between Friday, May 23 and Saturday, May 24, 2003, there were 13 firings (7 patients). Between Tuesday, May 27 and Wednesday, May 28, 2003, six firings took place (3 patients).

Ms. Savic testified that Dr. Taylor told her to "burn the cards for patients in 2003" (2-77) but the refunds for these patients were not issued until 2005. She testified that blank firings occurred in May 2003, although Ms. Savic could not recall the exact date (1-164). There was no other testimony about the May 2003 blank firings.

Ms. Furney (9-15) denied any knowledge of fake laser printouts in 2003. She acknowledged in her testimony that she was functioning as a laser technician by April 2003 (9-92).

FINDING

The Committee finds that Dr. Taylor directed the blank firings of the laser in April and May 2003 and thus contributed to the alteration of patient charts for the purpose of covering up the over-billing.

ANALYSIS

According to the Agreed Statement of Facts, two major bouts of firings occurred: one from April 25 to 29, 2003 (125 firings for 63 patients), and the other May 17-20, 2003 (113 firings for 58 patients).

The Committee found that the accounts of Ms. Yerich and Ms. Savic were more credible than those of Ms. Taylor and Dr. Taylor. Ms. Taylor's account of the blank firing incident was implausible in several respects. First, according to her evidence, she accepted an unusual and vague invitation on a Sunday to attend the laser clinic from someone she claimed she barely knew for an unspecified reason. Second, Ms. Taylor testified that she arrived at the clinic and was told by her son's employees that they were engaged in an illegal activity, altering medical charts. The Committee found it extremely unlikely that someone engaged in illegal activity would call in the mother of their employer, Ms. Taylor, to witness the activity and then so casually state this fact to her.

Ms. Taylor testified that her reaction to this declaration of illegal activity was limited to phoning Dr. Taylor and leaving shortly thereafter. According to her, she made no attempt to stay and make sure that the activity ceased, and she further testified that she made no attempt to follow up on what subsequently happened.

In view of her professional status as a registered nurse and her personal status as the mother of the physician who would suffer significant repercussions for having staff altering records, the Committee simply did not believe Ms. Taylor's account of the afternoon.

The Committee finds that Dr. Taylor's account is also implausible. The illegal activity his mother described was taking place shortly after the rumours of a police investigation surfaced. Yet by his account, his reaction was initially to discuss the matter over the phone only, with a mere next-day discussion with Ms. Savic.

Furthermore, Dr. Taylor took a lackadaisical approach to the fate of the blank-fired printouts, relying on the assurances of an employee who was, by his own view of events, involved in the deliberate chart alteration that his own mother had recently witnessed. Dr. Taylor's testimony that he trusted his laser technicians because they were like his right hand is viewed by the Committee as a very weak explanation for his lack of personal attention to the charts, given the seriousness of the situation for him as a professional. Both the rumoured police investigation and his apparent discovery of production of false laser print-outs should have been issues of grave concern to Dr. Taylor. The Committee did not believe Dr. Taylor's explanation and found that Dr. Taylor's purported reaction was disproportionate to the seriousness of the situation.

The Committee also noted that the blank firings incurred significant expense, in the tens of thousands of dollars, because of the cost of the cards. Although the Committee recognized that Ms. Yerich was in charge of the laser clinic's finances, one would expect that such a large expenditure over a short period of time would ultimately have been subject to external scrutiny. The Committee concluded that it is more plausible that Dr. Taylor was aware of and approved the blank firings.

The Committee found that Ms. Yerich's and Ms. Savic's testimony regarding the first round of blank firing was more credible than that of Ms. Taylor and Dr. Taylor. Both Ms. Yerich and Ms. Savic were clear that the instructions came from Dr. Taylor. Ms. Savic recalled the approximate number (60) of patient blank firings done on the April 26 to 29, 2003 weekend. That corresponded to the number of refund cheques issued to 63 patients on April 30, 2003. Ms. Savic also testified that the firings continued until Monday morning, at which time Ms. Taylor took the printouts (1-167).

The Committee found the Monday morning scenario more believable, given that Ms. Taylor normally attended at the laser clinic on Monday mornings to pick up charts of the patients who had cataract surgery on the preceding Friday.

On the matter of the deletion of computer files, the testimony of Ms. Savic is compatible with the uncontested evidence that records for patient procedures prior to January 2, 2003, were deleted from the laser eye program from the user's perspective but are still present on the hard drive. Ms. Savic was forthright in admitting that she did not know how to delete from the hard drive, and indeed this was confirmed by the forensic analysis of the computer.

The Committee was puzzled regarding the May 2003 blank firings. Ms. Savic did not testify about these occurrences in detail. If Dr. Taylor is to be believed, the May 2003 blank firings would have been carried out in direct contravention of his orders from a month earlier.

Ms. Furney's initial failure to recall her role as a laser technician in April 2003 made the Committee question the reliability of her testimony. Although the forensic computer report did not report on the time of day of the firings, the Committee noted that several of the firings occurred in the operating room during weekdays. This meant there was a higher risk of this activity being detected by others, including Dr. Taylor himself, who testified that he seldom left the operating room on days when he was performing procedures. Given that the blank firings occurred from May 17 to 20, the Committee finds it hard to believe they were not witnessed by either Ms. Furney or Dr. Taylor.

The College began its investigation of these allegations in 2008. Ms. Yerich and Ms. Savic both testified that Dr. Taylor instructed them to lie to the College by stating "they panicked and decided to blank-fire the laser to cover up their failure to refund all the patients" (1-217 and 3-103/4). Dr. Taylor denied these allegations. The Committee does not believe Dr. Taylor and finds that Dr. Taylor directed Ms. Yerich and Ms. Savic, his employees, to lie to the College.

CONCLUSION

The Committee finds that Dr. Taylor did order and was aware of the blank firings at the Material Time.

OTHER FACTUAL ALLEGATIONS IMPACTING CREDIBILITY

Significance of the evidence re movement of charts

Ms. Yerich testified that, at an unspecified date that was well before 2010, she, Ms. Savic, and Ms. Taylor moved the refunded patient charts in several boxes to various locations, including Ms. Savic's home (3-169), Dr. Taylor's home (3-170) for the purpose of him making changes to the charts (3-171), and to the home of a friend of Dr. Taylor in Niagara-on-the-Lake (3-148). In the latter instance, Dr. Taylor's friend had not been home, but Dr. Taylor provided a key to the house. The Committee noted that during much of her testimony on this issue, Ms. Yerich replied repeatedly, "I don't recall" and "I cannot be certain.".

Ms. Yerich also testified that the boxes of patient charts had been in Dr. Taylor's private office at the laser clinic for some period of time. Ms. Yerich further testified that, at some unknown date, these charts were also taken to Ms. Taylor's friend's house. Ms. Yerich was not aware of the location of this house, but did recall that the friend's first name was either Bernice or Vivienne. These occurrences took place "years before the theft" of the safe in 2010. There was no corroborating testimony from Ms. Savic about this issue.

Both Ms. B and Ms. A flatly denied that any charts had ever been brought to their homes. The Committee did have some concerns about Ms. A's ability to recall events accurately: Ms. A thought that she had met Ms. Yerich at Dr. Taylor's OHIP clinic (9-132), yet Ms. Yerich had never worked in the OHIP office.

The Committee noted that both Ms. B and Ms. A are longtime friends of Ms. Taylor and are also OHIP patients of Dr. Taylor. However, as a result of Ms. Yerich's failure to provide any particulars about the alleged movement of these records, the Committee was unable to determine which charts were moved, where, when, or why. Consequently, the Committee could draw no conclusions from this evidence.

Were the patient charts in an office safe that was stolen in May 2010?

In a matter unrelated to this case, the College had warned Dr. Taylor about exercising more care in the storage of patient records in his OHIP clinic.

The College investigation into the current matter began in 2008. Dr. Taylor testified that, in December 2009, he decided to place the files of the approximately 125 patients who had been refunded in 2002 and 2003 in safekeeping in the office safe, located in the general office of the laser clinic. Ms. Furney also testified that she assisted Dr. Taylor in placing the paper portions of the patient charts into envelopes that were then placed in the safe.

Ms. Furney testified (9-121) that she did not know the significance of the 125 charts being stored in the safe. Ms. Furney claimed that the first she heard about any chart alterations was in 2012, from College investigators (9-96).

From December 2009 to May 2010, the only people who knew the combination for the safe were Ms. Yerich, Ms. Furney, and Dr. Taylor.

Ms. Yerich testified, however, that she did not see any patient charts in the safe during this time period. The safe contained cash, leases, and a few other important documents (3-128). Ms. Yerich stated that she accessed the safe regularly to access the petty cash that was stored there, and that she had accessed the safe on the Friday before the theft. At no time did she see patient charts in the office safe.

The laser clinic was broken into on May 19, 2010. The safe and several pieces of ophthalmic diagnostic equipment were stolen.

Ms. Yerich testified that, on the morning after the break-in, Dr. Taylor expressed happiness that the theft had occurred, calling it “a gift from God” (3-137). She testified that Dr. Taylor then directed her to report to the police that patient charts were in the safe (3-143) and that a piece of equipment that he needed for his OHIP office was also missing. Ms. Yerich did not report either of these requests to the police.

Almost five months later, on October 6, 2010, Dr. Taylor notified patients that their medical records had been stolen. Ms. Furney assisted Dr. Taylor in this notification process and testified that the patient identities were obtained from the 2002 and 2003 refund cheques (9-113).

The Committee found that the patient charts were not in the safe in May 2010. The Committee believed Ms. Yerich's testimony that she did not see patient charts in the safe. She accessed the safe almost weekly between December 2009 and May 2010, when the safe was stolen. Her testimony about Dr. Taylor's "gift from God" reaction to the theft of the safe and his directions to Ms. Yerich to include missing charts in her police report supported a scheme that the charts, which would have ended up as evidence in the College investigation, were stolen.

As there were secure places in the laser clinic for all patient charts, the Committee did not accept the rationale that these charts – the subject of the current hearing – warranted special protection.

The Committee did not find Ms. Furney's testimony to be credible when she denied any knowledge of the relevance of the charts being placed in the safe in December 2009. Ms. Furney had been at the staff meeting of 2003, where overbilling was discussed. By 2010, Ms. Furney was the co-manager of the laser clinic.

The Committee was struck by the relative tardiness of the report to the police, authored by Ms. Furney. The break-in occurred on May 19, 2010 and the email from Ms. Furney to the police was sent on August 13, 2010. (exhibit 34). In addition, there was several months of delay in notifying the patients that their charts had been stolen. Furthermore, a small number of the allegedly-stolen charts were subsequently found in Dr. Taylor's accountant's office. In summary, the Committee concluded that both Dr. Taylor and Ms. Furney were not telling the truth about placing the charts in the safe.

Suggestion that the office manager, Ms. Yerich, engaged in improper financial dealings

In an attempt to undermine her credibility, counsel for Dr. Taylor questioned Ms. Yerich's process of withdrawing petty cash from the bank by making the cheque payable to her personally. During cross-examination, Ms. Yerich acknowledged that she had learned in her book-keeping training that cheques should be made out to "petty cash" (6-21).

When the new corporation was created in 2001, there were lots of expenditures. In addition, Ms. Yerich was learning the new Quickbooks accounting system. She frequently admitted to a lack of recall about the regularly monthly petty cash cheques for $500. Some amounts exceeded $500. There were even some occasions when the withdrawal interval was as short as every two weeks. (6-26-50)

Ms. Furney testified that when she withdrew petty cash, she wrote the cheque out to "petty cash." Ms. Furney reported that a petty cash float of $500 was typically replenished every two or three months (9-52), compared to the more frequent withdrawals initiated by Ms. Yerich.

Ms. Yerich admitted that a $10,000 cheque made payable to her mother was actually a corporate dividend owed to her (6-96). At no time did Ms. Yerich's mother provide any service to Dr. Taylor's operations. Ms. Yerich testified that Dr. Taylor advised her to make the cheque out to Ms. Yerich's mother so as to lessen Ms. Yerich's tax burden. Dr. Taylor denied providing this advice, stating that he was not a tax expert.

The Committee found that Dr. Taylor was aware that Ms. Yerich inappropriately made her personal corporate dividend payable to a non-employee of the clinic. The Committee did not find that the evidence with respect to Ms. Yerich's use of petty cash was strong enough to undermine her credibility.

There were repeated instances in which Ms. Yerich did not recall the details of petty cash transactions. Despite the passage of time between these events and the hearing, the petty cash cheques made payable to her were numerous and regular, over several years. The

cheques were frequently for the same amount of money. Ultimately, however, external accountants should have brought any concerns about any impropriety to Dr. Taylor's attention. There was no evidence that this occurred.

The Committee accepted Ms. Yerich's admission concerning the cheque issued improperly to her mother in an effort to reduce Ms. Yerich's tax burden. The Committee found Dr. Taylor's denial of involvement implausible. It does not require any special tax expertise to recognize that there would be a lessened tax burden when paying to an individual who was presumably in a lower tax bracket than the person to whom the dividend should have been paid.

Furthermore, the Committee would have expected that external accountants would have sought Dr. Taylor's acknowledgement and approval of such an amount to an individual who was not on the corporation payroll. In this matter, the Committee concluded that Ms. Yerich and Dr. Taylor collaborated in the manner in which the dividend to Ms. Yerich was paid.

Alleged collusion and the credibility of two related witnesses

Counsel for Dr. Taylor asserted that cousins Ms. Yerich and Ms. Savic colluded when preparing and presenting their evidence. Evidence alleged to support this argument included discrepancies between interviews given to the College in earlier years (starting in 2010) and evidence given at the hearing in the fall of 2014.

The Committee assessed the credibility and reliability of each witness, including the cousins Ms. Yerich and Ms. Savic. Ms. Yerich and Ms. Savic were credible in their respective testimony regarding the cutting and pasting, the blank firings, the police investigation rumours finally causing Dr. Taylor to cease the overbilling, the refunds process, the absence of charts in the stolen safe, and being asked to take the blame for the overbilling. Furthermore, Ms. Yerich confessed that the large payment to her mother was actually intended for her personally and also confessed to not telling the truth to Drs. Cohen and Wallerstein.

The Committee found Ms. Yerich's testimony about her management of petty cash in the office and the movement of patient charts vague but this testimony did not undermine her overall credibility. The Committee also concluded that Ms. Savic's belief that she observed Drs. Taylor and Nanini allegedly editing charts, although incorrect, was not a deliberate falsehood. Rather, it was most likely the result of a misinterpretation of events. It is not surprising that Ms. Savic would have drawn such a conclusion given her knowledge that charts had been altered in the office.

The Committee focused on the issues related to the Material Time. During the first several months of that period, Ms. Savic was not employed at the laser center. Rather, Ms. Perdikis was the laser technician who admittedly was the key figure in the chart alterations with the cutting and pasting procedure. If collusion related to chart alterations was a factor, at the minimum it would have involved Ms. Perdikis, a non-relative.

Furthermore, if collusion and fabrication had in fact played a role, the Committee would have expected that the testimony of the three alleged colluders to have been clearer regarding Dr. Taylor's direct instructions about cutting and pasting. Furthermore, Ms. Perdikis could have colluded by including the "zipping" terminology into her testimony.

In contrast, the evidence of Ms. Perdikis and Ms. Savic regarding the instructions about cutting and pasting showed discrepancies of recall, which the Committee concluded was related to the significant passage of time.

The Committee accepts that Ms. Yerich and Ms. Savic, theoretically, could have colluded in their evidence regarding the zipping, alteration of charts, the blank firings, refunds, and instructions given by Dr. Taylor. However, the Committee did not find this to be the case. The Committee found the evidence of Ms. Yerich and Ms. Savic in all of these matters to be more credible than Dr. Taylor's evidence. This is not simply because they corroborated one another, but more importantly because Dr. Taylor's explanations were not plausible.

Both women demonstrated remorse for their behaviour, accepted responsibility, and showed concern about the future implications of their past activities. The Committee was

struck in particular by Ms. Savic's testimony, which was consistent and non-evasive. She showed genuine emotion in acknowledging her lack of professional integrity at the Material Time and showed concern that her testimony may have potential implications on her current career as a regulated health professional.

SUMMARY

The Committee, in its final analysis, focused on the following central facts:

- Patients were over-billed for procedures that were not performed.
- Over 120 of these patients left the laser clinic after their procedure completely unaware that they were entitled to a refund.
- The charts of these patients were altered at the time of the procedure.
- These two activities – chart alteration and over-billing – were integrally linked.

In other words, chart alteration by cutting and pasting was a necessary complement to the over-billing and its associated lack of a refund. One did not and could not occur without the other.

The Committee concluded that both the over-billing and the chart alteration were deliberate, and, when considered together, could not have been the result of a communications gap or an administrative error.

The Committee found that Dr. Taylor's role was critical. Evidence points to his role in instructing a small number of staff, most likely through Ms. Yerich who typically gave orders to employees, to cut and paste the charts. Dr. Taylor's testimony that every patient was aware of the difference in costs between the promised Zyoptix and the delivered Planoscan was simply not credible since each of those patients left the clinic without asking for their substantial refund. The Committee also found that the letter accompanying the eventual refunds was not truthful.

There was no evidence of any motive for the laser technicians and the clinic manager to allegedly create a scheme of chart alteration and over-billing, when the people involved would have had to risk their employment and potential criminal charges without any

tangible financial benefit to themselves. The Committee took this into account in assessing the credibility of Ms. Yerich and Ms. Savic.

The Committee could not understand why Dr. Taylor failed to address the rumours of the police investigation by seeking clarification from the police. The Committee was struck by the lack of credibility of Dr. Taylor's claim that he entrusted the review of the financial records of over-billed patients to an individual who he allegedly believed was responsible for that administrative error. Two years later, when Dr. Taylor discovered that the same individual had failed to refund all patients properly, his supposed anger and disillusion were manifested by continuing that person's employment, without a salary reduction (despite a lessening of responsibilities) for a further four years.

In conclusion, the Committee found that Dr. Andrew Winston Taylor committed an act of professional misconduct:

1. under paragraph 1(1)33 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* ("O. Reg. 856/93"), in that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The disgraceful, dishonourable, or unprofessional conduct involved Dr. Taylor billing for medical procedures that were not performed and instructing others to create, alter, or otherwise manipulate medical records related to such procedures.

The Committee requests that the Hearings Office schedule a penalty hearing at the earliest opportunity.

Indexed as: Ontario (College of Physicians and Surgeons of Ontario) v. Taylor, 2017 ONCPSD 17

THE DISCIPLINE COMMITTEE OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

IN THE MATTER OF a Hearing directed by the Inquiries, Complaints and Reports Committee of the College of Physicians and Surgeons 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.

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. ANDREW WINSTON TAYLOR

PANEL MEMBERS:

DR. C. CLAPPERTON (CHAIR)
MR. S. BERI
DR. P. POLDRE
DR. P. TADROS

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS. E. WIDNER
MS. D. AWAD

COUNSEL FOR DR. TAYLOR:

MR. A. MATHESON
MS. K. SMITH
MS. M. BRIDGES

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MS. J. MCALEER

Penalty Hearing Date: January 5, 2017
Penalty Decision Date: April 24, 2017
Penalty Reasons Date: April 24, 2017

PENALTY DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario delivered its written Decision and Reasons on Finding in this matter on July 29, 2016 and found that Dr. Taylor committed an act of professional misconduct in that he engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The disgraceful, dishonourable, or unprofessional conduct involved Dr. Taylor billing for medical procedures that were not performed and instructing others to create, alter, or otherwise manipulate medical records related to such procedures.

The Committee heard evidence and submissions on penalty and costs on January 5, 2017 and reserved its decision and reasons on penalty.

SUBMISSIONS ON PENALTY

Counsel for the College sought revocation, a reprimand and costs of $54,560 (based on the daily tariff rate for a day of hearing at the time of the hearing).

Counsel for Dr. Taylor submitted that an appropriate penalty would be a moderate suspension, a reprimand, an ethics course and costs.

EVIDENCE ON PENALTY

Character Witnesses

The Committee heard evidence from three character witnesses, all of whom were called by Dr. Taylor.

Dr. Patricia Teal, an ophthalmologist, testified that Dr. Taylor is an excellent surgeon, a good colleague and was very good in his management role as chief of ophthalmology for the Niagara Health System during 2005 to 2016. Dr. Teal has known Dr. Taylor since 1998.

Dr. Steve Arshinoff, an ophthalmologist, has known Dr. Taylor since 1996. During the time that Dr. Arshinoff and Dr. Taylor worked together, Dr. Arshinoff recalled that there were no issues related to billing practices. Dr. Arshinoff testified that Dr. Taylor is an excellent doctor and colleague. Dr. Taylor was also noted to be an excellent mentor. Dr. Arshinoff and Dr. Taylor served together on the board of the Eye Foundation for six years and they were also partners in a real estate transaction.

Stephen Dembroski has been Dr. Taylor's life partner since 2007. Mr. Dembroski has expertise in business matters and is aware of Dr. Taylor's business operations. Mr. Dembroski described Dr. Taylor as a respected doctor as well as a caring and trusting individual.

Character References

The Committee reviewed written character references from 30 individuals, which were submitted as evidence by counsel for Dr. Taylor.

One reference (tab 9) was from a friend who has known Dr. Taylor since 2001 and who worked with Dr. Taylor in philanthropic efforts. Three references were from leaders in the community (tabs 7, 12, 22). The Committee noted that these three had only known or known of Dr. Taylor since 2010 or 2012. Fourteen letters of reference were provided by professional colleagues. These letters came from a clinic manager, a program director, an ophthalmologist, two anesthetists, three optometrists and six registered nurses. Only three of the professionals knew Dr. Taylor prior to 2002. Some of the professionals had also been patients of Dr. Taylor's or had family members as his patients. The comments provided by professional colleagues spoke to a variety of excellent clinical, management,

mentoring and personal attributes of Dr. Taylor. For example, one nurse wrote that, “Dr. Taylor has always been kind courteous and polite to the OR team. He is patient and willing to help and teach new staff during very intricate and delicate surgery.”

There were twelve letters of reference from Dr. Taylor’s patients. Seven had received their clinical care before 2003. One patient (tab 24) from 2003 noted “I have never been charged unfairly for any product or service; in fact, sometimes not charged at all”. One patient (tab 19), who was treated in 2004, wrote that Dr. Taylor, “made plain what costs, if any, would be involved. I have always had detailed communications from him in this area and been given forms to sign ahead of all procedures, which stated costs and potential risks.” The nature of the procedure was not described. All patients’ comments consistently mentioned Dr. Taylor’s clinical skill and his caring and compassionate manner.

Several reference letters, when commenting on the Committee’s Decision and Reasons on Finding, noted that the findings of the Committee were not consistent with the Dr. Taylor that they knew. For example, a charge nurse who has worked with Dr. Taylor for 15 years (and whose mother was also a patient of Dr. Taylor) wrote, “I have read the CPSO committee’s decision and it is not consistent with the person I have worked so closely with for 15 years”. A patient (tab 21) wrote that, “I have read the Committee’s decision and reasons in their entirety. I firmly believe that the Committee’s findings are neither consistent of the man I know, nor do they alter my opinion of Dr. Taylor. He is a professional, ethical and caring physician and a credit to his profession.”

Patients also expressed concern regarding the possible outcomes of the penalty hearing. One patient (tab 11) wrote, “I am afraid for my own care if I were to lose him as well as the loss to my community.” Another patient (tab 14) wrote, “I implore the College to hear my voice as being representative of my broader community in asking you to evaluate this surgeon’s considerable skills and contributions to this community when determining his

ability to continue to practice here. The loss of a professional of this caliber would be an irreplaceable loss to this region."

Weighing the Character Evidence

The Committee determined that the testimony of the three character witnesses who testified was of limited utility. One witness did not know Dr. Taylor until after most of the misconduct had occurred (2002 to 2005). Each testified about the many positive attributes of Dr. Taylor as a person but not his reputation in the community for financial integrity.

The Committee also concluded that the patients' testimonials regarding Dr. Taylor's clinical care were not helpful in deciding upon the appropriate penalty. In its decision, the Committee did not express any concern about Dr. Taylor's clinical skill or his clinical decision-making regarding the choice of procedure that was ultimately provided to the patients who were overbilled. Judgment can be biased when one trait, such as clinical excellence, is transferred to an unrelated attribute, such as billing honesty.

Further, individuals can be misled with respect to another individual's character. As noted in *R. v. Drabinsky (2011)*,

> …individuals who perpetuate frauds like these are usually seen in the community as solid, responsible and law-abiding citizens…The offender's prior good character and standing in the community are to some extent the tools by which they commit and sustain the frauds over lengthy time periods.

The College submitted that many of the character letters contained statements that undermined or challenged the Committee's findings. The Committee did not conclude that any of the referees were challenging the validity of the Committee's Decision and Reasons on Finding; rather, the Committee's view was that their knowledge and understanding of Dr. Taylor's character was different based on their experiences with him and inconsistent with the facts as found by the Committee.

The Committee was sensitive to the concerns expressed by patients that Dr. Taylor's penalty might deprive the community of a valued practitioner. A shortage of resources, however, cannot be used to justify a lowering of professional standards.

The Committee was assisted by the passage from *Bolton v. Law Society*, [1994] 2 ALL ER 486 at p. 492 quoted in *Moore v. CPSO*, 2002 ONCPSD 16*:*

> It often happens that a solicitor appearing before the tribunal can adduce a wealth of glowing tributes from his professional brethren. He can often show that for him and his family the consequences of striking off or suspension would be little short of tragic. All these matter are relevant and should be considered. But none of them touches the essential issue, which is the need to maintain among members of the public a well-founded confidence that any solicitor whom they instruct will be a person of unquestionable integrity, probity and trustworthiness. The reputation of the profession is more important than the fortunes of any individual member.

The Committee agrees with the conclusions in this passage, which are equally applicable to the medical profession.

ANALYSIS

Guiding Principles

The Committee, in arriving at its decision on an appropriate penalty, considered a number of guiding principles. Public protection and maintaining the public's confidence in the integrity of the profession and the ability of the College to regulate the profession in the public interest are primary considerations. In matters involving deceptive billing, general deterrence (aimed at the profession) is critical and of more importance than specific deterrence (aimed at the physician). Remediation of the physician, if appropriate, must also be considered.

Aggravating Factors

Dr. Taylor engaged in serious misconduct that had a number of aggravating features as follows:

Dr. Taylor deliberately billed patients for a procedure that was more expensive than the one that was actually performed.

Dr. Taylor involved his employees in his misconduct. As a critical component of the overbilling, Dr. Taylor directed his employees to alter the over-billed patients' charts at the end of the operating day or later by a series of blank firings of the laser. By involving his employees in his misconduct, he caused several of them emotional stress during their employment. The Committee found the manner in which Dr. Taylor involved his employees to be a significant aggravating factor.

The altered patient charts were rendered inaccurate, thus posing a potential risk for the future care of these patients.

Dr. Taylor took advantage of the position of trust physicians have with patients. Patients are vulnerable when paying privately for a medical service in that private payments are not subject to any system of external audit, such as would be conducted of OHIP billed services. When rumours of a police investigation led to the cessation of the over-billing, re-imbursement was provided initially only to those patients who were treated in 2002 and refunds were accompanied by a misleading cover letter. At this time, Dr. Taylor chose to not provide refunds to patients who were over-billed at the beginning of 2003. Those patients were refunded subsequently in 2005, but only after Dr. Taylor's business partners began to ask questions about his billing practices. This second wave of refunds was also accompanied by a similar misleading cover letter.

Dr. Taylor hampered the College investigation by directing his staff to falsely report that a safe had been stolen which contained the charts of patient who had been refunded. This

demonstrated his continued effort to cover up his misconduct and also showed disdain for his professional regulator.

Mitigating Factors

Dr. Taylor does not have a prior discipline history. In addition, full restitution had been made to the over-billed patients. These are mitigating factors.

The Committee was also asked to consider the passage of time between the wrongdoing and the present given there is no evidence that Dr. Taylor had engaged in any wrongdoing since the events at issue, suggesting that Dr. Taylor was rehabilitated. The dishonest billing occurred in 2002 and 2003, refunds were sent to patients in 2003 and 2005 with misleading letters and further attempts to hide the misconduct occurred as late as 2010 (the report of the stolen safe). Since these events, there have been no complaints against Dr. Taylor.

In *R v. S* (H), 2014 ONCA 323, the Court of Appeal considered a similar argument with respect to the passage of time. The Ontario Court of Appeal quoted with approval the decision of the Alberta Court of Appeal in *R. v. S.S.* 1992 ABCA 352 which stated: "The only sentencing principles which may be affected by the lapse of time are those of individual deterrence and rehabilitation." The decision went on to note, "that if despite having led an exemplary life, the offender lacks remorse, any potential discount must be less than it otherwise would have been." A demonstration of remorse can be a mitigating factor, even though a failure to show remorse cannot be considered an aggravating factor in respect to penalty, as a matter of law. Dr. Taylor has not acknowledged his misconduct nor has he shown any remorse.

When balancing the penalty principles in this case, the Committee concluded that individual deterrence and rehabilitation were of lesser importance than public protection, public confidence in the integrity of the profession and the College's ability to regulate the profession in the public interest, denunciation of the misconduct and general

deterrence, in particular, in relation to those who bill privately for medical services. Therefore, the passage of time without further complaint is a neutral factor in this case.

Prior Cases

Counsel for Dr. Taylor provided a number of cases to illustrate the range of penalties in cases of fraud or improper billing. These cases considered the magnitude of the fraud, the duration of the fraud, and many other factors.

At one extreme is the case of *CPSO v. Paikin* 2002, ONCPD 49. Dr. Paikin was found to have committed professional misconduct in relation to improper OHIP billings of approximately $10,000 between 1993 and 1998. His billings did not conform to the requirements of the schedule of benefits. The penalty involved a fine and a reprimand; there was no suspension ordered. Dr. Paikin was required to pay costs. The Committee notes that this was a case of failing to exercise due diligence, and not a case involving fraudulent intent.

Another case, *CPSO v. Sokol* 2011 ONCPD 42, is an example of professional misconduct involving both OHIP and WSIB fraud totaling over $3.5 million over a four-year period. Dr. Sokol pleaded guilty in the Ontario Court of Justice, paid a fine, and made significant restitution prior to his court hearing. Dr. Sokol argued that the improper billing was the result of a failure of due diligence. The Committee accepted a joint submission on penalty and ordered a three-month suspension, a reprimand, an education program, OHIP billing monitoring and costs.

The case of *CPSO v. Moore* 2002 ONCPSD 16 is similar to Dr. Taylor's case with respect to the amount of fraud and its duration. Dr. Moore was found guilty by the Ontario Court of Justice of fraud amounting to $75,000 between 1996 and 1999. He received a conditional sentence, probation and was ordered to make full restitution by the court. The Discipline Committee ordered a 12-month suspension, with a six-month reduction if a fine of $5,000 and costs to the College of $2,500 were paid within six

months. The Committee noted in that case that the incidence of health care fraud continued to be a significant problem in 2002 and noted "general deterrence and maintenance of public confidence in the profession and its ability to govern itself are of paramount importance". The decision went on to note that, "Notwithstanding the need to consider proportionality in its decision, the Committee believes it is not fettered by previous penalty decisions and may act in light of the evolving knowledge of the failure of these penalties to act as sufficient deterrents".

The Committee also reviewed several cases in which fraud resulted in revocation.

In *CPSO v. Marcin* 2016 ONCPSD 7, Dr. Marcin engaged in OHIP fraud between 2007 and 2009 in the amount of $100,000. Dr. Marcin was convicted in criminal court. Full restitution was made. The Discipline Committee made multiple findings of professional misconduct. The aggravating factors with respect to penalty included breaches of an undertaking, improper prescribing of narcotics, fabricating a patient's medical record, boundary violations and incompetence. The Committee accepted a joint submission on penalty and ordered revocation, a reprimand and costs.

In *CPSO v. Patel* 2015 ONCPSD 22, Dr. Patel billed OHIP for $34,000 during a span of time when he was away from the office. In addition, there were instances of inappropriate billing when he was present. The Committee made additional findings including that he failed to maintain the standard of practice of the profession and that he breached an undertaking. Dr. Patel also had a prior discipline history. Revocation and a reprimand were ordered.

In the case of *CPSO v. Scott* 2002 ONCPSD 15, the Committee also ordered revocation. Over a seven-year period, Dr. Scott defrauded OHIP of $592,000 by means of fictitious appointments and fabricated procedures, including false medical chart entries for many. Although Dr. Scott had addiction problems, the Committee noted that most of the fraud occurred after the addiction issue had resolved.

The Committee also reviewed the case of *College of Physicians and Surgeons of British Columbia v. Verma*, 1994 CanLII 252 (BCSC) in which a sham medical record was created in order to hide improper drug prescriptions to a patient whom Dr. Verma subsequently threatened in an attempt to interfere with the College's investigation. Dr. Verma was deprived of his license to practise medicine.

DECISION ON PENALTY AND COSTS

The Committee recognizes that, to the extent possible, cases of a similar nature should result in similar sanctions. It considered the advice given by the Divisional Court of Ontario in *Stevens v. the Law Society of Upper Canada*, 1979 CanLII 1739 (ONSC).

> A conscious comparison should be made between the case under consideration and similar cases wherein sentences were imposed. If the comparison with other cases is not undertaken, there may well be such a wide variation in the results so as to constitute not simply unfairness by injustice.

The Committee balanced this principle with the principle referred to in *Minnes v. CPSO* 2015 ONCPSD 3 (CanLII), at page 4:

> Each case is, however, unique. While a review of similar decisions can often disclose some commonality between the facts of the case under consideration and previous factual situations, there will be differences reflecting the individual circumstances of the cases. The challenge for the Committee is to carefully consider all the facts and circumstances of the case and, by weighing the accepted principles of penalty in a fashion that takes into account the unique features of the case, to arrive at a fair and just decision.

The Committee was also guided by the advice of the Supreme Court of Canada in *R. v. Lacasse*, [2015] 3 S.C.R. 1089 at page 1091:

> There will always be situations that call for a sentence outside a particular range: although ensuring parity in sentencing is in itself a desirable objective, the fact that each crime is committed in unique circumstances by an offender with a unique profile cannot be disregarded. The determination of a just and appropriate sentence is a highly individualized exercise that goes beyond a purely mathematical calculation. It involves a variety of factors that are difficult to define with precision. This is why it may happen that a sentence that, on its face, falls outside a particular range, and that may never have been imposed in the past for a similar crime, is not demonstrably unfit. Once again, everything depends on the gravity of the offence, the offender's degree of responsibility and the specific circumstances of each case.

The Committee considered the seriousness of Dr. Taylor's misconduct. Of paramount importance was his deliberate over-billing for non-OHIP services. The Committee noted that none of the prior cases presented by either legal counsel involved non-OHIP privately billed services.

Patients who pay privately for medical services do not have access to the potential protection, via audits, that is an important scrutiny process for OHIP billing. Privately billed patients are at the mercy of the honesty and integrity of the physician providing the service. Honesty and integrity of a physician are fundamental to the patient-physician relationship and a very serious breach of these principles deserves the strongest sanction of the practitioner and a strong signal to the profession as a whole.

The Committee reviewed the cases presented that spoke to the magnitude of billing fraud and the duration/pervasiveness of the misconduct. Each case had unique aggravating or mitigating factors that would elude a mathematical calculation in determining an appropriate penalty. These aggravating and mitigating factors, as well as the extent and duration of the fraud, played a significant role in each penalty decision. Furthermore, the duration and/or magnitude of fraudulent billing are typically related to how long it took for the fraud to be discovered.

In the case of Dr. Taylor, the 2003 rumour of a police investigation and the 2005 concerns raised by his business partners were the temporal precipitants for the two sets of refunds to the over-billed patients. In the absence of these external interventions, which stopped the dishonest billing and deceptive practices and lead to the refunds, it is conceivable that the over-billing would have continued. The Committee concludes that neither the magnitude nor the duration of improper billing, alone or in conjunction with one another, are the principal factors in assessing the appropriate penalty in this case. Rather, the Committee finds that the aggravating factors outlined above play a dominant role in determining the appropriate penalty in this case.

The deliberate and planned nature of the improper billing and cover-up was a factor that the Committee considered in assessing the seriousness of the misconduct. Unlike some of the other cited cases in which there was a failure of due diligence or a failure to understand the OHIP schedule of benefits, Dr. Taylor's over-billing was calculated and deliberate, as demonstrated by the associated medical chart alterations done in an attempt to cover up the over-billing.

To make matters worse, Dr. Taylor directed members of his professional staff to make these chart alterations. This caused significant emotional distress to at least two employees who testified at the hearing. In addition to the medical chart alterations that were expected of his employees, Dr. Taylor directed employees to take personal responsibility for the over-billing once rumours of the 2003 police investigation surfaced. Similar expectations were demanded when the 2005 queries by Dr. Taylor's business partners arose. The Committee noted some similarity of Dr. Taylor's coercive behaviour with employees to the case of Dr. Verma (1994) cited above, in which a patient was intimidated when the fraudulent behaviour was uncovered. However, the Committee was not presented with a case in which the physician's employees were subjected to the kind of emotional distress that Dr. Taylor caused in directing them to participate in his dishonest billing scheme.

Dr. Taylor's misleading letter to patients receiving a refund was another example of the deliberate and calculated nature of his misconduct.

The Committee found the false 2010 reports of the stolen safe containing the files of the refunded patients as an attempt to interfere with the investigation of the College, which started in 2008. These actions demonstrated a fundamental lack of respect for professional ethics and the medical profession's regulator.

The Committee found that Dr. Taylor's misconduct included several unique features that were not seen in the precedent cases presented. His misconduct was characterized by premeditation, exploitation, dishonesty and lack of integrity.

CONCLUSION

The Committee echoed the views of the Discipline Committee in *CPSO v. Moore*, 2002 ONCPSD 16 that "in most cases of substantial *premeditated* fraud, the penalty of revocation should be the norm" (*emphasis added*).

The Committee had no doubt that Dr. Taylor's misconduct was premeditated. The misconduct occurred in the context of private billing, free from the potential audit protection available with OHIP billing. The misconduct compromised his employees by their participation in chart alterations and subsequent cover-up efforts and caused them distress. Ultimately, all dishonest billing is a betrayal of the honesty and integrity expected of the physician in the patient-physician relationship. The public must be confident not only in the clinical skills of a practitioner, but in the honesty of a practitioner to bill correctly for services rendered.

Dr. Taylor's misconduct warrants the most serious of sanctions, revocation.

COSTS

The Committee awarded costs of $54,560, based on the daily tariff rate, at the time of the hearing.

ORDER

The Committee therefore orders and directs that:

1. The Registrar revoke Dr. Taylor's certificate of registration effective immediately;

2. Dr. Taylor appear before the panel to be reprimanded within three months of this Order becoming final; and

3. Dr. Taylor pay costs to the College in the amount of $54,560 within six months of this Order becoming final.