

NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Alexander Franklin, this is notice that the Discipline Committee ordered that there shall be a ban on publication or disclosure of the identity, and any information that would disclose the identity, of the patients who are referred to during the hearing or in any other document 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 to a fine of not more than \$10,000 for a first offence and not more than \$20,000 for a subsequent offence.

Indexed as Franklin (Re)

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

IN THE MATTER OF a Hearing directed
by the Complaints Committee or the Executive Committee of
the College of Physicians and Surgeons of Ontario
pursuant to Section 26(2) or Section 36(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. ALEXANDER FRANKLIN

PANEL MEMBERS:

DR. J. SCHILLINGER (CHAIR)
R. PRATT
DR. O. KOFMAN
M. POWER

Hearing Dates:	December 11 & 12, 2006 April 16-18 & 23, 2007
Decision Date:	July 19, 2007
Release of Written Reasons Date:	July 19, 2007

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

The Discipline Committee of the College of Physicians and Surgeons (the “Committee”) heard this matter at Toronto on December 11 and 12, 2006 and April 16 to 18 and 23, 2007. At the conclusion of the hearing, the Committee reserved its decision. One of the original members of the panel that heard this matter, Dr. Guscott, withdrew for medical reasons on April 23, 2007. He has therefore not participated in this decision.

PUBLICATION BAN

On April 18, 2007 the Discipline Committee ordered that there shall be a ban on publication or disclosure of the identity, and any information that would disclose the identity, of the patients who are referred to during the hearing or in any other document 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. The Committee delivered in writing its order and reasons for this order.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Franklin committed an act of professional misconduct under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* (“O. Reg. 856/93”), in that he failed to meet the standard of the profession.

The Notice of Hearing also alleged that Dr. Franklin is incompetent as defined by subsection 52(1) of the Code, in that his care of patients displayed a lack of knowledge, skill or judgment or disregard for the welfare of his patients of a nature or to an extent that demonstrates that he is unfit to continue to practise or that his practice should be restricted.

RESPONSE TO THE ALLEGATIONS

At the outset of the hearing on December 11, 2006, Dr. Franklin denied the allegations set out in the Notice of Hearing.

FACTS AND EVIDENCE

Overview of the Issues

1. Allegation that Dr. Franklin Failed to Meet the Standard of the Profession

Dr. Alexander Franklin is a general physician who, for over 25 years, has seen patients primarily for eyeglass prescriptions in various optical stores. It is alleged that Dr.

Franklin failed to meet the standard of the profession in respect to his record-keeping and his conduct of eye examinations in the care of 28 patients, two of whom had complained to the College and the other 26 of whom had been the subject of an investigation under section 75(b) of the *Health Professions Procedural Code*. The examinations all took place in 2003 and 2004.

There was an issue as to whether the standard of care should be different for Dr. Franklin because he had essentially a “walk-in” practice. College counsel submitted that, based on the testimony of their expert witness, the standard of care should not be different. A full record should be kept for all patients, and all patients are entitled to a full eye examination. Counsel for Dr. Franklin submitted that the Committee should look to the standard of a reasonably prudent general practitioner performing ocular visual assessments rather than the standard of an ophthalmologist.

2. Allegation that Dr. Franklin is Incompetent

This allegation, which relates to the same 28 patients, is also based on Dr. Franklin’s record-keeping and his ocular visual assessments with particular emphasis on his method of measuring intraocular pressures. The issue is whether Dr. Franklin’s professional care of these 28 patients displayed a lack of knowledge, skill or judgment or disregard for the welfare of the patients of a nature or to an extent that demonstrates that Dr. Franklin is unfit to continue to practice or that his practice should be restricted.

Summary of the Evidence

The Committee heard the testimony of five patients on behalf of the College, two of whom were the complainants. There were three other witnesses on behalf of the College. They included Dr. Z, an optometrist, who had examined the complainant, Ms. B, and Dr.

Y, an optometrist, who had examined the complainant, Ms. A. The Committee also heard the testimony of Dr. X, an ophthalmologist, who was accepted as an expert in eye examinations. Dr. X reviewed 26 charts from Dr. Franklin's practice as well as the charts of the two complainants. All 28 charts were placed in evidence and were reviewed by the Committee.

On behalf of the defence, the Committee heard the testimony of Dr. W, a general practitioner, who, on the basis of his extensive experience as a peer assessor, for the College, of general practitioners who perform ocular visual assessments, was accepted as a qualified expert in this area. He gave evidence regarding the standard of care expected by a peer such as Dr. Franklin. He also gave evidence concerning whether Dr. Franklin met the standard, based upon his review of the complaints filed with the College, the medical records of the patients seen by Dr. Franklin, the report of Dr. X and Dr. Franklin's response to that report.

Dr. Franklin testified on his own behalf. His testimony was somewhat inconsistent and often difficult to extract. In terms of credibility, the Committee had some doubts and concerns with Dr. Franklin's testimony. He frequently attempted to avoid giving a direct or consistent response to the examination and questions posed by College counsel. The Committee was satisfied with the credibility of the other witnesses.

1. Evidence Concerning the Allegation of Failure to Meet the Standard of the Profession

(a) Record-keeping

It was alleged that Dr. Franklin failed to meet the standard of practice in record-keeping for all of the 28 charts that were reviewed. This allegation was supported by the College's expert Dr. X, who testified to Dr. Franklin's failure in the following respects:

- i. not recording significant negative findings or positive findings in sufficient detail;
- ii. not recording visual acuity with prescribed glasses;
- iii. not documenting follow-up care properly;

- iv. not documenting whether or not patients were taking medications (only noted in 17 of 28 charts);
- v. not documenting ocular history in eight charts;
- vi. documenting chief complaint in only eight of 28 charts;
- vii. not recording allergies in any charts; and,
- viii. not recording addresses in any charts.

Dr. W, the defence expert, agreed with the majority of Dr. X's evidence and opinions regarding Dr. Franklin's record-keeping. Dr. W agreed that Dr. Franklin did not meet the standard of care with respect to his record keeping. Dr. Franklin himself eventually agreed that his charts for these 28 patients were not acceptable. Defence counsel conceded that Dr. Franklin's charting practices fell below the standard of the profession.

(b) Tonometry

i. Performing scleral tonometry as opposed to corneal tonometry to test intraocular pressure in his patients.

It was alleged that Dr. Franklin failed to meet the standard of practice in that he performed scleral tonometry rather than corneal tonometry to test intra-ocular pressures in his patients. The evidence in respect of this allegation is as follows:

- Dr. X testified that scleral tonometry is not an acceptable measure of intraocular pressures.
- Dr. W, who has been a peer assessor for the College for the past ten years, did not support the use of scleral tonometry to measure intra-ocular pressures. He testified that he is not aware of any other physician who performs scleral tonometry. On cross-examination he said that after reviewing material received from Dr. Franklin's counsel, including the 28 charts at issue, he had formed the opinion that Dr. Franklin's method of tonometry was not acceptable and that he did not meet the standard of care with respect to this method of tonometry. He said that the standard of care requires measurement of intraocular pressures at the cornea. However he later

refused to agree that the only acceptable measure of pressures was corneal. He professed unfamiliarity with scleral tonometry and said that he did not know if it would be acceptable practice to perform tonometry at the sclera. He acknowledged making a notation of “useless??” next to a passage in a letter from Dr. Franklin’s former counsel in which the counsel described Dr. Franklin’s use of scleral tonometry; he said that the notation did not mean that he thought scleral tonometry was useless, but rather he was questioning whether it was an accurate way to determine intraocular pressure. Finally he testified that he would defer to Dr. X, given Dr. X’s expertise in glaucoma, or some other glaucoma specialist, on whether performing scleral tonometry was acceptable, and that he was not equipped to opine on it.

- Dr. X testified that he was not aware of any evidence that scleral pressure is a multiple of corneal pressure.
- Dr. Franklin acknowledged in his evidence that he performed scleral tonometry on patients at the relevant time. Dr. Franklin testified that he believes that scleral pressure is approximately double corneal pressure. He made reference to the fact that he had been told this by somebody 25 years ago. When he was specifically asked about research studies in this regard, he replied that some people in India had measured pressures on cadavers, but he presented no evidence in support of this.
- Dr. Franklin stated that he prefers to use scleral pressure readings because eye drops are not required, there is less pain and little risk of corneal damage. Dr. X testified that patients do not experience pain with corneal tonometry, and the risk of damage to the cornea is extremely minimal if corneal tonometry is properly done.
- Dr. Franklin was asked about a question that he posed to the “Consultant’s Corner” of the website of the Canadian Journal of CME in February 2006 asking, “What is scleral tonometry?” The answer provided by the consultant, Dr. V, was, “There is no true scleral tonometry.” This reply was not accepted by Dr. Franklin.

ii) Not conducting tonometry on all cooperative patients or, in the alternative, those over age 40.

It was alleged that Dr. Franklin failed to meet the standard of practice by not conducting tonometry on all cooperative patients or in the alternative on those over age 40. The evidence in respect of this allegation is as follows:

- Dr. Franklin testified in chief that, during 2003 and 2004, the time period reviewed, he would only do tonometry when he thought it was medically necessary, for example where there was a family history of glaucoma, or if the patient had diabetes or was “getting on in years”, or if there were significant changes in refraction which were not easily explainable, or if there were symptoms that raised a suspicion. On cross-examination, first he changed his story, denying that he had tested pressures on those who were “getting on in years”. He said that it would depend on medical necessity for the individual, and he called the term “getting on in years” “very vague”. Later, he acknowledged that whether a patient was getting on in years was, in fact, one of the factors he would have considered. When asked what it meant, he obfuscated- he said it would be earlier than the 70’s, “sort of the 50’s”, “over 45”. However he then said that he would not necessarily have tested the eyes of someone over 45 if he thought there was no medical necessity, unless they asked. He said that he probably would not have offered to test intraocular pressures in patients over 50 if he thought there was no medical necessity to do it, unless they requested it, and he said that he likely would not have tested them in patients over 55. He said that he probably would have offered screening at age 60, he might have started offering it at age 55, that it really did not depend on chronological age but on the effect of the aging process on the particular patient, and that he had no fixed rule.
- Dr. X testified that, in his opinion, tonometry should be conducted on all patients who are cooperative.
- Dr. W testified that the standard of practice for a general practitioner performing ocular visual assessments requires that tonometry be performed on all patients over

40. In Dr. W's opinion, all patients over age 40 and those in high-risk groups must have their intraocular pressures tested. He agreed that it would be unacceptable not to do tonometry on a patient who was over 40 years of age.

- Both experts agreed that the validity of tonometry measurement as a tool for screening glaucoma is by no means definitive. There is a significant percent of false negatives and false positives, hence, other factors must be considered including corneal thickness, which requires testing that would not be expected from a primary health provider.
- Two of the patients who testified. Ms. C and Ms. A, were over 40 years of age at the time Dr. Franklin examined them. Ms. A testified that Dr. Franklin did not test her for glaucoma, and Dr. Franklin acknowledged that he did not test her intraocular pressure. Ms. C testified that Dr. Franklin did not use a pen-like instrument during his examination of her. (Dr. Franklin testified that he used a pen-like instrument to conduct scleral tonometry.) She also denied that Dr. Franklin touched her eyes at all. A third patient who testified, Ms. D, was 24 years old at the time of the examination. She also denied having a pen-like instrument touching her eye or pointed toward her eye. It appeared from the testimony of patient Ms. B, who also over age 40 at the time of the examination, that Dr. Franklin did not perform tonometry on her either, but she was less clear in her testimony on this than the others. The charts of all four of these patients Ms. C, Ms. A, Ms. B, and Ms. D do not record any tonometry results.

Dr. Franklin's counsel conceded in closing submissions that Dr. Franklin did not routinely screen patients over the age of 40 by using tonometry at the relevant time, and accordingly that Dr. Franklin's practice did not satisfy the standard of practice at that time.

(c) Referring Patients for Follow-up Care

It is alleged that Dr. Franklin failed to meet the standard of practice of the profession by not providing appropriate follow-up care in respect of three specific patients. The evidence in respect of this allegation is as follows:

Mr. E

- Dr. X testified that Dr. Franklin's care of Mr. E was unacceptable because of elevated pressures and no mention of the patient being informed that this needed further review. He said there was a high risk of damage to his eyes because of the elevated pressures.
- Dr. Franklin saw Mr. E in November 2004. The chart indicates that there are elevated intraocular pressures and there is no mention of a referral or informing the patient of this fact. Mr. E testified that during the November 2004 assessment, Dr. Franklin did not refer him to anyone and did not ask him to follow-up with a specialist.
- Dr. Franklin testified in chief that Mr. E's tonometry readings were "on the upper side of normal", and that he concluded further action was required, although he did not feel that urgent attention was required. He said that Mr. E mentioned that he was seeing an optometrist, Dr. U, and he recommended that he continue with Dr. U, who would have "known the story from several years before". He said that he recommended that Mr. E see Dr. U rather than referring him somewhere else because it was good to have a professional who had seen the patient and his records before. However, when Dr. Franklin was first notified of Dr. X's concern about his not referring Mr. E, he responded by way of a letter from his lawyer dated September 13, 2005 (Exhibit 12), that he had no independent recollection of Mr. E's visit but, based on the tonometry reading, he would have insisted on follow-up specialist care. The letter also said that Dr. Franklin did not make a referral because Mr. E said that he was already attending a Dr. U. At the hearing some 19 months later, Dr. Franklin stated that after having seen him testify, he

now recalled his discussion with Mr. E. He testified that Mr. E told him that he was still seeing Dr. U and, hence, he made no follow-up arrangements for him. There is nothing in the chart to indicate that Mr. E told Dr. Franklin that he was still seeing Dr. U. Mr. E testified that he told Dr. Franklin he had last seen Dr. U about five years before. Dr. Franklin agreed that it would not have been acceptable to fail to refer this patient for follow-up care.

Ms. A

- Ms. A was one of two patients who complained to the College with regard to the care she received from Dr. Franklin. She had paid \$60.00 for the ocular visual assessment that she regarded as not satisfactory. Her patient chart with Dr. Franklin did not record a complete history and examination. The prescription for her new glasses proved to be unsatisfactory for her. When she returned to Dr. Franklin, he provided her with a referral note that stated, “early cat (cataract) OS (left eye), headache history 25 yrs, for Stratus”. Stratus is an imaging device for retinal thickness and is not covered by OHIP. It is not used to diagnose or manage cataracts or headaches. A stamp on the referral note advised the patient to “consult family doctor about free referral to ophthalmologist.”
- Dr. X testified that there is no indication in Ms. A’s chart regarding why this test would be required. He also stated that the note was lacking in detail and simple basic information with regard to ophthalmologic consultation or the urgency of referral. He expressed the opinion that Dr. Franklin did not refer Ms. A for follow-up care appropriately.

Ms. B

- Dr. Franklin provided Ms. B with a referral note for an ophthalmologic assessment. This noted Meniere’s disease with blurred vision. A refraction prescription was also provided for Ms. B. There was no additional detail with regard to the reason for the referral. Dr. X testified that in his opinion the care that Dr. Franklin provided to Ms. B did not meet the standard of the profession. He stated further that he was not

aware of any reason why the patient should be referred to an ophthalmologist for Meniere's disease, which is an inner ear disease unrelated to the eyes. He also testified that the referral note was unhelpful because it was insufficiently detailed, and that an ophthalmologist would not understand the reason for the referral or its urgency. Dr. Franklin testified that he was concerned that Ms. B might have a brain tumour (or intra-cranial pathology), but the records did not substantiate this. Ms. B filed a letter of complaint with the College expressing concern about the eye examination conducted by Dr. Franklin in April 2003, for the purpose of obtaining a prescription for eyeglasses. She was apparently unhappy with the prescription that did not adequately correct her vision.

(d) Conduct of the Remainder of the Ocular Visual Assessment

It is alleged that Dr. Franklin failed to meet the standard of practice of the profession in respect of the remainder of his ocular visual assessments. The evidence relevant to this allegation is as follows:

- Dr. X testified that Dr. Franklin's poor record-keeping raises serious doubts about the quality of Dr. Franklin's eye examinations.
- Dr. W agreed that, because of the poor records, it was difficult to assess whether Dr. Franklin's conduct of his eye examinations met the standard of care. That is because one has to make assumptions about what examinations were done and were not done.
- Dr. X testified that the consequences of doing incomplete examinations vary as to what may be missed, and may include asymptomatic glaucoma, hypertension, diabetes, and intraocular tumours, which may be asymptomatic. Dr. X characterized the consequences of an incomplete eye examination as serious. He elaborated on the basic elements of any eye examination for any person doing a primary eye evaluation including a refracting general physician such as Dr. Franklin. The examination expected would include the following elements:

- a) History and chief complaint;
- b) Visual acuity and refraction including visual acuity with glasses;
- c) Examination of the anterior segment of the eye, including the use of a slit lamp;
- d) Tonometry to measure the intraocular pressure at the cornea, not the sclera; and,
- e) Retinal examination of the optic disk, macula, retinal vessels, with dilation of the pupils.

Dr. W agreed that the above components are essential elements of an eye evaluation performed by a general physician. He did however differ with regard to dilating the pupils, and did not regard it as necessary for a family practitioner's assessment. He also noted that it was not required in the OHIP schedule.

- Dr. Franklin testified that he used an autolensometer to assess the patient's current prescription for eyeglasses. He used an autorefractor followed by trial lenses. He testified that he did an external eye exam followed by a retinal exam using an ophthalmoscope with a slit lamp aperture. He performed scleral tonometry in cases where he felt it was indicated. His practice was to chart only significant positive findings.
- Patients Ms. B, Ms. D, Mr. E, Ms. C and Ms. A gave evidence about the eye examinations that Dr. Franklin conducted on them. Their evidence did not confirm that Dr. Franklin conducted anterior or posterior segment exams on them (although a left cataract was noted in Ms. A's chart).

In her closing submissions, counsel for the College stated that the record was not clear at times as to which examinations Dr. Franklin performed and which he did not. She stated that the College was therefore not asking for a positive finding that Dr. Franklin failed to perform these other eye examinations (ie., other than tonometry).

2. Evidence Concerning the Allegation of Incompetence

Dr. Franklin is alleged to be incompetent as defined by subsection 52(1) of the Code, in that his care of patients displayed a lack of knowledge, skill or judgment or disregard for the welfare of his patients of a nature or to an extent that demonstrates that he is unfit to continue to practise or that his practice should be restricted.

Dr. X's Evidence

Dr. X testified that:

- Measuring intraocular pressures using scleral tonometry as opposed to corneal tonometry reflects a lack of knowledge, skill and judgment and disregard for patient welfare. This raises doubts as to whether Dr. Franklin is capable of testing corneal tonometry. Glaucoma could be missed.
- Conducting an ocular visual examination without measuring intraocular pressures reflects a lack of knowledge, skill and judgment and disregard for patient welfare. Glaucoma could be missed.
- A practice of only testing intraocular pressures in patients over age 40 or in a recognized genetic risk group, as opposed to all patients, would reflect a lack of knowledge, skill and judgment and disregard for the welfare of the patient.
- Dr. Franklin's records reflect a lack of knowledge and judgment about what items are important to document. Poor charting does not provide a useful picture of the patient's ocular health, which could lead to a delay in treatment and therefore reflects disregard for patient welfare.
- It is Dr. X's opinion that, because Mr. E had elevated pressures, a failure to refer this patient who was at risk, reflected a lack of knowledge, skill and judgment and disregard for patient welfare.

- Dr. Franklin gave Ms. A an incomplete note requesting Stratus imaging that was not indicated for either cataract or headache and which was not covered by OHIP. Dr. Franklin's follow-up care of Ms. A reflected a lack of knowledge, skill and judgment and disregard for the welfare of this patient.
- The referral note given to Ms. B does not provide a reason for referral as Meniere's disease is not an ocular disease. This note reflects a lack of knowledge, skill and judgment and disregard of the patient's welfare.

Dr. W's Evidence

Dr. W testified that:

- He would not agree that using scleral tonometry as opposed to corneal tonometry would reflect a lack of knowledge or judgment about the appropriate method of measuring tonometry, because of his lack of familiarity with scleral tonometry. However he did finally agree that if a physician decides not to measure tonometry at the cornea, that could reflect a lack of knowledge about the right way to test intraocular pressures.
- Not conducting tonometry on all patients over age 40 could reflect lack of knowledge, it would reflect a lack of judgment and it would reflect disregard for patient welfare.

Dr. Franklin's Evidence

- In response to the above-listed concerns, Dr. Franklin testified that he has changed his practice since the relevant time (2003-2004). He testified in chief, that he now "offers" tonometry to everyone over age 40 (he pointed out that it is no longer covered by OHIP), if they consent. He added that anyone can have tonometry if they want it. He recommends tonometry to those with a maternal genetic history of glaucoma, those in certain ethnic groups, and those who present with abnormal symptoms. The method of tonometry that he now uses is corneal tonometry, unless a person has contraindications. However, he continues to believe that it is acceptable to use scleral tonometry rather than corneal tonometry to test intraocular pressure. He

does corneal tonometry because his instructions in this case from the College and Dr. X have been to do corneal tonometry. He agrees that corneal is also acceptable, and that corneal is better.

- Dr. Franklin also testified that he now charts all patient visits using the template that he had developed, and has been doing so since October 2006. Both Dr. X and Dr. W agreed that the template was acceptable. Dr. X further testified that, if Dr. Franklin was following the template in his patient assessments and documenting that he was doing so, and if he was measuring intraocular pressure at the cornea, he would, subject to an exception concerning pupil dilation, be meeting the standard of care and demonstrating regard for the welfare of his patients. Dr. W testified that if Dr. Franklin charted everything on the template and did everything he charted properly, it would comprise a good record of a satisfactory assessment, and he would meet the standard of care.
- On cross-examination, Dr. Franklin acknowledged that in March 2004, his then-lawyer told the Health Professions Appeal and Review Board that Dr. Franklin had changed his practice of only making a note of negative test results on his charts. (The evidence is confusing. Apparently, Dr. Franklin's lawyer said "negative", and Dr. Franklin stated on cross-examination that up until March 2004 it had been his practice to make note of only negative test results but later testimony was that Dr. Franklin's practice was only to record positive findings, not negative findings.) He also acknowledged being aware as of that time that the College expected him to record all significant negative findings on his charts. He was then shown the charts of numerous patients whom he saw after March 2004. He was asked specifically about one of those charts. He acknowledged that he had not recorded any negative findings on the chart, nor any positive or negative findings from anterior or posterior segment examinations, nor any indication of intraocular pressure being tested. He also acknowledged that he had not recorded any negative findings on the chart for Mr. S, whom he also saw after March 2004. He further acknowledged that in September 2005 (Exhibit 12) his then-lawyer had advised the College that Dr. Franklin's general

practice was to note only positive findings, but that going forward, negative findings would also be noted on the template. However he said that the letter should have said that at that time he recorded “mainly” positive findings rather than “only”. He also acknowledged that he only began using the template as of about October 2006, over a year later, although he said that in the interim he began using plastic stamps that he obtained from another clinic that he thought would improve the quality of the charts, and he used “Coldwell” charts.

In respect of follow-up care, Dr. Franklin testified that if he sees an abnormality in an eye examination, he would suggest the patient see their family doctor who would refer them to an ophthalmologist. He also testified that if he becomes concerned as a result of a tonometry test, if the matter is urgent he refers the patient to the hospital, but if the reading is at the upper range of normal, he refers the patient to his or her family doctor with a note indicating the cause of his concern.

FINDINGS AND REASONS

The Committee carefully reviewed the evidence presented by testimony of the various witnesses and by means of multiple exhibits. The Committee found that Dr. Franklin’s evidence in the main was inconsistent and problematic.

According to Dr. Franklin, his poor record-keeping was the College’s fault because the College had not provided him with a template for his eye examinations. Dr. Franklin testified that he had repeatedly requested a template during 2005 but did not receive a reply. He acknowledged, however, that he had received Dr. X’s report of September 28, 2005, in which Dr. X commented that he had reviewed Dr. Franklin’s template and, subject to one comment concerning pupil dilation, thought it would provide excellent documentation of an eye examination. Dr. W testified that he was not aware of any such College template and has conducted many satisfactory peer assessments of physicians who did not have a College template.

Dr. Franklin’s prescription pads for the period from 2003 to 2004 stated, “Practice Limited to Eye Exams.” In fact, Dr. Franklin’s practice was not limited to eye

examinations during this period. He testified that approximately 75% to 80% of his practice was devoted to eye examinations. He blamed the College requirements and stated that he was obliged to make this statement on his prescription pad. This was not supported by any of the evidence.

Dr. Franklin's C.V. has been exaggerated. It indicates that he is a member of the Glaucoma Research Society. However, he testified that there was only an invitation to an annual speaker's dinner with no other involvement. He is also listed as a member of the Jung Foundation but in effect is only a donor. Dr. Franklin testified that the Glaucoma Society and Jung references should be removed from his C.V.

Dr. Franklin's September 2005 response, by way of a letter from his then-lawyer, to the section 75(b) report from Dr. X, indicated that his general practice at that time was to note "only positive findings" and that "going forward, negative findings (would) also be noted." When questioned why he continued to note only positive findings despite his lawyer's representation in March 2004 that he would change his practice, Dr. Franklin said his September 2005 response was inaccurate and he blamed his former counsel for the inaccuracy.

Dr. Franklin was found by the Committee to lack insight and he did not always accept opinions that did not accord with his views:

- Notwithstanding that he testified that doing corneal tonometry is not at all difficult, Dr. Franklin disagreed with the Canadian Ophthalmological Society that tests for glaucoma including corneal tonometry are "quick and painless";
- Dr. Franklin disagreed with the answer he received from "Consultant's Corner" of the Canadian Journal of CME in February 2006 that "there is no true scleral tonometry" Without any reasonable explanation, he continued to insist that scleral tonometry was acceptable even after receiving the answer, and he continued to perform scleral tonometry after that.

1. Failed to Meet the Standard of the Profession

In considering the allegation that Dr. Franklin has committed an act of professional misconduct in that he failed to meet the standard of the profession, the Committee was mindful of the fact that the College bears the onus of proof and that the standard of proof is on the balance of probabilities. Given the seriousness of the allegations, and the possible consequences from a finding, this requires that the proof must clear and convincing and based on cogent evidence (*Bernstein v College of Physicians and Surgeons* (1977)).

The evidence admitted at the hearing was carefully considered and assessed. The review of the records of the 28 cases, which included the two complainants, and Dr. Franklin's own testimony, were particularly useful in conjunction with the opinions of the two experts.

The Committee finds that Dr. Franklin committed an act of professional misconduct in that he failed to meet the standard of the profession in the following respects:

- a) Dr. Franklin's record-keeping was deficient and fell below the standard of the profession in all 28 cases that were the subject matter of the allegations against him. This was supported by the testimony of Drs. X, W and Franklin and conceded by counsel for Dr. Franklin. In particular, of the 28 charts reviewed by Dr. X, details with respect to history and eye examinations were lacking in the majority.
- b) Dr. Franklin fell below the standard of the profession in his conduct of tonometry in that he:
 - i) Performed scleral tonometry rather than corneal tonometry to test intraocular pressures on four of the 28 patients at issue; and,
 - ii) Failed to conduct tonometry on all cooperative patients over age 40.

Defence counsel submitted that Dr. W is better situated to opine on the standard of practice of a general physician who does refraction and ocular visual assessments. The Committee considered this to have merit. Nevertheless, the Committee

determined that, in many respects, Dr. W's evidence, particularly with regard to tonometry, was consistent with Dr. X's evidence. The Committee accepted the opinion of Dr. X, deferred to by Dr. W, regarding the use of corneal tonometry, rather than scleral tonometry, to test intraocular pressure. The Committee accepted Dr. W's peer opinion that the standard for a general practitioner who conducts ocular visual assessments is to conduct tonometry on all patients over 40 and on patients in high risk groups. The Committee finds that Dr. Franklin failed to maintain the standard of the profession in conducting scleral tonometry and in not conducting tonometry on all co-operative patients over age 40.

- c) Dr. Franklin failed to provide appropriate follow-up care to three specific patients, namely Mr. E, Ms. A and Ms. B.

The Committee finds that Dr. Franklin did not refer Mr. E for follow-up care. As indicated, there is no mention of a referral or informing the patient of this fact in the patient chart. Dr. Franklin testified that he did not refer Mr. E because Mr. E told him he was seeing Dr. U. Mr. E testified that he told Dr. Franklin that he had last seen Dr. U about five years before. The Committee accepts the evidence of Mr. E over Dr. Franklin on this point. (That said, the Committee accepts that Dr. Franklin may have mistakenly concluded at the time he saw Mr. E that in fact he was still seeing Dr. U, even though, as we have found, Mr. E did not tell him that.) The Committee also accepts the opinion of Dr. X that, because of elevated pressures, a failure to refer Mr. E for follow-up care was unacceptable.

Regarding Ms. A, the Committee accepted Dr. X's opinion that there was no indication in the chart regarding why she would require a Stratus test and that the referral note was lacking in detail and basic information, and that Dr. Franklin did not refer Ms. A for follow-up care appropriately.

The Committee concluded that Dr. Franklin's referral of Ms. B to an ophthalmologist for Meniere's disease lacked a rationale. The Committee found that Dr. Franklin did not meet the standard of the profession in respect of this referral. There was inadequate detail in the referral note, and the patient chart does not substantiate Dr.

Franklin's testimony that he was concerned that Ms. B might have a brain tumour. If Dr. Franklin did have a concern that Ms. B might have a brain tumour, his failure to provide a substantive note to the ophthalmologist also did not meet the standard of the profession.

These findings are all clearly supported by the evidence that has been presented by the various witnesses including the experts for the College and the defence as well as the five patients who testified and the records of other patients as noted.

The Committee was mindful of the fact that Dr. Franklin is a general physician who performed ocular visual assessments for patients primarily seeking prescription eyeglasses. These assessments were performed in the facilities provided by stores that sold eyeglasses. The majority of Dr. Franklin's patients presented with simple refractive errors. Dr. Franklin did not provide care for patients who presented with acute visual problems. He did not provide follow-up care and, essentially, referred patients to their family physician when indicated. The Committee considered all of these factors in arriving at its findings.

Accordingly, the Committee finds that the College has met its onus of proof on the *Bernstein* standard that Dr. Franklin committed an act of professional misconduct in that he failed to meet the standard of the profession as set out above.

d) The College in final argument submitted that it is not asking for a finding that Dr. Franklin did not do other eye examinations, as had been alleged. The College submitted that the Committee should make a finding that in many of the cases it is not clear, on the evidence, what kind of exams were done or not done. The Committee makes this finding.

2. Incompetence

The College alleged that Dr. Franklin is incompetent as defined by subsection 52(1) of the Code, in that his care of patients displayed a lack of knowledge, skill or judgment or disregard for the welfare of his patients of a nature or to an extent that demonstrates that he is unfit to continue to practise or that his practice should be restricted.

In addressing this issue, the Committee was again mindful of the rule in the *Bernstein* case that the College bears the onus of proof, and that the standard of proof is on the balance of probabilities. Given the seriousness of the allegations, and the possible consequences from a finding, the proof must be clear and convincing and based on cogent evidence.

The Committee considered, and has unanimously accepted, Dr. Franklin's evidence that as of October 2006 he has changed his practice on charting to comply with the template that he developed. The Committee notes that this template is acceptable in the whole to both the College's expert and to Dr. Franklin's expert, with the sole exception being the need for pupil dilation. The Committee gives more weight to the opinion of Dr. W on this point, given his position as a peer assessor for the College of general practitioners who perform eye examinations. The Committee thus finds the template meets the standard of the profession.

Similarly, the Committee has unanimously accepted Dr. Franklin's evidence that he now performs corneal tonometry rather than scleral tonometry, and that he now routinely offers corneal tonometry to everyone over age 40 and recommends tonometry to those with a maternal genetic history of glaucoma, those in certain ethnic groups, and those who present with abnormal symptoms as well as to diabetics. This meets the standard as enunciated above with regard to corneal tonometry and also meets the age standard as stated by Dr. W, which was accepted by the Committee.

The Committee reasoned that, during the period 2003 to 2004, these aspects of Dr. Franklin's ocular visual assessment may have been indicative of incompetence. However, and although the Committee had some reservations about Dr. Franklin's credibility, it accepted his testimony with regard to his current practice of recordkeeping

and use of corneal tonometry. The Committee regarded these changes to Dr. Franklin's practice as significant.

Dr. X expressed concern as to whether Dr. Franklin was capable of performing corneal tonometry. Based on Dr. Franklin's evidence as to how he performs corneal tonometry, the Committee accepted that he was capable of performing this procedure.

While the Committee has found that Dr. Franklin fell below the standard of the profession in respect of his follow-up care of the three patients referred to above, the Committee was not satisfied that his follow-up care in respect of those patients displayed a lack of knowledge, skill or judgment or disregard for the welfare of the patients of a nature or to an extent that demonstrates that he is unfit to continue to practise or that his practice should be restricted. In addition, the Committee was satisfied based on Dr. Franklin's testimony that his current practice is to send patients to their family doctors for referral to an ophthalmologist if he sees an abnormality during an eye examination, with a note indicating the cause of his concern.

A Committee can consider the passage of time since the dates of the conduct that has been found to be deficient, and whether there is evidence of insight into the past deficiencies and any change in the practice of the physician. The Committee in this case has concluded that there was a clear failure by Dr. Franklin to meet the standards of the profession in 2003 and 2004, and therefore that he committed an act of professional misconduct. However on the basis of the evidence concerning the changes to his practice since that date, the Committee does not find Dr. Franklin to be incompetent at the present time.

In some respects, this case is similar to the case of *Adamo (Re)* [2005] O.C.P.S.D. No. 22 at paragraphs 64-66. It is not sufficient for a finding of incompetence that a physician committed acts of professional misconduct in the past. In *Adamo*, the Committee stated (at paragraph 64):

A physician may be found to have committed acts of professional misconduct for failure to maintain standards but, if he has demonstrated insight into his failure . . .

and has changed his practice to meet present standards, he would not be found to be incompetent.

Dr. Franklin has indicated some insight, notably with regard to the changes that he has made in his ocular visual assessments and record-keeping. As noted above, the Committee accepts his evidence that he now performs corneal tonometry and that he no longer performs scleral tonometry on patients. Nevertheless, the Committee is troubled by the fact that Dr. Franklin continues to express the view that scleral tonometry is acceptable notwithstanding the extensive evidence that it is not.

Summary of Findings

1. The Committee finds that Dr. Franklin has committed an act of professional misconduct, in that he failed to meet the standard of the profession in the following respects:
 - i) Dr. Franklin failed to maintain adequate patient records and charts in the care of 28 patients, including the complainants Ms. A and Ms. B.
 - ii) Dr. Franklin conducted scleral tonometry rather than corneal tonometry to test intraocular pressures on four of these patients;
 - iii) Dr. Franklin failed to conduct tonometry on all co-operative patients over age 40 as part of his ocular visual assessments.
 - iv) Dr. Franklin failed to provide appropriate follow-up care to Mr. E, Ms. A and Ms. B.
2. The Committee does not find that Dr. Franklin is currently incompetent as alleged.

Therefore, the Committee directs the Hearings Office to arrange a date for a penalty hearing at the earliest possible date in respect to the findings made.

NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Alexander Franklin, this is notice that the Discipline Committee ordered that there shall be a ban on publication or disclosure of the identity, and any information that would disclose the identity, of the patients who are referred to during the hearing or in any other document 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 to a fine of not more than \$10,000 for a first offence and not more than \$20,000 for a subsequent offence.

Indexed as: Franklin (Re)

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

IN THE MATTER OF a Hearing directed
by the Complaints Committee and the Executive Committee of
the College of Physicians and Surgeons of Ontario
pursuant to Section 26(2) and Section 36(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. ALEXANDER FRANKLIN

PANEL MEMBERS:

DR. J. SCHILLINGER (CHAIR)
R. PRATT
DR. O. KOFMAN
M. POWER

Hearing Dates:	October 10, 2007
Decision Date:	December 6, 2007
Release of Written Reasons Date:	December 6, 2007

PUBLICATION BAN

PENALTY AND REASONS FOR PENALTY

The Discipline Committee of the College of Physicians and Surgeons of Ontario (the “Committee”) heard this matter at Toronto on December 11 and 12, 2006 and April 16 to 18 and 23, 2007. At the conclusion of the hearing, the Committee reserved its decision. On July 19, 2007, the Committee delivered its written decision and found that Dr. Franklin has committed an act of professional misconduct, in that he failed to meet the standard of the profession in failing to maintain adequate patient records and charts in the care of 28 patients, including the complainants Ms. A and Ms. B; in respect of his conduct of tonometry; and in his failure to provide appropriate follow-up care to three patients.

The Committee did not find that Dr. Franklin is currently incompetent as alleged.

The Committee heard evidence and submissions on penalty and costs on October 10, 2007, and reserved its decision. Dr. Franklin was not present during the penalty phase of the hearing, but was represented by counsel. In accordance with a timetable that it set on October 10, it received further written submissions from counsel for both parties on the issue of costs thrown away on an adjournment of the hearing in October 2006.

EVIDENCE AND SUBMISSIONS ON PENALTY

Counsel for the College requested costs and a penalty that consisted of the following components:

1. Suspension of Dr. Franklin’s certificate of registration for six months, three months of which will be suspended conditional on Dr. Franklin successfully completing, at his own expense, the College’s “Medical Record-Keeping for Physicians” course.
2. The Registrar impose terms, conditions and limitations on Dr. Franklin’s certificate of registration that include a preceptorship, re-inspection of his practice and that Dr. Franklin abide by any recommendations of the inspector.

3. A reprimand.
4. Payment of costs to the College in the amount of \$26,625, broken down between costs of the hearing (\$15,000) and costs relating to a late adjournment of the hearing in October 2006 (\$11,625).
5. The results of this proceeding be included in the register.

Counsel for Dr. Franklin submitted that there should be no suspension but said that if the panel was inclined to order a suspension, more than one month would be out of proportion to the panel's finding. He did not agree with and questioned the need for a medical record-keeping course, as the Committee had accepted Dr. Franklin's evidence with regard to his current practice.

Counsel for Dr. Franklin submitted that if the panel was inclined to order the suggested preceptorship, as well as the re-inspection within six months, that would be reasonable (although he had no instructions to accept it). He did not agree with the College's request for a reprimand as, in his view, the disciplinary process itself was punishment enough. He also argued against the College's request for costs of the hearing and of the late adjournment and he proposed that no costs should be awarded.

College counsel submitted that the penalty the College proposed was appropriate in view of the finding that Dr. Franklin had committed an act of professional misconduct in that he failed to meet the standard of the profession. She submitted that the penalty would act as a specific deterrent to Dr. Franklin and a general deterrent to the profession.

Counsel for the College further submitted that the penalty the College requested took into account the mitigating factor that Dr. Franklin had no previous discipline findings during his many years of general practice. It also took into account aggravating factors that included the potential for harm in that glaucoma, diabetes mellitus and intraocular tumour could have been overlooked. Counsel for Dr. Franklin submitted that no harm came to

Dr. Franklin's patients. In reply, College counsel submitted that only five of the twenty-eight patients testified and there was no evidence one way or the other as to whether any of the remaining patients had been harmed. She further submitted that what matters is not actual harm, but the care that was given to patients. She further submitted that potential harm to a patient was a consideration.

Both counsel presented a brief of authorities of discipline cases where the findings involved a failure to maintain the standard of practice. For each case, counsel referred to whether a suspension was ordered and, if so, to the period of suspension. The penalty orders ranged from no suspension to revocation. In several cases in which a suspension was ordered, the suspension was in the three to six month range. No case was clearly comparable to Dr. Franklin's case but the references served as a guide to the Committee.

College counsel submitted that there was a need for a preceptorship for protection of the public. This was particularly important in view of Dr. Franklin's use of scleral tonometry rather than the accepted corneal tonometry. She noted that Dr. Franklin continued to show lack of insight in this regard despite his evidence that he had changed to corneal tonometry. In addition, she noted the Committee's finding that in many cases, it was not clear on the evidence what kind of examinations were or were not done, and to the quality of those examinations. She submitted that re-inspection of Dr. Franklin's practice was required to determine whether he was continuing to address the multiple problems that were referred to in the Committee's findings.

In support of her request for a reprimand, College counsel submitted that the Committee had ordered reprimands in other cases in which members had been found to have breached the standard of practice. She further submitted that a reprimand, in conjunction with a suspension, would serve as both a specific and general deterrent.

COSTS

The issue of costs was divided into two components. College counsel requested hearing costs of \$15,000 based on \$2,500 per day for six days. Defence counsel submitted that

there should be no costs awarded of the hearing as the allegation of incompetence, which was one of the two allegations against Dr. Franklin, had not been proved. He submitted that the allegation of incompetence was the more serious allegation and that the finding of failure to meet the standard of the profession was relatively minor. He submitted that, in the case of *CPSO v. Adamo* (2005), costs were reduced from \$10,000 to \$5,000 as some of the allegations had not been proved. College counsel submitted that *Adamo* was not a standards case. The findings in *Adamo* included falsifying a record relating to the member's practice.

College counsel submitted that section 53.1 of the Code deals with costs at the end of the hearing. Section 53.1 says that in an appropriate case, the Committee may order a member, after a finding of professional misconduct or incompetence, to pay all or part of certain costs and expenses, including the College's legal costs and expenses incurred in conducting the hearing. Factors relevant to whether a matter is "an appropriate case" include the nature of the misconduct and the conduct of the physician during the hearing. College counsel stated that the CPSO tariff for the hearing at that time was \$3,650 per diem, but that the College's policy was to claim only \$2,500 per diem, for a total of \$15,000 for the six days of the hearing.

College counsel requested an additional amount of \$11,625 for costs thrown away due to a late request for adjournment in October 2006. Defence counsel provided written submissions on this issue, to which College counsel replied.

The Order of the Co-Chair of the Discipline Committee granting the adjournment indicates that Dr. Franklin brought a motion to adjourn the hearing on October 19, 2006, which was four days in advance of the scheduled commencement date of October 23, 2006. The hearing was scheduled for four and one-half days from October 23 to 27, inclusive. The costs of \$11,625 requested are comprised of the costs of the expert, Dr. X (\$750 per day x 2 days = \$1,500) and the per diems of the physician panel members (\$750 per day x 4.5 days x 3 physicians = \$10,125) for those cancelled days.

The Committee's late cancellation policy regarding physician members of the Committee, as stated in a memorandum dated October 5, 2007 from the Manager of the Hearings Office to the Legal Office at the request of the Legal Office states that: "A member of the Discipline Committee may bill for cancelled hearing dates when the member receives notification of cancellation within ten (10) business days of the scheduled commencement of the hearing."

In *CPSO v. Yar* (2007), which was primarily a standards case, Dr. Yar was ordered to pay costs for unnecessary delay, which resulted in two adjournments.

Defence counsel submitted that, while the Discipline Committee has the jurisdiction to order a member to pay costs thrown away following a finding of professional misconduct, it would be an error to exercise that jurisdiction in the circumstances of this case. His written submissions note that, under s. 53.1 of the Code, the Committee may order costs in an appropriate case. He submitted that this is not an appropriate case for the imposition of costs thrown away for several reasons:

- a) There is no allegation that Dr. Franklin acted improperly in the conduct of the hearing or that the adjournment was sought for frivolous or vexatious reasons. The adjournment was necessary to permit new counsel to prepare for the hearing.
- b) The College failed to mitigate its costs thrown away. Defence counsel submitted that he advised the Hearings Office on October 11, 2006 that he would require a short adjournment. He regarded this date as ten (10) business days prior to the scheduled hearing date of October 23, 2006. However, the Committee notes that the Order granting the adjournment confirms that Dr. Franklin brought his motion for adjournment on October 19, 2006. In any event, even October 11, 2006 was less than ten business days before the scheduled hearing date.
- c) Costs should not be routinely ordered in discipline cases, even where they would have been ordered by a court. Defence counsel submitted that there is no

provision whatsoever for payment by a member of costs thrown away as the result of an adjournment. Rule 5.01.01, which concerns adjournments, is silent as to the issue of costs. He further submitted that none of the letters sent by the College alerted Dr. Franklin to the possibility that costs might be ordered should the hearing be adjourned. However, Dr. Franklin's then-counsel was informed by way of letters from the Hearings Office in 2005 and 2006 that costs are incurred if scheduled hearing dates are cancelled with less than ten business days' notice to Committee members. He was also told prior to an adjournment that he requested in August 2006 that should the matter be adjourned at that date, the College would incur costs associated with the cancellation of panel members and that Dr. Franklin may also be required to pay costs of the College's expert witness.

Defence counsel also submitted that it is extremely unusual for a party to be ordered to pay the costs of a tribunal. However, in the case of *Freedman v. Royal College of Dental Surgeons*, the Discipline Committee of the Royal College of Dental Surgeons made an order for costs against a member that included per diems paid to Committee members, and the Divisional Court upheld the cost order.

DECISION AND REASONS ON PENALTY

The Committee accepted the need for a period of suspension of Dr. Franklin's certificate of registration. This was based on the gravity of the finding of failure to meet the standard of the profession. The deficiency in Dr. Franklin's record-keeping was noted in all of the 28 patient charts that were reviewed by the two experts and the panel. Dr. Franklin's conduct had the potential for causing harm to the public. A period of suspension would serve as a specific deterrent to Dr. Franklin and a general deterrent to the profession.

The mitigating factor that Dr. Franklin had no previous discipline finding was considered. On this basis, the Committee concluded that a four month suspension was appropriate and that two months of the suspension would be suspended on the condition that Dr. Franklin successfully complete the College's record-keeping course. The Committee

considered that it was necessary for Dr. Franklin to complete the record-keeping course in view of the finding that Dr. Franklin failed to meet the standard of the profession in respect of all of the 28 patient charts that were the subject matter of the allegations against him and that were reviewed by both experts and found to be deficient. The Committee concluded that completing this course will ensure that Dr. Franklin understands the need to keep complete and accurate records, and will ensure that he follows through with the changes that he has made to his record-keeping practices.

Also, the Committee concluded that terms, conditions and limitations should be imposed on Dr. Franklin's certificate of registration requiring that: 1) immediately following the suspension, Dr. Franklin participate in a preceptorship for a minimum of one week, or until the preceptor determines that Dr. Franklin meets the standard of care expected of the profession; and 2) Dr. Franklin undergo a re-inspection of his practice within three to six months of resuming practice and abide by any recommendations of the inspector, which could include additional re-inspection. The Committee noted the fact that defence counsel agreed that a preceptorship and a re-inspection would be reasonable although he had no instructions to accept them. The Committee accepted that a preceptorship and re-inspection would protect the public interest and serve in the rehabilitation of Dr. Franklin by ensuring that Dr. Franklin was maintaining the standard of the profession.

The Committee agreed with College counsel's request for a reprimand as this would serve as a specific deterrent to Dr. Franklin by impressing on him the seriousness of the proven allegations noting that he only reluctantly accepts the opinion of even his own expert, and as a general deterrent for the profession.

The Committee also concluded that this was an appropriate case for costs given its findings of serious breaches by Dr. Franklin of the standard of the profession. The Committee noted as well that many of the allegations against Dr. Franklin with respect to his charting and tonometry were accepted by Dr. Franklin's own expert and only conceded by Dr. Franklin, with reluctance, on cross-examination. However, the Committee concluded that it would only award costs of the hearing of \$10,000 rather than

the \$15,000 requested by College counsel. The Committee considered that this was an appropriate amount as it takes into account that not all of the allegations were proved.

The Committee also concluded that costs should be awarded to the College in the amount of \$11,625 for costs thrown away on the late adjournment. The Committee determined this amount after consideration of each counsel's oral and written submissions. The Committee noted that the late cancellation policy of the Committee allows for late cancellation costs to be paid to the physician panel members who receive notice of cancellation within ten business days of the scheduled commencement date of the hearing. The evidence was that the request for an adjournment in October 2006 was made less than ten business days before the scheduled date of the hearing. The evidence also was that, on August 8, 2006, the Co-Chair of the Discipline Committee ordered as a condition of a previous adjournment that Dr. Franklin pay to the College costs thrown away as a result of the adjournment in the amount of \$3,500, and that Dr. Franklin consented to this. The Committee concluded that this, along with the other documents referred to above, would strongly support the fact that Dr. Franklin was aware that the College would incur costs thrown away as a result of late adjournment requests.

The Committee accepted the argument of College counsel that this was an appropriate case to order costs based on the serious nature of the proven allegations. The Committee did not find that the College failed to mitigate its costs thrown away. The Committee concluded that pursuant to the late cancellation policy, the College incurred costs of \$10,125 for per diems payable to panel members. The Committee also accepted that the College incurred costs of \$1,500 for its expert. The Committee took note of the fact that in *CPSO v. Yar* (2007), the member was ordered to pay costs for unnecessary delay, which resulted in two adjournments. The Committee concluded that it was appropriate that Dr. Franklin pay these costs thrown away. In support of its claim to costs, the College relied on section 53.1 of the Code that includes a payment of all or part of the following costs and expenses:

- The College's legal costs and expenses which would allow for costs that the College paid to its expert.
- The College's cost and expenses incurred in conducting the hearing, which would allow the College to pay for the per diem costs to the physicians.

This authority was accepted by the Committee.

ORDER

The Discipline Committee therefore orders and directs that:

1. The Registrar suspend Dr. Franklin's certificate of registration for a period of four (4) months commencing one (1) week after the date of this Order. Two (2) months of the suspension shall be suspended on the condition that:
 - a) Dr. Franklin successfully completes, at his own expense, the College's "Medical Record-Keeping for Physicians" course, at the earliest available date, and provides proof that he has done so to the College.
 - b) Two (2) months after the suspension commences, the remaining two months of the suspension will be held in abeyance until one (1) week after the date of completion of the next available College "Medical Record-Keeping Course for Physicians". If Dr. Franklin submits proof of satisfactorily completing the course to the College within one (1) week of the course completion date, the balance of the suspension will be suspended. Should he fail to submit that proof within that one (1) week, the remainder of the two (2) months of the suspension will commence immediately on the date that is one (1) week after the course completion date.
2. The Registrar impose the following terms, conditions and limitations on Dr. Franklin's certificate of registration as of the date of this Order:

- a) That Dr. Franklin participate in a preceptorship, at his own expense, with a preceptor who is acceptable to the College, for a minimum period of one week, or until the preceptor determines that Dr. Franklin meets the standard of care expected of the general practitioner limited to eye examinations. The preceptor will sign an undertaking with the College in this matter and will report to the College after one (1) week, as to Dr. Franklin's capabilities with reference to eye examinations and, if he/she deems it necessary, on a monthly basis until such time as he/she deems Dr. Franklin capable to perform eye examinations to the standard of a general practitioner limited to eye examinations. The preceptorship will commence, if Dr. Franklin meets the conditions in paragraph 1 of this Order, immediately after the balance of the suspension is suspended. If Dr. Franklin fails to meet the conditions in paragraph 1 of this Order, the preceptorship will commence immediately following the completion in full of the full four (4) months suspension.
 - b) That Dr. Franklin undergo, at his own expense, a re-inspection of his practice by a physician selected by the College, no sooner than three (3) months and no later than six (6) months after the end of his preceptorship. The inspector shall report his findings to the College.
 - c) That Dr. Franklin shall abide by any recommendations of the inspector with reference to his practice. This could include the need for a further re-inspection, at Dr. Franklin's expense, should the inspector deem it necessary. This re-inspection would occur within six (6) months of the initial re-inspection.
3. Dr. Franklin is required to attend before the panel to be reprimanded on a date to be fixed by the panel of the Discipline Committee of the College, but no later than three (3) months from the date this Order becomes final.
 4. Dr. Franklin pay costs to the College in the amount of \$21,625.00 within 90 days of the date of this Order.

5. The results of this proceeding be included on the register.